NSPCC Repository – November 2018

In November 2018 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Camden LSCB: Baby C

Death of a 7-week-old infant from non-accidental injuries caused by shaking in February 2016. His father was convicted of manslaughter in March 2018. Baby C lived with both parents. His mother had lived in the UK for around 20 years and worked as a nanny.

The pregnancy was uneventful and the mother attended all routine antenatal appointments. No concerns were identified regarding her physical or mental health. Records from postnatal visits by midwives and health visitors reported no concerns. Health visitor identified that the mother had no family or local social support so made a referral to baby massage and a course for parents with young babies.

On the day of Baby C's death the father was caring for him alone. He called emergency services and reported that Baby D had fallen out of his bouncer and was bleeding. When the ambulance service arrived Baby D was not breathing, and he died in hospital four days later. The review concluded that the death could not have been prevented since there were no warning signs that Baby C was at risk.

Learning include: there is no specific universal programme of work with fathers in the antenatal or postnatal period.

Recommendations include: contact with fathers should be routinely recorded in midwifery and health visitor records; information about the link between crying babies and non-accidental head injury should be included in the core health promotion package offered to new parents.

Download the full report here

Manchester LSCB: Child F1

Death of an eastern European 13-year-old child from a heart condition that was exacerbated by their morbid obesity. Child F1 had been obese for at least 10 years and their Sibling F3 (aged 4 years old) was also obese. Child F1 was seen by a number of health professionals as their morbid obesity was causing a number of health problems. Mother did not consistently attend appointments and did not follow professional advice.

The Family Weight Management Service (FWMS) and F1's school both tried to help manage F1's obesity but F1's mother did not follow the advice given. There is a lack of clarity regarding childhood obesity as a child neglect concern, and children's help seeking behaviour needs to be recognised and responded to with support.

Learning includes: the need for the development of a strength-based psychosocial approach to the identification and management of childhood obesity. Children's help-seeking behaviour is insufficiently recognised and responded to by professionals, leaving them unsupported in the short term and potentially less likely to ask for help in the future.

Recommendations to the LSCB include: to consider undertaking work around the effectiveness of the current approach taken by their partner agencies and staff in facilitating child focused practice, exploring known barriers and build on this work to support future.

Download the full report here

Manchester LSCB: Child G1

Non-accidental injuries sustained by a 4-year-old girl of Nigerian heritage in June 2015. Child G1 was found to have broken ankles, 29 suspicious injuries including a possible fracture to her spine. Her mother and partner were each given custodial sentences of six years. Child G1 and her 7-month-old sibling were placed in foster care.

Child G1's mother and father were in a relationship which ended in late 2012 after which Child G1 and her mother moved in with her mother's partner and adult son. Concerns were expressed after Child G1 started nursery school in 2013 and primary school in 2014. Referrals were made by the school to children's social care (CSC) about injuries to her forehead, and information about stealing, taking extra food, aggressive behaviour towards other children and animals and absences were passed on.

In May 2015, a referral from school to CSC triggered a Child and Family Assessment. Child G1's mother attributed these injuries to Child G1's father; she also made allegations of domestic abuse against him. Child G1's father was seeking access to his daughter through the Family Court. Child G1 said her injuries were caused by her mother's partner.

Findings identified include: the power of the adults' narrative in drowning out the voice of the child; high caseloads leading to superficial assessments; approaches to domestic abuse that did not allow for the possibility of malicious allegations.

Recommendations include: that disclosure by children must be given priority and investigated; information gathering on all members of the household should be a basic requirement of practice; the development of a culture of challenge and reflection to enable practitioners to question what they are told.

Download the full report here

Manchester LSCB: Child L1

Non-accidental head injury to an infant just under 8-weeks-old, of Pakistani heritage, in September 2016.

Mother disclosed to a GP practice nurse during a routine appointment in July 2016 that father would be violent towards herself and Child L's older sibling, aged 10-months, if the latter would not stop crying. Mother declined to give consent for any referral for support being fearful of further violence. The specialist nurse for safeguarding children was informed and a referral to children's social care was agreed.

During an assessment of Child L's sibling, no concerns were raised and mother retracted her allegations. Child L was born prematurely during a visit to Norwich and placed in neonatal intensive care, first in Norwich and then at the local hospital. Child L was discharged home at age 3-weeks.

On 30 August children's social care closed the case due to lack of evidence. On 30 September Child L was admitted to hospital with a large subdural haemorrhage, caused by violent shaking.

Key findings: good practice by the GP practice nurse; information elicited from mother by practice nurse became diluted during recording; implications for sharing safeguarding information in the case of out of area births.

Recommendations include: to develop practitioner guidance on available options when a victim decides to retract allegations of domestic violence; to develop an abusive head trauma strategy to ensure effective prevention of abusive head injury in babies; to obtain assurance that partner agencies fulfil their statutory obligations to ensure strategy meetings take place when necessary and include all necessary partner agencies.

Download the full report here

Unnamed LSCB: Learning Summary

Death by suicide of a 17-year-old young person in 2016.

There were over 30 multi-agency contacts or events involving the young person and/or their close family in the ten month period prior to the young person's death. Professionals saw no self-harming behaviours or ideation in the young person.

Key lessons: the need to further develop the knowledge and skills in understanding and responding appropriately to adolescents and young people at risk of self-harm; to review how agencies fulfil their statutory obligations by recognising a 17-year-old as a child and ensure the child's voice and views are key elements in the decision-making process; training to enable practitioners to be confident in recognising the impact of religious, ethnic and cultural influences; the need to actively promote support and advocacy services for young carers; to understand communication needs particularly in families whose first language is not English.

There are no recommendations in this learning summary.

Download the full report here

Unnamed LSCB: Darry

Attempted suicide of a 17-years-6-month-old young person in December 2016 resulting in significant and life changing injuries.

The young person Darry exhibited behavioural and language concerns at secondary school which led to a move to a school for children and young people with special educational needs at age 15. From the beginning of Year 12 the school became concerned about Darry with evidence of increased anxiety, low mood, lack of interaction with peers and self-harm and referred Darry to CAMHS Learning Disability Team.

A meeting with CAMHS, Special Educational Needs, school staff and mother in November 2016 summarised Darry's recent deteriorating mental state and mother's views regarding long term bullying, family losses and domestic abuse.

Findings: young people with deteriorating mental health require a holistic multi-agency response which takes account of all factors and does not focus on the young person as the problem; self-harm is a serious issue which needs robust multi-professional action; referrals to children's social care need to make clear the concerns to enable a decision to be made on the best available information; there is professional confusion about the Mental Capacity Act as it relates to 16 and 17-year olds, particularly in the context of parental decision making and professional advocacy. Uses a hybrid version of a systems process.

There are no recommendations in this overview.

Download the full report here