NSPCC Repository – October 2020

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

1. Serious case review: Isabella [full overview report].

Death of a 14-month-old girl in August 2019. Isabella's mother found her unresponsive at home and she was transferred to hospital by ambulance but died after resuscitation failed. Isabella had complex medical needs and global developmental delay. Parents were known to children's services. Mother had been subject to a child protection plan and there were concerns for her around child sexual exploitation. These increased when her relationship with Father became known when she was 16 and he was 21-years-old. Father had issues with alcohol misuse. Isabella was born prematurely and spent 13 weeks in neonatal intensive care, under the care of several consultants with different medical expertise. Concerns were raised about parents' parenting capacity due in part to their young age and missed medical appointments, lack of support, and home environment. Mother gave birth to Isabella's sibling in July 2019.

Learning includes: considerations should be given as to how professionals engage with fathers. If a father has not engaged, it should be clearly recorded that he remains an unassessed risk; if a parent does not consent to Local Authority support for a Child in Need (CIN), careful consideration should be given to escalating the protection provided; information about avoidant behaviour should be shared with all other professionals involved. Ethnicity and nationality not stated. Recommendations include: ensure that the language change - 'Was Not Brought' is reinforced across partner agencies and make certain that practitioners are trained to realise 'medical neglect' and recognise missed appointments as an indicator.

Other resources **Read full overview (PDF)**

2. Overview report in respect of the serious case review for Liam.

Sudden unexpected death of a 1-month-old boy in 2019. During the night Liam's mother awoke to feed him but could not remember the details around this; the following morning she found Liam unresponsive on the sofa. Liam and his half-sibling were subjects of child protection plans for neglect. Half-sibling Emma was subject to a Special Guardianship Order. Mother was known to police as a victim of domestic abuse, and had a history of poor mental health, drug misuse and self-harm as a child, as well as child sexual exploitation. At the time of Liam's death the family was receiving support from health providers, children's social care, psychology service, paediatric and speech and language services. Police were satisfied there were no suspicious circumstances surrounding Liam's death. Inquest concluded that the cause of death was unascertainable. Ethnicity and nationality not stated. Learning includes: pre-birth planning and assessment is important in ensuring early understanding of possible risks; practitioners should be equipped to recognise possible feigned compliance and to address this in assessments and plans;

record keeping was not of sufficient content or quality to know what was happening to the family and what risks were identified.

Recommendations include: where information is missing and reliant on another practitioner or agency to provide it this should be addressed by practitioners through the Escalation Policy; practitioners should be equipped to assess the significance of substance misuse and poor maternal mental health and its impact on parenting capability and put in place an appropriate plan of support and intervention.

Other resources **Read full overview (PDF)**

3. Serious case review for the Children of Family Y: overview report.

Significant and chronic neglect of four siblings over many years. Mother and father were estranged and had lived apart. Children were placed on a child protection plan on two occasions under the category of neglect. Several recordings and anonymous referrals regarding the poor living conditions at the mother's home. Mother displayed disguised compliance in telling professionals this would be improved, as well as not bringing children to medical appointments. Two of the children were reported to be soiling themselves daily at school. The eldest sibling committed intra-familial child sexual abuse (CSA) on his three younger siblings on numerous occasions from 2012 to 2016. Both parents were charged with neglect offences. Learning includes: practitioners should improve their awareness and personal knowledge in being able to recognise and identify symptoms of CSA and neglect; risk assessments must be carried out with the rationale recorded and supervised; 'was not brought' is a more relevant term than 'did not attend' as the emphasis is placed on the parent or carer who does not bring a child to an appointment. Ethnicity and nationality not stated.

Recommendations include: all safeguarding partner agencies ensure that staff are aware of the signs and symptoms of CSA and know what to do if they are seen or suspected; assure that staff complete background chronologies on their case files on children and families subject to child protection enquiries; ensure that staff capture the voice of the child in safeguarding cases and focus on the experience and impact on children.

Other resources **Read full overview (PDF)**

4. Family G: executive summary.

Chronic neglect and intrafamilial child sexual abuse of male and female children, who were aged between 3-9-years-old at the time abuse was first reported. Mother and her male partner were subsequently convicted of multiple offences of sexual abuse. Family were known to multi agency services, and had period of child protection planning under the category of neglect, later stepped down to child in need plans. Concerns re-emerged and children were removed from the family home, on an interim basis, into care. Shortly after the children were removed they made disclosures about their previous home life and of being sexually abused. Ethnicity or nationality not stated. Learning includes: information exchange between professionals must be comprehensive and timely;

professionals need to recognise the different indicators of possible child sexual abuse so that potential indicators are not misunderstood, dismissed or ignored; professionals need to use curiosity, hypothesising and a critical analytical mindset throughout the risk assessment process; if an agency decides not to implement an important case conference recommendation, the relevant agency professional must notify the case conference chair with reasons. Uses the Significant Incident Learning Process (SILP).

Recommendations include: professionals must have knowledge to enable them to identify and respond effectively to children who are or who may be at risk of suffering multiple categories of abuse; professionals must have knowledge of child sexual abuse, including female perpetrator behaviours; Achieving Best Evidence (ABE) interviews and medical examinations must be child centred and undertaken in a timely way; effective management and multi-agency oversight must be child focused, analytical and reflective.

Other resources Read executive summary (PDF)

5. Learning summary in relation to Baby L.

Serious injuries to a 3-month-old infant in December 2018. Baby L was taken to hospital by ambulance. Subsequent medical assessments concluded that some of the injuries had happened prior to the hospital admission. Parents were arrested and bailed pending further criminal enquiries. At the time of the reported injuries, Baby L and their older half-sibling had been subject to Child Protection Plans and to a Public Law Outline (PLO) process. Baby L's parents had lived separately in several other areas of England prior to meeting in 2017. Father had two children from a previous relationship where there had been concerns about neglect and historic injuries. Mother had a child from a previous relationship; contacts made to Children's Services in relation to Baby L's half-sibling. Paternal history of mental health problems and domestic abuse. Ethnicity or nationality not stated. Learning centres around: the effectiveness of pre-birth and post-birth multi-agency assessment, multi-agency case management, inter-agency communication and information sharing; how well practitioners considered the inherent vulnerability of babies to abuse and non-accidental injury, particularly in the context of the trilogy of risk; barriers to recognising and addressing over optimism in parents. Uses the Welsh Model.

Recommendations include: ensure that pre-birth assessments are completed on time by social workers and include all relevant information, and parents' accounts and views are appropriately tested and triangulated by evidence from other sources; ensure that guidance on injuries to non-mobile babies has been widely disseminated to all front-line practitioners and embedded in practice.

Other resources Read summary (PDF)

6. Serious case review: Child A and Child B [full overview report].

Sexual abuse of two children by a carer whilst in a long-term kinship care placement. An older sibling living in the same placement witnessed Child A being sexually abused by the carer and informed Mother and then the Police. Carer received a custodial sentence for

the sexual abuse of Child A and Child B. Prior to entering care, Child A, Child B and Sibling 1 witnessed extensive and serious domestic abuse between their Mother and Father. Initially, the children were placed with Mother under an Interim Care Order, and later placed with Carer 1 and Carer 2 as kinship carers. The carers were subsequently approved as foster carers, and the placement became permanent for the children for 12 years. Learning includes: importance of robust exploration during the approval process for kinship foster carers; placement reviews for looked after children in kinship care placements should identify when National Minimum Standards are not met to avoid children remaining long term in inadequate accommodation; without consistent, rigorous and child focussed oversight by supervising social workers, shortcomings in the parenting capacity of kinship foster carers may not be identified or challenged. Uses the Welsh Child Practice Review model.

Recommendations include: ensure that social workers support children in kinship care to identify a trusted professional who will enable them to get their voice heard in the decisions which impact on their lives; ensure that social workers have access to regular supervision which provides opportunities for reflection and critical challenge with a specific focus on the effectiveness of care plans for looked after children.

Other resources **Read full overview (PDF)**

7. Child sexual exploitation review.

Review of the partnership response to child sexual exploitation (CSE) over two sites in January 2019. Commissioned following an Ofsted inspection of children's services and subsequent monitoring visits. Focuses on the current policies, procedures and practices, with a view to improving the outcomes and responses for children who had been or were at risk of CSE. Review included a literature review of policies and procedures relevant to CSE, analysis of seven case audits, focus groups with professionals, and conversations with young people and their caregivers. Identifies 14 areas for consideration representing issues which are national areas for development. Ethnicity and nationality not stated. Observations include: there was evidence of good recording and record keeping throughout the case audits; six out of the seven cases audited involved children in care, and the relevant statutory processes and CSE process observed worked well together; social workers welcomed moves towards reflective practice within children's services; professionals wanted further support to apply their existing skills to the online context to enable them to respond to online abuse and exploitation.

Key areas of focus going forward include: consider reviewing training to ensure that it provides staff with the relevant knowledge and support they need to complete CSE risk assessments to quality assurance standards; ensure that professionals are aware that where there are safeguarding risks, consent is not required prior to making a referral; enhance work with children at 'low risk' of CSE to ensure an effective pathway and escalation process.

Other resources **Read report (PDF)**

8. Serious case review overview report in respect of: Child E 2016.

Death of a 5-year-old child in July 2016. Child E's step-father pleaded guilty to manslaughter and no inquest was carried out. Family had contact with children's services over 14-month period prior to Child E's death, with fluctuating concerns by professionals about care being provided by Step-father and home environment. Step-father was judged as “medium risk” to the children concerning domestic abuse, alcohol use, driving without a license, and sexual offending. Concerns over contact with unknown men who posed risks to the children. Mother had some level of learning difficulty. Significant incident in May 2015 when children were pulled from the family car by Step-father and left on the pavement. Learning includes: focus on the physical care of the children and home conditions diverted attention from other serious issues, including risk of being in contact with people who presented risks to the children; professional challenge and escalation is important in effective intra and inter-agency work; agencies that saw signs of concern dealt with them appropriately most of the time but some intra and inter-agency communication and information sharing could have been better. Ethnicity and nationality not stated.

Recommendations include: more training on neglect and its impact on children, more understanding of legal processes and what local authorities must evidence to secure statutory orders; raise awareness of the Escalation Procedure and the importance of robust, respectful professional challenge between and within agencies; consider the introduction of a panel, chaired by a different professional to take a “fresh look” at cases that are making insufficient progress.

Other resources **Read full overview (PDF)**