Bromley Safeguarding Children Partnership

BSCB Serious Case Review 'Hannah': Overview Summary

In 2017, a Child Protection Medical found that 'Hannah' had been sexually abused. Hannah was taken in to Care the next day and now lives in long term foster care, where she is doing well. Hannah has not disclosed anything about her abuse but experience tells us she may do in the future. For that reason, this SCR has not been published since it could be prejudicial to any future criminal case. Detailed learning from the case has been shared with the children's workforce in Bromley.

Finding 1 – Compliance to Safeguarding Policies and Procedures.
Remind all CP practitioners of their responsibilities in complying with local and national Safeguarding Policy and Procedures.

When Hannah was possibly showing signs and symptoms of CSA, the London Child Protection Procedures were not followed.

Finding 2 – Signs and symptoms of CSA.
Remind all CP practitioners of their responsibilities to familiarise themselves with the signs and symptoms of CSA and appropriate referral.

This review has identified a consistent failure by professionals involved in Hannah's case, to identify the clear signs and symptoms she was displaying of a possible victim of CSA. It has been established some professionals suspected CSA but did not raise or were unsure to share the concern. CSA was never considered within safeguarding meetings and all professionals pursued safeguarding Hannah under the category of neglect.

Finding 3 – Escalation and empowerment.
All CP practitioners concerned in this review, should be reminded of their responsibilities to escalate cases they believe are safeguarding risks for a child and young person.

There were numerous missed opportunities to safeguard Hannah from further abuse and to escalate concerns. There was no formal escalation from professionals who need to know they will have the support that empowers them to escalate and challenge when they do not agree with a decision made by another colleague or agency.
All unresolved concerns and differences of opinion on a child protection case should be made subject to escalation processes and should be recorded on the Local Authority or agency Case Management System for future reference and supervisory oversight.

Finding 4 – Chairs of safeguarding meetings and responsibilities.
Remind all CP practitioners in multi-agency meetings of their responsibilities in complying with local and national Safeguarding Policy and Procedures.

Chairs of meetings should ensure the significant history and that all aspects of child abuse including signs and symptoms of possible CSA are considered. They should encourage the views of all attendees are taken into account and considered.
All attendees at meetings have a responsibility to share their concerns.

Finding 5 – Enhancement of referral and contact procedure for police- for all agencies.
Ensure all CP practitioners are aware of the correct procedure how police should be contacted in urgent safeguarding cases including out of hours.

All agencies should be aware of when to contact 101 and when to call the 999 emergency number where any police officer could respond. All police officers have the powers to safeguard a child in an emergency and if necessary invoke Police Protection procedures and remove a child to a place of safety.

Finding 6 – Professional curiosity, optimism and disguised compliance.
Remind all CP practitioners of their responsibilities in complying with local and national Safeguarding Policy and Procedures in relation professional curiosity, optimism and disguised compliance.

Mother displayed clear disguised compliance practices and there was too much professional optimism on Mother who ignored advice and persistently failed to support and protect her daughter.

Finding 7 – Case Allocation and Research.
CSC should review referrals into the MASH to ensure that historical child protection research is carried out and taken into consideration to capture all available information and to identify possible High-Risk cases before a decision to close a case is made.

Mother's full history was not adequately taken in to account when CSC considered referrals. The Threshold of Needs was not appropriately applied when the case was stepped down to Early Intervention.

Finding 8 – Governance and Supervision.
Identify high-risk cases, ensuring effective supervision and compliance with agreed multi-agency thresholds.

Any safeguarding referral where there are previous substantiated child protection concerns should be considered as high-risk and warrants a management decision. This review has identified there was a lack of effective supervision, with many missed opportunities to challenge and escalate Hannah's case.

Finding 9 – Adopting Was Not Brought (WNB) terminology.
DNA should be replaced by WNB as suggested by the British Medical Journal.

Finding 10 – Record keeping and information sharing.
Remind all CP practitioners concerned in the SCR to comply with local and national Safeguarding Policy and Procedures regarding recording and sharing information.

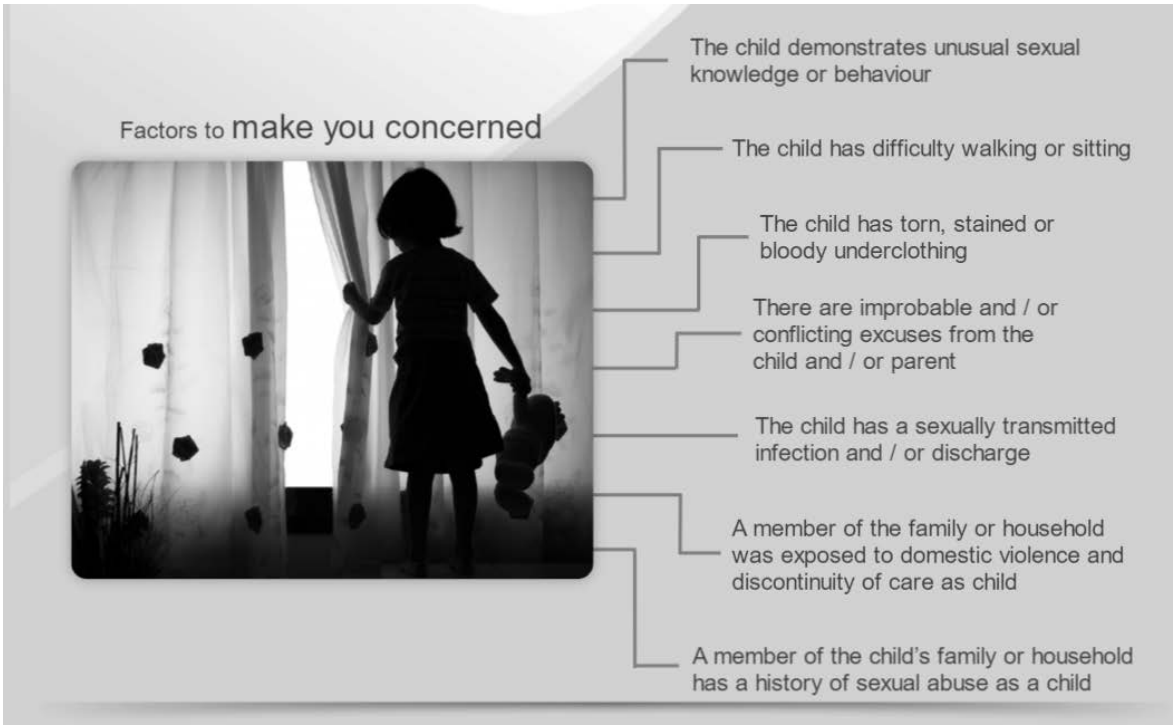
Regular communication and information sharing between agencies may have resulted in a different outcome being taken much earlier for Hannah with an opportunity to have held a ICPC many years earlier.
Child's records must be retained in accordance with policy.

Finding 11 – Police Investigation and Securing Evidence.
MPS Child Abuse and Sexual Offences (CASO) staff should be reminded to consider all available inquiries when investigating a Child Protection case when a victim fails to disclose to secure and preserve evidence for a future disclosure.

Improvement Plans
CSC were judged to be inadequate by Ofsted in June 2016; The findings of this review reflect that. Many of the shortcomings in this case were identified during the inspection and have since been addressed as part of an overall CSC improvement plan in partnership with other agencies. During the more recent Ofsted inspection of Bromley CSC, they were judged to be good in all areas with outstanding leadership. This is a direct reflection on the many improvements made since 2016.

All agencies involved in this SCR have submitted an action plan to address recommendations and these are being monitored by the BSCB.

Signs of Sexual Abuse – from our free level 1 Safeguarding Children training on Me Learning:



- The child may also display extreme behaviour such as depression, self-mutilation, running away, overdoses and eating disorders.
- May start to wet again, day or night, and may complain of nightmares
- Deviation in normal behaviour e.g. insecure and clingy, or unusually quiet and withdrawn, or become aggressive
- The child's schoolwork might be noticeably affected. They may start misbehaving in school or have difficulty concentrating. They may truant or refuse to attend school.
- Genital, anal or perinanal injury (bruising, laceration, swelling or abrasion) with absent or unsuitable explanation.
- Persistent genital or anal symptom with no medical explanation