Lancashire Safeguarding Children Board Learning Brief

Child LA Serious Case Review – December 2016

Case Summary

Lancashire LSCB has published a Serious Case Review (SCR) about a child known as Child LA; the time period for the review was when LA was between 15 and 17 years old. In September 2015 Child LA sadly died at home after being found collapsed. The death is due to natural causes and toxicology result found no evidence to suggest substances (within the scope of testing) or alcohol, were directly implicated in the death of the child. The child and family were known to services since LA was at least 12 years old; the primary concerns were neglect, child sexual exploitation and missing from home episodes. The SCR concluded that professionals involved with Child LA and family members, could not have predicted or prevented this child's death.

The review highlighted key themes which are listed below, if you want more information the full SCR report is available on the LSCB website.

1. **Age of the Child** - professionals treated LA, in terms of her age, as if she were an adult and this was a significant issue which impacted on interventions considered and offered. Children are children until aged 18 in law; the Children Act 1989 defines a child as any person under the age of 18 (section 105(1));
2. **Identification of learning disabilities / difficulties** – LA did not have a formal assessment/ diagnosis but there were overwhelming concerns LA had additional needs and there was a lack of communication regarding this;
3. **Transition in mental health services** – LA was referred to Child and Adolescent Mental Health Service (CAMHS) and non-attendance was an issue. It had been recognised that there would need to be a transition to adult mental health services; however, there was no evidence that a plan was in place for a safe exit strategy from CAMHS and a safe entrance, or transition into adult mental health services;
4. **Decision and outcomes regarding Children's Social Care intervention** - the outcomes for LA and a sibling were different at the initial child protection conference and there was a significant difference in how the children were considered in terms of risk. There was a sense of over optimism in terms of what LA and her mother were capable of and professionals are reminded to utilise formal processes such as the Lancashire Continuum of Need and Threshold Guidance when working jointly on complex cases;
5. **Reponses to Child Sexual Exploitation (CSE)** – The report highlights it was positive that LA was identified as being at risk of child sexual exploitation (CSE). Creative disruption techniques in response to concerns were used as child abduction warning notices could not be issued due to LA's age;
6. **Managing Allegations which are retracted** - The report highlights holding strategy discussions despite allegations being retracted to share multi agency intelligence and inform investigations would be good practice;
7. **Responses to children who go missing from home** – LA was formally reported missing seven times during the review period and was found on occasions to be in circumstances where CSE was known or suspected. The return interviews were not robust and were not consistently documented;
8. **Engaging parents and carers/ disguised compliance** – It was evident that Mother was not consistently difficult to engage, however there were concerns about mother's parenting capacity and her ability to support and protect her children. Disengagement, resistance and disguised

compliance should be included as a key area of concern when assessing risk to a child, and therefore be included in supervision discussions about decisions and risk analysis;

9. **Threshold for neglect** - LA and the family lived with a number of concerns including mental health, issues, suspected substance misuse, self-harm, sexual exploitation, emotional abuse and neglect. The conditions wherever LA lived during the timeframe were poor, especially where LA stayed predominantly, which was with Mother at home. Professionals did visit and record their concerns and at times challenged Mother about what they saw; however, there was a sense of acceptance on the behalf of professionals. The independent reviewer discusses the definition of neglect and that the circumstances /environment do not have to get progressively worse for the threshold to be met, it can also be met by the neglect concerns not getting any better, despite professional intervention;
10. **Recording of professional judgement -** there were some concerns suggesting that LA was misusing substances, particularly in the last six months prior to the death. Professionals were unanimous in the view that there was little evidence to substantiate the claim of drugs misuse. In this case there was limited recording of concerns and/ or professional judgement and there were no rationales for decisions and actions taken. Accurate case recording is an absolute requirement of professional practice and all professionals should be expected to meet such standards;

The SCR report also includes information on practice issues, good practice and recommendations, there is an action plan to address these. If you require more detail about this please contact your agency safeguarding lead in the first instance.

Contact the LSCB:

LSCB, Room D40, County Hall, Preston, PR1 0LD
01772 532088 / 01772 538351
LSCB website