Harrow Local Safeguarding Children Board

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Letter from the Chair:

A warm welcome from the Chair of the Local Safeguarding Children Board (LSCB) in Harrow, Deborah Lightfoot. This bi-annual newsletter brings news of Harrow's safeguarding learning – through the work of CDOP (Child Death Overview Panel) and local and national Learning Lessons and Serious Case Reviews (SCRs)

Ofsted recently carried out a thematic inspection of early help in Harrow. I was delighted that the dissemination of learning from our local case reviews was seen to be "noteworthy" and special mention was made of our use of dramatization of learning, which makes a clear impact on our frontline practice. Whilst there has been recent publicity around frontline practitioners having little time to read SCRs, it was great to hear that inspectors interviewed staff, who could explain about local learning in Harrow.

The Biennial analysis of Serious Case Reviews – has pointed out that best learning comes from the process of carrying out the review. Action plans do not equal learning. Often LSCBs are under pressure to make prolific recommendations. (**New learning from serious case reviews: a two year report for 2009-2011 (PDF)**; Brandon, Sidebotham, Bailey, Belderson, Hawley, Ellis, and Megson,DfE, 2012; ***Learning from Serious Case Reviews*** 2010 DfE Sidebotham, Brandon, Powell, Solebo, Koistinen, Ellis).

Sidebotham writes that " **lessons are so important they need to be repeatedly learnt",** and many lessons from national reviews are very similar. In Harrow, we have sought to disseminate learning through drama, cascade sheets to teams, the Monthly Chair's newsletter; using IMR (Individual Management Review) agency authors to spread learning, and our Conference and lunchtime seminars.

You can find our learning here http://www.harrowlscb.co.uk/serioucasereviews.aspx:

Deborah Lightfoot

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Learning and improvement

Our LSCB Conference in January focussed on Neglect, and Edi Carmi, overview author of many UK Case Reviews spoke. Neglect is often a hidden issue in our multi agency casework and is a feature of many child protection plans in Harrow, and has been a significant factor in our local learning case reviews. We looked at the parental concerns which may lead to neglect, such as substance misuse, mental health problems and learning difficulties, and domestic and sexual violence. Often practitioners overlook the neglect of teenagers, instead of noting their needs for appropriate supervision and continued care. Seeking the voice of the child was key.

Recent research has found that:

- neglect is much more prevalent in serious case reviews than had previously been understood (neglect was present in 60% of the 139 reviews from 2009-2011);
- neglect can be life threatening and needs to be treated with as much urgency as other categories of maltreatment;
- neglect with the most serious outcomes is not confined to the youngest children, and occurs across all ages;
- the possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mindset. Practitioners, managers, policy makers and decision makers should be discouraged from minimising or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift;
- the key aim for the practitioner working with neglect is to ensure a healthy living environment and healthy relationships for children.

  Practitioners need to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment. This includes the harm from neglect and the way that neglect can conceal other risks and dangers. This study does not provide easy answers about the difficult judgements and decisions that may need to be made where neglect is present but shows how important it is to be open-minded and vigilant about where and how these risks manifest themselves.***(Brandon, M., Bailey, S., Belderson, P., Larsson, B. (2013) Neglect and serious case reviews. London: NSPCC)***

Neglected adolescents: literature review.
Stein, Mike, and Rees, Gwyther, and Hicks, Leslie, and Gorin, Sarah. London: Department for Children, Schools and Families (DCSF), 2009

Review of research on adolescent neglect. Findings highlight the sparseness of literature on adolescent neglect and the differences in the way neglect is conceptualised at different stages of childhood. Statistics indicate neglect is the most common form of maltreatment suggesting even within existing definitions there is a substantial incidence of neglect of adolescents. Evidence correlates experiences of neglect during adolescence and a range of negative outcomes.

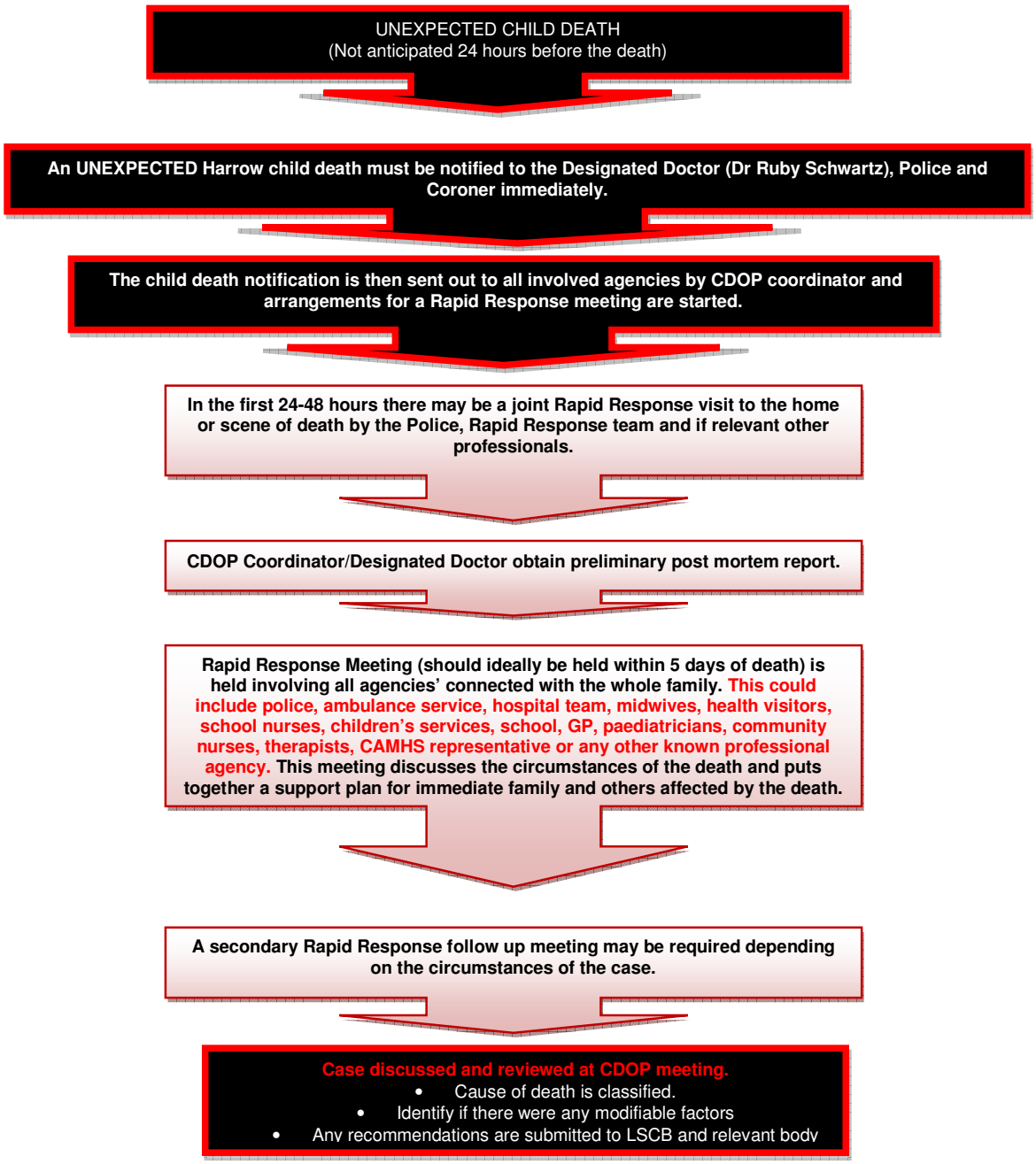
Safeguarding babies and very young children from abuse and neglect.
Ward, Harriet, and Brown, Rebecca, and Westlake, DavidLondon: Jessica Kingsley, 2012

Based on a research study (funded by the DCSF, now Department for Education) which followed children who were identified as likely to suffer from harm before their first birthdays until they were three years old. It explores key issues surrounding the safeguarding process, including how decisions on removing children from their families are made, whether interventions from social workers and other professionals work, and the impact they have on children's life pathways. Also examines the role various participants, including parents, have in decision-making. Findings of the study show a close link between decisions, maltreatment and children's emotional and behavioural difficulties and developmental delay. Key implications and recommendations for policy and practice are made.

Rapid Response Process

In accordance with Chapter 5 'Working Together to Safeguard Children' (March 2013), the LSCB is responsible for ensuring that a review of each death of a child (up to the age of 18, excluding still born babies and lawful terminations of babies) normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP).

DEALING WITH AN UNEXPECTED DEATH & RAPID RESPONSE



Learning Lessons

Our February LSCB Newsletter highlighted learning from the East Sussex LSCB regarding an SCR re Child G (December 2013), and more information can be found here: https://czone.eastsussex.gov.uk/partnerships/lscb/pages/main.aspx This was learning particularly for education and the role of the LADO (Local Authority Designated Officer) in dealing with allegations made against staff who work with children and young people. I met with Heads and Directors of local maintained schools in January to highlight these matters.

Serious Case Reviews must now be published, and the **NSPCC** is hosting a library of reviews, which can be found here:
http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=9300F5F6-960A-4ED4-9F2E-32EBE961ABF8&LabelText=Media%20type%3A%20Case%20review&searchterm=%22official%20inquiries%22&Fields=%40&Media=SCR&Bool=AND&SearchPrecision=20&DataSetName=HERITAGE
These are two important reviews:

Serious case review: the Anderson family: executive summary of overview report. **Suffolk LSCB. (2014)** This is an Executive summary of a review into the death of three children and their mother in April 2013. Children were aged 3-years, 2-years and 13-months at the time of their deaths and mother was 7 months pregnant. Evidence suggests mother killed the children prior to committing suicide by jumping from a multi-story car park. All three children were subject to child protection plans under the category of neglect. Parents, particularly mother, were highly resistant to professional involvement; father's presence in the home was not constant and it is unclear what periods of the children's lives he was involved in. Issues identified include: adversarial relationship between parents and professionals from outset; parental non-attendance at health appointments and child protection meetings; lack of stimulation and infrequent opportunities for children to interact with others leading to social, language and emotional development delays; and professional uncertainty over mother's mental and emotional health. Identifies lessons learned, including: background information about parents' childhoods is essential to understanding their parenting capacity; and the Public Law Outline process requires strong management oversight and an understanding of the separate roles, responsibilities and accountability for decision-making of children's services and legal services.

Hamzah Khan: the Executive Summary. Bradford LSCB (2013) Executive summary of a review into the death of a 4-year-old boy in December 2009, as a result of chronic neglect; Hamzah's body was discovered by police during a search of the family home in September 2011. Six of Hamzah's seven siblings were living in the family home at the time of the discovery of his body; all siblings under the age of 18 became subjects of care proceedings at this time. Mother was convicted of manslaughter and child cruelty in October 2013.Sets out key findings using a systems model based typology developed by Social Care Institute for Excellence (SCIE) and raises issues for consideration in regards to identified themes for learning. Themes include: cognitive influence and human biases; viewing incidents in isolation and failing to identify patterns that represent harm to children; and tools for effective sharing and analysis of information.

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