Croydon Safeguarding Children Partnership

SPR/Learning Review – Ben

1 Critical Events

Ben died from significant injuries, aged two years and one month.

His Mother (Ms A) and her new Partner (Mr D) have been charged with Ben's murder and causing or allowing the death of a child. Their trial began January 2022.

Ms A was offered a range of services due to her vulnerabilities but did not engage.

Opportunities were missed to identify a new male partner (Mr D) who was known to be a potential risk.

2 Key Information and Safeguarding Concerns

- Absence of information sharing between agencies.
- Unsuitable housing and homelessness.
- Coercive Control.
- Adverse Childhood Experiences (Ms A).
- Offending behaviour (Mr D).
- Domestic Abuse (discussed twice at MARAC whilst pregnant).
- Suspected Parental Substance Misuse.
- Parental Mental Health.
- Victim of un explained injuries.
- No engagement with father (separated from Ms A).
- Ms A engaged with services when she perceived a 'need'. Disengaged when 'need' was met.

3 Learning

- The need for an understanding of how parenting education is provided for new and inexperienced parents.
- It is Important that Health record as 'Was Not Brought' (to medical appointments or checks) rather than 'did not attend' in mind as a possible indicator of neglect of young children. Health now have a 'Was not Bought' policy in place.
- Keeping the child in mind and the child's experience central, to ensure the Voice of the Child.
- Assessments, Engagement and non-Engagement, where parental consent is required – the challenges of seeking to engage vulnerable parents who choose not to engage.
- Assessing the risk of domestic abuse and supporting women who have experienced domestic abuse.
- The importance of tracking known violent adults and identifying them when there are concerns about children with whom they are in contact.
- Practitioners need to understand how Professional Curiosity can be beneficial to their practice.
- When a referral does not meet the criteria of one service it is important to find another agency to refer the client to e.g counselling.
- Agencies must ensure that practitioners are responsible for making and recording on their system that a referral has been made to another service and do not think that someone else has completed a referral.
- The importance of assessing the whole family, social care assessed brother with disabilities but did not assess Ms A missed opportunity re unborn Ben's needs and to explore Ms A 'suspected substance misuse.
- Multiple agencies involved with Ms A with one agency across 2 boroughs, important to share information and record information shared.
- Good contact with first Health Visitor.
- Good practice that Health contacted MASH to discuss and agree an assessment. However the referral did not reflect the discussion and the CP concerns, refers to social care need to ensure referrals reflect safeguarding concerns and meet thresholds.

4 Achieving Change

- Reflect on the findings and discuss the implications for your practice/team.
- Outline steps you/team will take going forward.

The full SPR Report can be downloaded at: **www.croydonlscb.org.uk**

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