NSPCC Respository – December 2017 & January 2018

In Decmeber 2017 / January 2018 eleven SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Unnamed LSCB: Children F, G and H

Concerns about serious harm to three siblings due to suspected fabricated or induced illness (FII). Child F, Child G and Child H lived with their parents and a number of siblings. The children had extensive medical histories, including invasive surgical interventions, and had been seen by a large number of health practitioners in a number of hospitals. Two of the children were seen by more than 30 doctors. Their perceived medical needs had an impact on their educational, social and emotional development. Health and education staff had expressed concerns about the possibility of FII for a number of years, but a referral was not made until 2013.

The Significant Learning Incident Process methodology was used to conduct the review.

Key learning points include: GPs should take a coordinating role when a child is attending a variety of clinics and hospitals for treatment; practitioners should be wary of relying solely on information provided by parents and ensure that the child's views are sought and listened to; practitioners should be alert to signs of disguised compliance by parents; early concerns about FII should be recorded and discussed with Safeguarding Leads; practitioners need to maintain professional curiosity in cases where concerns emerge over a period of time.

Recommendations for the LSCB include: request a review of the national Child Protection Procedures regarding FII to ensure that learning from this review and NSPCC research are reflected in the procedures; share learning from this review with NHS England; request that the Department for Education updates guidance on safeguarding and FII.

Download the full report here

Central Bedfordshire LSCB: Nolan and Family

Death of a one-year-old boy, Nolan, in 2015 as a result of serious head injuries with the explanation inconsistent with the injuries sustained. Mother had a troubled childhood including exposure to domestic violence and neglectful care and was on the Special Educational Needs register at school. She lived with her mother and partner. Her first child was born when she was 16 and Nolan was born when she was 17. Both infants were born prematurely and had medical problems. Nolan's father had mental health issues, a permanent movement disorder and lived in supported housing. Reluctance by mother to engage with services, including late booking for pregnancies and missed medical appointments for the children. Five referrals were made to Children's Social Care, the last eight days before Nolan's injuries.

Identifies learning including: lack of curiosity about late booked pregnancy; no recognition of the impact of prematurity, unexpected home birth and illness on the parents' ability to cope and implications of any rejection of help; challenges to parenting capacity should be communicated; the need to follow up referrals with checks and a visit.

Follows a systems based methodology which maximised staff involvement and kept the depth of the inquiry proportionate to the complexity of the case.

Recommendations include: make the reporting of bruising to non-mobile babies mandatory; ask member agencies to report on how they ensure the role of fathers and wider family members in the household are properly assessed; ask the Police to review its internal handover processes; and the LSCB should demonstrate the essential value of professional curiosity.

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Hertfordshire LSCB: Child G

Death of a boy aged less than 1 year from unknown causes. A post mortem examination identified seven fractures which predated the death. Child G had been taken out in his mother's partner's van and had been driven around for about two hours. He stopped breathing, an ambulance was called to the family home and the child was pronounced dead on arrival at hospital.

Child G lived with his three older siblings and parents in a relationship of violence and temporary separations. The family had been in receipt of services from Children's Social Care, health visiting, general practice and nursery and primary school. Four months prior to the death, the father left and a new partner moved into the family home. The mother and partner were charged with neglect.

Issues identified include: reluctance to name neglect by professionals involved with the family; the crucial importance of the assessment process to ensure appropriate intervention; the need to review the types of cases that are discussed in supervision. Uses a systems approach drawing significantly on the work undertaken by Professor Munro and SCIE to identify greater understanding of safeguarding practice.

Recommendations include: the need to challenge agencies to demonstrate they are working in line with its strategic approach to neglect; to ensure that those families and children managed under Children in Need are the correct ones and are properly reviewed; the need to deliver safe and effective services for children within its traveller communities and to use this learning to enhance services to other minority communities.

Download the full report here.

Somerset LSCB: Child SAM

Severe and irreversible brain damage caused to a 6-month-old boy as a result of non-accidental injury. The parents' relationship broke down early in the pregnancy. His mother started a new relationship and the family moved to a local market town, away from extended family after Sam's birth. Sam's mother expressed low mood during the antenatal and postnatal period and reported feeling lonely and isolated as the stepfather worked away from the family home for two week periods. In November 2015 Sam was brought to the hospital minor injury unit where he suffered a respiratory arrest. A CT scan showed subdural haemorrhages. The injuries resulted in permanent disabilities, including blindness. Sam's stepfather was found guilty of grievous bodily harm and received a custodial sentence.

Issues identified include: professionals working with the family failed to recognise the increasing risk factors within the family and the impact these might have on the parents' ability to care for Sam; little evidence of information sharing between professionals or a joined-up plan.

Recommendations include: ensuring that agencies identify and respond to risks and vulnerabilities within families where domestic abuse is a concern; appropriate training given about the importance of measuring and recording growth measurements; and training for health care professionals to highlight the signs and symptoms of brain injuries in young babies.

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Durham LSCB: Baby Bailey 2016

Death of a seven-week-old boy in November 2015. Baby Bailey had been co-sleeping on the couch before being found in the Moses basket; the post mortem gave the cause of death as "unascertained". Parents were known to police due to the supply and use of drugs and related offences; the family was known to multiple agencies due to concerns about the neglect of two older siblings.

Parents were arrested and interviewed but there was insufficient evidence to substantiate criminal neglect. Mother declined support from the Education Welfare Officer and Parent Support Adviser. Mother didn't present for antenatal care until she was over 26 weeks pregnant with Bailey and did not attend several medical appointments for herself and her children. Bailey's birth was registered late. Home conditions throughout the period under review fluctuated from "just good enough" to "unsafe".

Uses the Child Practice Review process to identify how agencies worked together.

Issues include: drug use and related offending was not recognised or responded to as a child safeguarding issue; there was no multi-agency strategy meeting following the parents' arrest for alleged neglect; the implications of denied or concealed pregnancy were not understood; the day-to-day lived experiences of Bailey's older siblings were not sought.

Recommendations include: implement a protocol for concealed and denied pregnancy; provide guidance for instances when children are not brought to medical appointments; ensure there is a standardised approach to strategy meetings. Please note that this report was written in 2016 but was published in 2017.

Download the full report here.

Unnammed LSCB: Services provided in a complex case of fabricated or induced illness

Serious health and developmental impairment of a teenage boy due to fabricated or induced illness (FII) over a number of years. Child Y and his younger sister lived with their mother, and had moved three times to different local authority areas between 2002-2012, due to domestic abuse by mother's ex-partner. The siblings had a history of poor school attendance and were made subjects of child protection in 2014.

In 2015, Child Y had a potentially fatal fall, which resulted in the local authority making an application in the family court. The local authority informed the LSCB that Child Y and his younger sister had attended hospital emergency departments over 250 times over a period of four years, in three different hospital trusts, with no medical causes found for many of the symptoms. Both siblings had undergone a number of medical interventions, including medication, intrusive investigations and surgery.

Lessons learned include: the difficulties faced by professionals in working with a family when FII is suspected; challenging the family and coordinating a response were not supported by the prevailing organisational arrangements and culture in which healthcare was provided.

Recommendations include: the LSCB should develop and implement pathways for the early identification and management of perplexing presentations, including suspected cases of FII, and for the management of identified cases of FII, including those who are subject to child protection plans; the Department of Health and the Department for Education should be asked to commission national research to establish the prevalence, incidence and case characteristics and outcomes for children who have perplexing presentations or FII.

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Luton LSCB: Child J

Death of a 13-month old boy in November 2015 from non-accidental head injuries inflicted on the day of his death. Child J lived with his parents at the home of his grandparents for the first weeks of his life. Parents had a history of domestic abuse and became known to children's social care services following two incidents. They separated in Spring 2015, after which Child J's mother became involved with a new partner and moved to a new area, where children's social services were informed about the family. A post mortem found several fractures. Mother and her partner were imprisoned for offences connected with his death.

Key findings include: transfer arrangements within health visiting and between Family Nurse Partnership (FNP) and health visiting assume a degree of cooperation from families, which may leave children of avoidant parents at risk of harm when families move; the current emphasis on the emotional harm to children of domestic abuse causes professionals to underestimate the risk of physical harm to young children in domestic abuse situations involving physical violence.

Used the SCIE Learning Together systems model.

Recommendations centre around a number of questions to the LSCB, focusing on effective transfer arrangements between local authorities to avoid losing sight of vulnerable children when families move; and transfer of information between health visitors where families are transient.

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North East Lincolnshire: Child T

Death of a four-year-one-month-old girl as a result of non-accidental head injuries and ingestion of a range of illegal drugs. Child T was subject to a Child in Need plan for 13 months following her birth. For at least 6 months before her death, she was exposed to and ingested heroin, methadone, ketamine and various benzodiazepines. Mother and new partner were charged with neglect, child cruelty and drugs offences. First child was taken into care before the birth of Child T as a result of domestic violence and drug misuse by both parents; father was in prison at time of death.

Learning includes: the need for robust assessment to understand family functioning and assessing parental capacity to change; where siblings are born to children subject to a Child Protection Plan, a proactive decision is needed about the unborn or newborn baby; all contacts from family members raising concerns about the welfare of a child should automatically be treated as a referral; the need for multi-agency professionals to develop tools and skills to combat disguised compliance, particularly where parental substance misuse or domestic abuse are key causes of concern.

Recommendations include: all children identified as a Child in Need should have a multi-agency plan with a level of management oversight equal to children subject to a Child Protection Plan; multi-agency professional meetings should ensure attendees understand the status and range of kinship care arrangements and their implications for the child; practitioners should develop increased skills in analytical thinking to apply at points of assessment and decision making.

Download full review here.

Rochdale LSCB: Child L

Death of Child L aged 14 found hanging in her home in February 2016. A coroner's verdict found the cause of death to be 'death by misadventure'. Child L had attempted suicide on two occasions in the previous two years by taking overdoses and had a history of self harming from the age of seven. She had witnessed persistent domestic abuse from an early age. Maternal history of alcohol misuse led to mother's ill health including frequent seizures. Child L's grandmother, identified as a protective factor, was also seriously ill. Child L had contact with Child and Adolescent Mental Health Services (CAMHS) and Children's Social Care (CSC). A common assessment framework (CAF) and a Child in Need assessment were completed.

Learning includes: keeping the focus on the child at risk when dealing with resistant parents or assessing parental capacity; critical thinking skills are necessary when assessing families with complex dysfunction; remaining attuned to the presence of unknown men.

The recommendation is made that all children assessed as medium to high risk through self-harm or suicide are referred directly to CSC to coordinate multi-agency working.

Download full review here.

Brighton and Hove LSCB: Child A

Death by suicide of a 17-year-old boy in January 2016 who was found lying on a railway track. 'A's' mother had mental health problems and 'A' had been exposed to physical and emotional abuse and witnessed domestic violence from an early age. Over 19 foster care break-downs led to placements in therapeutic units at age eight and age 12. Throughout his life 'A' displayed challenging behaviour including aggression and violence, self harm and regularly going missing from placement.

In 2006 he reported historic child sexual abuse. Later he was identified as being at risk for child sexual exploitation and expressed fears that he may sexually harm other children. In 2015, plans had been made to transfer A to a foster home, in preparation for independence, and a proposed moving date was set for January 2016.

Identifies learning under three headings: choice and initiation of placement; issues arising during placement, such as identifying the need for additional therapeutic support; and transition towards greater independence including help with coping with change and his move from therapeutic care.

Recommendations include the need for training around the vulnerability of care leavers for Brighton and Hove Children's Social Care; all care and placement plans should include a contingency position; and the therapeutic unit should review organisational capacity to challenge care plans if they deem it necessary.

Download the full report here.

Redcar and Cleveland LSCB: "Emma"

Serious non-accidental injuries to a one-year-11-month-old girl requiring hospital treatment and made subject to police protection. Parents supported to care for first child Sarah through a multi-agency Child in Need plan in 2011; parents split up that year with concerns voiced about the mother's lifestyle. Following the birth of Emma at the end of 2011 both children became subject to Child in Need plans, continuing to be cared for by mother and new partner. After Emma's injuries, she and her sister were placed in foster care. Police charged the mother with neglect and she was given a custodial sentence.

Identifies learning: all legal and case work decisions and their rationales need to be recorded, including reasons for children's social care not following legal advice when care proceedings are proposed; all actions assigned to professionals, especially assessments, must be completed before Child Protection (CP) Plans are discontinued; need to engage with individual members of the family including significant others; case management needs to be authoritative and robust when working with difficult to engage and non-cooperative parents/carers.

Recommendations include: the appointment of a named GP for Safeguarding Children with a priority on supporting GP practices put in place robust internal policies and practice; the quality of first line management supervision and case work oversight of both Child Protection and Child in Need cases is consistent with agency standards; the impact of the toxic trio (domestic abuse, adult mental health and adult substance misuse) on children and young people must be included in all family and risk assessments.

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