**NSPCC Repository – April 2020**

***In April 2020 eight SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:***

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| 1. **Serious case review: Bilal (full overview report)**   Abstract Serious neglect and physical and emotional abuse of a 9-year-old boy and his siblings by their parents. Bilal (known as Billy) had not been seen by any professional since the age of 14-months and had not received education, health or social care services to meet his diagnosis of autism. Children were removed from state education and faith schools to be electively home educated. Parents believed spirit possession had caused Billy's autism and sought faith-based treatment overseas. Older sibling emailed Childline after concerns about Billy's declining health and possibility that parents would take family to Africa. Police attended and took children into police protection. Parents arrested and serving custodial sentences for child cruelty.  **Learning includes:** the role of neighbours and local communities in recognising and responding to concerns about children and young people; areas that usefully inform practitioner learning and improvements in practice include taking a child-focused approach, cultural sensitivity and professional curiosity; contact with the family at transition from health visiting to school nursing services can help determine 'school readiness' of a child and to identify unmet needs. Billy is Black British of African heritage. Recommendations include: identify how to report and share information about children who have not been seen for a significant amount of time and triangulate whether there are further concerns across agencies; ensure that children and young people who are home educated can access help and support to meet their needs via the current children and young people section of the LA schools and learning webpage.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousBilalOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73EE57526EE7EC0A82BFD51F9CB13BB656AE0DFA091D5DB02E76CDD9BDD761CC58A924A9AA177FB8654&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child Tracy: overview report.**   Death of a 3-month-old girl in March 2019. Tracy was found deceased at home. Criminal investigation commenced by police and care proceedings instigated for siblings. Tracy was the youngest of three siblings; all had recently been made subject to a Child Protection Plan for neglect. In 2018, an anonymous referral regarding malnourishment resulted in sibling made subject to Child in Need. Family history of domestic abuse; father arrested on several occasions and had restraining order not to contact mother. Concerns about parenting capacity and neglect. Maternal history of depression, alcohol and cannabis use. Several agencies tried to engage with mother and offered to provide services within the Early Help Assessment Tool (EHAT); all offers of supports were refused.  **Learning includes:** responsibility to initiate an Early Help Assessment (EHAT) is that of any professional who is working with a child and/or family; lack of support and alternative options available to professionals when responding to a persistent refusal of services; anonymous reports of safeguarding concerns can create a challenge for professionals in identifying the facts and responding to safeguarding concerns in a timely and evidence based approach. Recommendations include: produce a pathway for professionals which details what support, processes and resources are available for engaging resistant families; agency access to policies which detail how they should respond to refusals to engage, share information and escalate concerns into statutory intervention; ensure that information is available to the public on the timeliness of reporting concerns and outcomes available to agencies in response to those concerns.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousChildTracyOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73FE4702BE665C4AC3AF277EAD94FBD686924922CA8DF812AA5F9B4059209C5C995FC4CDE7A1C159DCBE19CE12145&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child G (full overview report)**   Death of a 10-week-old baby boy in March 2017. Child G was a twin, born prematurely and spent the first six weeks of his life in hospital. When discharged the twins lived with their mother and father, and older half sibling (Child I) and Mr B, Child I's father who pleaded guilty to the manslaughter of Child G. Mother had a child who was removed from her care by a neighbouring local authority and placed for adoption. Child I was on a supervision order to this authority, but this was not transferred to other council. Child G's mother shared this information and her history of depression and self-harming with a community midwife; no further action was taken. There was no information of concern held by any agency regarding Mr B; he was considerably older than mother and was seen as a protective factor. Evidence that the adults in this case convincingly lied to professionals about who the father of the children was. Ethnicity or nationality not stated. Learning includes: evidence that there was a potential systemic weakness in the way that information about unborn babies is sought and shared; professionals should always be alert to the possibility that family members may not always tell the truth. Uses the Welsh Model methodology.  **Recommendations include:** ensuring that staff use the correct unambiguous terminology; professionals should consider consulting with the GP's of parents as this will avoid missing information on parental mental health and parenting capacity; professionals should document and share any history of risk/vulnerability when making referrals and providing or seeking information.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SwindonChildGOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93662FA24AC30887DEC15E07D00CD47D3BF2FE25DEB924DAF678F1AB899A072E0B2CE3ADE121CED21EC105C7AC09DACC207&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child V (full overview report)**   Significant non-accidental head injuries to a 7-week-old infant in 2018, attributed to shaking. Father charged with an offence relating to the injury and received prison sentence. Child V lived with Mother and Father; Father had two other children living elsewhere. No Children's Social Care involvement during pregnancy; parents attended routine health appointments. When Child V was 2-weeks-old Police interviewed Father regarding an incident of non-recent sexual abuse; information about the allegation not shared by Police service with any external agency. During last visit by Health Visitor, parents explained that Mother needed to return to work and that Father was caring for Child V. Later the same day Father called ambulance reporting that Child V was unwell; at hospital investigations revealed significant brain trauma. Unconnected allegation of non-recent sexual abuse made against Father in 2016. Ethnicity or nationality not stated. Learning focuses on the following themes: preventing abusive head trauma; opportunities to consider safeguarding in health appointments pre- and post-birth; information sharing to enable wider safeguarding. Identifies good practice: health visitor was professionally curious whilst conducting thorough observations of Child V and the family, supported by detailed recording. Uses the Welsh Child Practice Review process.  **Recommendations include:** programme of awareness and prevention relating to abusive head trauma is developed, agreed and implemented across the partnership area with all parents and carers; explore opportunities locally for professionals to be more aware of the significance of adverse childhood experiences and the importance of proactive professional enquiry regarding family histories.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SwindonChildGOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93662FA24AC30887DEC15E07D00CD47D3BF2FE25DEB924DAF67E8DEC297A072E0B2A09EC7FDC8DEF19DBACDB0093D13EA4F&DataSetName=LIVEDATA) |
| 1. **Serious case review: 'Child N' (full overview report)**   Sexual abuse of a girl between the ages 10-16 years old. Child N disclosed the abuse to a mental health worker in September 2015 at age 19-years-old. Perpetrator convicted of multiple offences against her. Family is white British. Child N lived with her mother and older sister. Maternal history of: foster care; mental health problems; attempted suicides. Child Protection Plan initiated for both siblings for emotional abuse in 2007 due to concerns about multiple men in the home, and Child N being collected from school by different men; stepped down to Child in Need Plan and closed in 2008. Child N known to multiple agencies. Child N's sexual abuse was not identified; several professionals aware of her sexual relationship with an older man. Learning includes: need to reduce thresholds for intervention in complex cases involving neglect; need for professional curiosity and challenge; using historical information, including timelines, can help build a true picture, especially in neglect cases; a multi-disciplinary and/or multi-agency approach is good practice; need to 'think family'; need to consider sexual abuse when very young children self-harm or have injuries to intimate areas; perpetrator confession should be acted on. Uses a hybrid Individual Agency Review and Learning Review methodology.  **No recommendations.** Considerations for the board include ensuring: all practitioners understand the indicators for neglect and are trained to do this effectively; guidance for sexual abuse, including the threshold guidance, is robust and understood; Child Protection Plans are outcome focused; all agencies escalate concerns and use a case resolution protocol appropriately.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019DevonChildNOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02170E525A61C8E57E818C25631E743C0A43CFC16ECD85B73B95C2AD0973CF94E325926627CC05C5FA0311E1DC0024C&DataSetName=LIVEDATA) |
| 1. **Child safeguarding practice review: overview report: Child Ab.**   Neglect and physical abuse of a child over many years. Child Ab and siblings were removed from the care of their mother and stepfather. Child Ab was the second oldest child in the family when stepfather arrived. Stepfather dominated and controlled mother and the children; his behaviour towards Child Ab amounted to extreme cruelty. He did not have parental responsibility but controlled decisions concerning Child Ab, including health appointments. Case for Child in Need plans was closed due to decision that there were no concerns. Stepfather made professionals aware of his intention to electively home educate Child Ab, resulting in Child Ab not being seen by any professional for over a year.  **Learning includes:** lack of curiosity about stepfather's past, or challenge to his dominance and control; need to question and challenge whether an adult who states that they are the parent of a child does indeed have parental responsibility; importance of professionals to challenge parental non-engagement with agencies and to be alert to disguised compliance; consideration of the national plans regarding home educated children and resources to enable elective home education to be effectively assessed and monitored. Ethnicity or nationality not stated. Recommendations include: reinforce the requirement for professionals to maintain vigilance and professional curiosity when engaging with families where there are safeguarding concerns and a step-parent is present; consider the issue of elective home education and hidden children, which is a national issue, with a view to undertaking a future thematic review.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019NorthamptonshireChildAbOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02B7AE13EA03E8B4EF013E26A2FEB43D38E31E254F8FD5F84776921CA35A9CE3E82C3F9B99FB4C80B8D6E8F1F4A75E1F62D5FBF305297C0095FE588&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child Q (full overview report)**   Neglect of a 5-year-old girl in September 2015. Child Q was admitted to hospital in a severely malnourished and dehydrated state. Family was known to children and family services, police and housing authorities. Child Q and her siblings were subject to a Child Protection Plan for neglect in 2014. Moved to Child in Need plan in 2015; cases were later closed and family referred to Families First service. Child Q born prematurely at 27 weeks gestation with significant medical issues. The first day Child Q attended school, staff contacted children's services and Child Q was taken to hospital. Mother and step-father charged with offences against Child Q and other children in the family. Both convicted in 2018 and received custodial sentences. Learning includes: the number of children in the family and the number and range of professionals involved posed a challenge to effective communication; professionals were not curious enough about Child Q's experiences and too quick to accept parents' explanations without considering the whole context of her life; the implementation of the child protection plan was inconsistent and the needs of Child Q were not given sufficient focus. Ethnicity and nationality not stated.  **Recommendations include:** develop a multi-agency policy for the management of non-attended appointments across multiple services; review of information sharing systems between hospitals, GP practices and child health professionals, focusing on communication; ensure that requirements for all children's voices to be heard at child protection conferences are met and that those who cannot speak for themselves are adequately represented.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019SwindonChildQOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE03662FA24AC30887DEC15E07D16CD47D3BF2FE25DEB924DAF679861D2D4A072E0B2EBB1E496EF1C7FD92B01E20DEC02D42E&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child G: review report (full overview report)**   Death of a 2-month-old girl in 2017 due to injuries consistent with being shaken. Mother called an ambulance when Child G went limp while in Father's care. Father admitted manslaughter and was convicted and sentenced in June 2018. Mother had a history of mental health issues, including self harm and suicide attempts and a 12-month stay in a mental health unit, and was receiving support from mental health services. Mother and Father had a history of cannabis use and mother did not attend several appointments. Mother stated that father had been reluctant to help with child care. Ethnicity and nationality of family not stated. Learning includes: it is important to assess and provide support and services to both parents, regardless of gender; when a parent is vulnerable, professionals may struggle to identify that they are not meaningfully engaging with services; there is a need for on-going communication and information sharing around, and following, transitions between services; supervision and clear processes for professionals to follow if they are not receiving supervision as required is vital. Uses the Significant Incident Learning Process (SILP) methodology.  **Recommendations include:** request assurance and evidence from partner agencies that services for young parents include the expectation of appropriate engagement with father's or mother's partners; partner agencies to provide assurance that when vulnerable young parents transition between services, there is a robust and joined up plan to ensure their children's needs and their own needs continue to be met.  **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018KentChildGOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12E70FD3E8B378F52E03BC36F22F047DFA82EA548F8DA1116C19E3F77AC8C891BAD1892A28BC04E7F9D1483460830&DataSetName=LIVEDATA) |