NSPCC Repository – January 2019

In January 2019 nine SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Blackpool LSCB: Child CB

Death of a 17-year-old boy from fatal injuries incurred by jumping from the roof of a building in December 2017.

Child CB struggled with his identity and did not want others to know he was adopted. His overall wellbeing and behaviour was impacted by attachment difficulties first identified in 2009 when a CAMHS referral was made. He suffered emotional and physical harm before moving to foster care in September 2014 when relationship with adoptive family (White British) broke down. He had five foster carers and it is unclear how well they were able to respond to and cope with his difficulties.

Issues identified include: to seek assurance that the preparation, training and ongoing development and support of foster carers enables them to offer long term, stable and therapeutic placements to children who share Child CB's vulnerabilities; to review what support and development arrangements are currently in place for adopted children and adoptive parents for children with adverse childhood experiences, attachment and identity issues.

Model: developed to enable participants to consider events and circumstances which led up to the death of Child CB.

Recommendations include: to review existing arrangements for care leavers and ensure that the care plan considers the young person's views; to review current suicide prevention strategies; to include known suicide risk factors for children and young people into ongoing staff development and training; focus on the impact of cannabis and other substances on mental health and other outcomes for children and young people, the potential interactions of cannabis with prescribed mental health (and other) medications and agency responses.

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Coventry LSCB: Baby F

Serious and life threatening non-accidental head injury to a 4-week-old boy in September 2015.

Baby F was admitted to hospital with an intracranial bleed and resuscitated by senior medical and nursing staff. Family of Baby F was known to children's social care and mother had been in contact with services sporadically since 2008. Parents were arrested and on bail during the serious case review, so did not contribute to the process. Case is still subject to police proceedings. Baby F requires continuous care and is being looked after by foster parents.

Focuses on mothers care of 8-year-old half-sibling Child V and the missed opportunities to identify historic concerns over mother's parenting. In particular, record keeping and inter-agency cooperation and information sharing are presented as lacking.

Similar concerns identified from other recent case reviews over a similar time period include: poor quality and inconsistent record keeping within children's social care; absence of the 'voice of the child' either in practice or in record keeping; a lack of professional curiosity about new male partners, their past history as a father and the potential impact this may have on an existing family unit.

Recommendations include: ensure that each GP practice holds multi-agency safeguarding meetings involving midwifery and health visiting teams so that timely, accurate information regarding vulnerable families is appropriately shared; that children's social care refresh its guidance on record keeping to ensure the accuracy and quality of chronologies maintained in case notes; reaffirm the importance of the voice of the child in the work of all services.

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Croyden and Lambeth LSCB: Child L

Cardiac arrest of 11-month-old child as a result of cocaine ingestion in July 2016. Child L survived the incident and was made subject to care proceedings. Criminal proceedings were brought against both parents in June 2018, and both were found not guilty.

Child L was the subject of a Child Protection Plan in Lambeth since before his birth in July 2015. Family had a history of domestic abuse, mental health problems, and alleged self harm. Father had a history of drug misuse. There was a background of cultural tension between the parents, including an allegation of forced marriage.

In May 2016 the family moved to Croydon who took over responsibility for his child protection plan. The case review was jointly commissioned by both LSCBs and led by Croydon LSCB. Uses the Welsh model methodology.

Key lessons include: keeping the child's lived experience at the centre of safeguarding children practice; knowledge and skills in working with drug using parents; impact of homelessness and temporary accommodation on child protection; cross-borough working; getting the basics right, adherence to procedures and supporting frontline practitioners with guidance and reflective supervision.

Recommendations include: ensure that safeguarding practice and supervisory system in place keep the child's lived experience at the core of all safeguarding work; the LSCBs and partner agencies should review practitioner knowledge and skills in understanding, assessing and responding to hidden substance misuse by parents where there is no sign of addiction or problematic lifestyle.

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Dorset LSCB: S26 – Child S

Death of a 3-year-old child in August 2017 as a result of injuries following a road traffic collision caused by the mother who was intoxicated by alcohol and drugs. Mother was convicted of death by dangerous driving and imprisoned.

Mother had a known history of alcohol dependency and had been in contact with a range of agencies over a number of years. She concealed her alcohol dependency and any impact on parenting capacity of Child S. Between 2014 and 2017 Children's Services had nine contacts and referrals, and conducted four Child in Need assessments, but when information was sought from other professionals, evidence did not support the concerns. Ethnicity/nationality of Child S is not stated.

Learning includes: when predominantly working with adults, it is important to think more widely and remain alert to how the adult's behaviour might impact on children and family life; professionals do not always talk enough to other people involved in a child's life, which can result in them missing crucial information and failing to spot inconsistencies in the mother's account. Uses a learning model based on a Soft Systems methodology.

Recommendations include: review training to ensure that there is sufficient focus on parental alcohol use, misuse and functioning alcoholics, how this can impact parenting capacity and children's welfare and development; ensure that there is a focus on the need to involve and assess fathers and adult men connected to children; to seek reassurance that information sharing protocols between Midwifery services and primary care are robust and that information of relevance to safeguarding is shared.

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Manchester LSCB: Child M1 and M2

Non-accidental injury of child M1 in August 2016 aged under-one-month which led to M1 and M2 becoming subjects of interim care orders and being placed in foster care.

M2 had disclosed to the school twice earlier that year that mother (MM) had hit them, but no further action was taken at the time. MM denied inflicting the injury on M1. Sibling C1 died in 2013 after choking on a small item whilst under the care of father (FM). A serious case review was carried out and M2 was made subject of a full care order at the time but was returned to their mother's care in July 2014. MM was a victim of domestic abuse throughout her relationship with FM and reports continued in spite of MM agreeing not to see FM because of domestic abuse and the choking incident. Family was known to multiple agencies including police, general practitioners, children's services and health visitors. Family is Black Caribbean and White.

Findings include: professionals were generally over optimistic about MM's ability to protect her children; M2's poor behaviour in school was an example of listening to the voice of the child; where there is conflicting information professionals need to seek independent sources and escalate concerns when they have evidenced based doubts on decisions pertaining to safeguarding children. Uses a variant of the systems approach developed by Social Care Institute for Excellence (SCIE).

Recommendations include taking account of and thoroughly understanding any previous serious case reviews in relation to a family.

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Norfolk LSCB: SCR Child V

Death of a six-month-old baby girl from serious head injuries in March 2016. Evidence of previous head trauma and a fracture to her arm. Child V's father was convicted of manslaughter in December 2017.

Child V was born at 26 weeks gestation and was discharged from hospital three months later in November 2015. Child V's brother was 4 years and 4 months at the time of her death. Evidence that he was witness to domestic abuse including serious sexual assault, his father's attempted suicide and alcohol misuse in the family home. The family was known to safeguarding services after police responded to domestic abuse incidents in 2013 and 2014. The police informed the Multi-Agency Safeguarding Hub (MASH). Family is from Eastern Europe.

Learning includes: victims of domestic abuse often withdraw police statements which complicates the prosecution process; professionals must question and challenge decisions and concerns directly with colleagues, irrespective of their professional background or status; the matter of language difficulties and consistent use of interpreters is an area for improvement. Uses the NSCB Thematic Learning Framework model.

Recommendations include: Norfolk LSCB and partner agencies need to develop a system to support non-engaging parents in domestic abuse offences and rape criminal cases; to have robust and easily accessible systems in place to support team functioning and staff wellbeing; ensure that the children's services workforce understands the limitations of solution focused interventions for relationship counselling where domestic abuse is suspected; neonatal and maternity services should implement systems to routinely gather and share safeguarding/domestic abuse information.

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Wakefield LSCB: Ollie

Serious and life-threatening injuries of a 5-week-old infant girl in August 2017 due to shaking. Father subsequently sentenced to three years in prison for grievous bodily harm and neglect. Mother became pregnant shortly after the relationship with father started. Mother attended regular ante-natal appointments.

In February 2017 contact with and by a number of professionals occurred, including by a family member who shared concerns about domestic violence and coercive and controlling behaviour by the father. Father had been known to Children's Services as a child due to concern about domestic violence. In August 2017 mother attended A&E with Ollie who was reported to be vomiting and having spasms in one arm. A number of bruises and injuries consistent with non-accidental injuries were found. The ethnicity/nationality of the child and family is not stated.

Learning includes: understanding parental history and vulnerability is important in assessing actual or potential risk to children; sharing information between health professionals should be seen as standard practice, especially during pregnancy and early childhood; the practical use of information, rather than just recording it, is critical to effective safeguarding arrangements; knowledge of controlling and coercive control in adult relationships can help practitioners make informed decisions about risk to children. The Significant Incident Learning Process (SILP) methodology was used to conduct the review.

Recommendations include: to ensure that there is ongoing scrutiny to evaluate how effective improvement action has become embedded into routine practice; to seek reassurance that the decision making at the point of contact and referral are appropriate and based on appropriate information sharing.

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Wigan LSCB: Child M

Death of a 10-week-old infant in July 2016, found unresponsive in a car baby seat by father in hotel room.

Child M was a second twin, born at 28 weeks gestation, discharged from hospital at age 8 weeks. Mother had three primary school aged children from a previous relationship. The first set of twins were born in June 2015; one twin died at age 3 days, the second had complex health and developmental needs and was 11 months old when the second set of twins were born.

Father of twins had long-term mental health issues; the relationship was not always stable and mother was often left to care for the six children on her own. Family was on holiday when death occurred. No charges were brought in the criminal investigation.

Issues identified include: assessment of parental capacity should include all adults that undertake a parenting/caregiver role with children; infants should never be left to sleep in a car travel seat except for the recommended time span; opportunity to refer mother to Specialist Midwifery Drug and Alcohol Services during first twin pregnancy was missed; inconsistent provision of bereavement support. A hybrid methodology was used to complete the review, combining several theoretical models and techniques.

Recommendations include: partner agencies should have in place a robust Early Help offer to include the unborn child; threshold guidance should have clear step-up and step-down escalation processes when working with Early Help; participation of adult services to support assessment of risk, planning and intervention when working with adults with parental responsibilities; improved focus on the hidden male.

The full report for this SCR is not currently available at this time.

Wiltshire LSCB: Family M

Concerns regarding five children aged between 4- and 12-years in February 2016. Mr W, father of the two youngest children, had watched Category A, B and C child abuse images and uploaded them for others to watch.

In September 2014 he admitted the offences, was arrested and released on bail conditions not to have unsupervised contact with any child. In February 2016 evidence was found that Mr W had sexually abused one of the children living in the family home; he pleaded guilty to 43 child sex offences and was jailed for 18 years.

There had been historic concerns from schools and the police regarding neglect and potential emotional abuse starting in 2007, concerns of domestic violence between mother and Mr W and physical abuse towards the children by them both.

Prioritises six findings: the huge increase in the number of men viewing online child sexual abuse images has not been matched by professional knowledge; the absence of a clear framework for interviewing children outside the established process; insufficient appropriate professional challenge and the use of escalation processes; a tendency for professionals to uncritically accept what parents tell them about their children; professionals are deskilled in their response and inconsistent in how they name child and adolescent neglect; and evidence of lack of rigour and focus in child protection processes. The review was undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence.

There are no recommendations presented as such, but under each finding are questions for the Board.

Concludes by raising concerns regarding the collective and cumulative impact that resource pressures can have on delivery of services.

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