Serious case reviews in childcare sector

Family, Children

Unit 25Understand how to Safeguard the Wellbeing of Children and Young People Outcome 1. 4 Explain when and why inquiries and serious case reviews are required and how the sharing of the findings informs practice. Serious Case Reviews (SCR's) are undertaken when a child dies (including death by suspectedsuicide), by a local authority (and more often than not by the Local Children's Safeguarding Board) if abuse or neglect is known or suspected to be a factor in the death.

SCR's are not enquiries into how a child died or who was responsible; that is a matter for the Coroner's and Criminal Courts to determine. Instead the purpose of Serious Case Reviews is to: • Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote thewelfare of children. • Identify clearly what those lessons are, how they will be acted on and what is expected to change as a result. • Improve inter-agency working and better safeguard and promote the welfare of children.

Additionally, LSCB's may decide to conduct a SCR whenever a child has been seriously harmed in any of the following situations and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children (including inter-agency and inter-disciplinary working). The two most popular deaths in recent years to be highlighted by the media which highlighted public concern about safeguarding concerns within the children are undoubtedly the deaths of Victoria Climbie and Peter Connelly (Baby P).

In both of these cases there was public outrage, especially at the magnitude of Peter's injuries, and partly because Peter had lived in the London Borough

of Haringey, North London, under the same child care authorities that had already failed ten years earlier in the case of Victoria Climbie. Her tragic circumstances had led to a public enquiry which resulted in measures being put in place in an effort to prevent similar cases happening. Thechild protectionservices of Haringey and other agencies were widely criticised following Baby P's death.

Following the conviction, three inquiries and a nationwide review of social service care were launched, and the Head of Children's Services at Haringey removed from post. Another nationwide review was conducted by Lord Laming into his own recommendations concerning Victoria Climbie's killing in 2000. The death was also the subject of debate in the House of Commons of the United Kingdom. The public's viewpoint on the tragedy of Baby P was that it should never have happened as he was already known to social services and was seen as many as sixty times by social services, but still died horrifically at the hands of his carers.

All of these incidents have resulted in a distinct lack of confidence in the work that social workers do and the children's sector overall, and it will take a long time to rebuild that trust. The Baby P case in particular has damaged social work's public image, led to fewer people entering the profession and made it harder to retain experienced staff. It is certainly the case that social work has a rather poor public image and that it seemingly can do no right whatever it does.

At times, the profession is castigated for putting children at risk by failing to intervene early enough intofamilylife, whilst on other occasions it is criticised for undermining parental authority by interfering too readily. Partnership

working increased and tightened after the death of Victoria Climbie and included the implementation of the Children Act 2004 and the public enquiry into the circumstances surrounding her death. The inquiry, chaired by Lord Laming, found massive failings on the part of as many as twelve agencies with a role to play in protecting children.

The findings led to recommendations for a radical reform of services, particularly in the areas of better joined up working and information sharing. Following this, several programmes and frameworks were later implemented into all establishments that worked with children, and these included “ Every Child Matters” services, planned around children’s and young people’s needs and the improvement of the five key outcomes which contribute to their well-being: be healthy, stay safe, enjoy & achieve, make a positive contribution and achieve economic well-being.

There was also the implementation of the Common Assessment Framework (CAF) system which enables multi agencies to access and add information about a child’s needs. The CAF is used at the earliest opportunity when it is highlighted that a baby, child or young person may need help in their lives in order to progress. It is used when there is concern about a child, or agencies have recognised a child has additional needs, that require further exploration and a multi-agency response.

The assessment provides further information and understanding of the child’s circumstances. Another more recently publicised incident, included the review into “ Little Teds” nursery whereby a member of staff, Vanessa George abused toddlers at the nursery, photographed it and publicised it on

the internet, showed a lack of staff supervision and training within the setting, which again caused public outrage.

The serious case review for this incident report detailed a number of lessons learned, which included the danger of mobile phones within day care settings. As a result locally the use of mobile phones is now prohibited in any children’s centre within the Wakefield district, however it is recognised that this alone will not prevent abuse or transmission of images on the internet from taking place.

Other lessons learned is that staff at Little Ted’s Nursery did not recognise the escalation of George's sexualised behaviour as a warning sign and there is an urgent need for staff working in early years settings to receive training to help recognise potential signs of abuse and become confident in responding to a fellow staff member's behaviour. As a result, training on “ whistle blowing” and the need for policies and procedures to be in place has become a more urgent need in the childcare sector.

Other recommendations set out by the Little Teds SCR include the need for The Early Years Foundation Stage to set out specific requirements for child protection training which considers sexual abuse and the recognition of abuse within the workplace; also the need for the Government to review and consider changing the status of day care settings operating as unincorporated bodies to ensure that governance andaccountabilityarrangements are fit for purpose and are sufficiently clear to enable parents and professionals to raise concerns and challenge poor practice.