'Becky' Serious Case Review Briefing

Bristol Safeguarding Children Board **March 2018**

Overview

In March 2018 the Bristol Safeguarding Children Board published a Serious Case Review concerning the death of Becky, a 16 year old girl who was murdered in 2015. Her Step-brother was convicted of her murder and his then partner was convicted of manslaughter. The review considered the involvement of services in the three years preceding Becky's death. This included Early Help, family support, youth and mental health services. A Domestic Homicide Review commissioned by Safer Bristol is ongoing.

The full report can be accessed on the BSCB's website.

It is the expectation of the BSCB that all professionals in Bristol know the findings of Serious Case Reviews in order that they can make changes to their practice to safeguard children in the future.

Relevant Policies

Resolution of Professional Disagreements

Neglect Strategy and Guidance

Responding to Abuse and Neglect

Supervision Good Practice Guide

Relevant Resources

Bristol Think Family Approach

Guidance and training slides - making a First Response Referral

Online safety resources

BSCB Training

The BSCB runs a wide range of inter-agency training which is available to all professionals working in Bristol. The following courses will be relevant to the findings of this review:

- Adolescents and Child Protection
- Courageous Conversations
- Disguised Compliance and Working More Effectively with Hard to Engage Families
- Child Protection and Neglect

For more information and to book please go to: https://bristolsafeguarding.org/children-home/training/

Becky

Becky was 16 years old when she dies. She is described by family and friends as having been loyal, caring and funny. Becky had lived with her Father and Step-mother since she was 3. Her father was granted a Residence Order following concerns that Becky was experiencing neglect. Becky remained in regular contact with her mother and maternal grandmother throughout her life.

When Becky was 13 her Step-mother requested support from children social care citing Becky's behaviour and poor relationship with her father. An initial assessment was undertaken and Becky received support from the now ended Family Intervention and Support Service. In this time there were concerns about Becky's attendance and emotional wellbeing. She was rarely in school and expressed high levels of social anxiety. Becky was referred to and attended the Hospital Education Service where her attendance and confidence increased. CAMHS supported Becky and her family over a number of years, including providing Becky with specialist support for anorexia nervosa when Becky became ill. CAMHS recognized that Becky's difficulties were impacted by the challenges experienced by her parents, all of whom had their own significant needs.

When Becky was 16 there were concerns identified by the school that she may be experiencing adolescent neglect as she reported that her father was regularly threatening to throw her out of the home and she was often hungry. They were also concerned that Becky might be vulnerable to sexual exploitation. First Response triaged the referral to Early Help. The review found that the referral would have been better assessed by the social work units as it should have met the threshold for a Child in Need response. Early Help requested that a commissioned family support service from Action for Children respond and some weeks later (due to a family holiday) a visit was undertaken. The case was then referred on to youth services. Aside from her education provision, Becky had no services working with her when she died.

Systems Learning

Over three and a half years Becky had 17 allocated workers. The review identified this was a significant barrier to her building a relationship with a professional in which she may have been able to disclose. The report findings highlight that the arrangement and coordination of services when there is not an allocated social worker contributed to Becky being offered multiple short term interventions with different professionals.

Bristol is implementing a new locality meeting model for reviewing cases including cases within Early Help. This model is designed to ensure that children receive the right service at the right time. The Bristol Safeguarding Children Board in partnership with the Children and Families Partnership Board will be monitoring the effectiveness of this.

"Mother and Maternal Grandmother said that it was important for the public and professionals to hear how important it was for children and young people to be believed when they talk about their worries and that they were not blamed for their behaviour. They said that the review had shown that Becky was expected to engage and meet with too many different professionals and so could not build the trust she needed to speak out" - Becky SCR, 1.15

Things to Consider

Think Family

Do you sufficiently engage with and understand the views of all key family members when you are working with a child or young person? In this case professionals did not always sufficiently consider family members who were not living with Becky when understanding both risk and protective factors for her. It is essential that any assessments consider the full family network so that a holistic understanding can be developed.

ACTION: Review the current cases you are working with – have you spoken and engaged with male family members? Do you know who is regularly visiting the house? Are you in contact with family members or parents who the child does not live with where this is safe to do so?

Children with complex emotional, social and health needs

Children with complex health, SEND and social needs who are in alternative education provision often require multi-agency involvement in their care and support plans for extended periods of time. It is essential that education providers can access advice and consultation from specialists and that all services understand the additional vulnerabilities and needs of children in these settings.

ACTION: Do you have sufficient understanding of the additional needs of children in this cohort? If not, discuss the findings of this review at a team meeting or training day. Ask your manager to undertake an audit of cases with children in these settings to review how effectively your service is working with them.

Working with Adolescents

Children of any age have a right to be safe in our city. Often adolescents who have experienced trauma or neglect can present with behaviour that professionals and their parents find challenging to manage. Behaviour should be seen in this context and professionals should seek ways of understanding what adverse childhood experiences may have impacted on their current presentation. This assessment should inform what service and interventions are offered to support the child and family to cope and recover.

ACTION: Watch this short film on Adverse Childhood Experiences and review how you might adjust your practice to ensure you offer a trauma informed approach to adolescents.

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb