Torbay Safeguarding Children Partnership

NSPCC Repository – November 2020

In November 2020 seven 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: Child CH: review report (full overview report)

Death of a 14-year-old girl in June 2018. In May 2016, Child CH was placed in care due to long-term neglect and emotional abuse. She had three foster placements and two placements in children's homes. Whilst in care, she disclosed previous sexual abuse. Throughout her time in care, Child CH had many missing episodes and was seen at hospitals on several occasions for self-harm and suicidal ideation. She was kept in hospital following tying a ligature around her neck as her placement said they could not manage her safely. From May 2018, Child CH was at a mental health hospital and continued to display ligaturing behaviours. She went missing from the hospital and was found dead four hours later. Ethnicity/nationality not stated. Uses the Significant Incident Learning Process (SILP) methodology. Learning includes: risk assessments need to be holistic, shared across agencies and reviewed regularly; perceived risk can increase professional anxiety and be a barrier for access to services and placements; and when a child in care is particularly vulnerable, there should be a plan for service delivery which takes this vulnerability into consideration.

Recommendations include: request assurance on the commissioning arrangements for placements for children who require stable and safe care; ensure information about looked after children is shared with a placement or hospital when a child is moved; and write to the Department for Education and Ofsted about the challenge in finding placements for children with significant risks and vulnerabilities.

Other resources Read full overview: www.cumbria.gov.uk/eLibrary/Content/Internet/537/6683/6687/17955/4403591118.pdf

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2. Serious case review: Child H (full overview report)

Death of a 9-month-old child in February 2014 as the result of a hypoxic brain injury. Mother convicted of causing or allowing her child's death; her male partner was convicted of murder. Mother and her partner both known to health, children's services and the police. Initial assessment by Children's services; no further action taken. Maternal history of premature birth; partner history of domestic violence towards two previous partners. Ethnicity or nationality of Child H is not stated.

Learning includes: need for multi-agency collaboration, assessment, managerial oversight, supervision and challenge; if duty officers in children's services do not routinely communicate with the referring practitioner before making decisions about a referral, misunderstandings can occur and this leaves children vulnerable; need for agreements and plans to be monitored, reviewed, checked and shared with other agencies; all family

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members, especially those living in the household, should be subject to assessments, both to determine risk and to confirm and assess their ability to protect children in the family; need to engage men; unaddressed domestic abuse can leave some children vulnerable and with ineffective help. Makes no recommendations but sets out questions and issues for the safeguarding board to consider around practice, procedures and strategies.

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

3. Child I serious case review: overview report: version 8

Death of a 9-week-old infant in 2018. Child I had no identified health concerns and the cause of death was unascertained. Child I was found unresponsive in an unsafe sleeping position co-sleeping with his mother, Mrs I. Resuscitation was attempted and during this Mrs I made statements of guilt to hospital staff and police who identified that Mrs I was under the influence of alcohol. Parents were known to Police for alcohol related incidents. At the time of death there were concerns that Child I had been subject to neglect. Two hours following Child I's death Mrs I was arrested at hospital for driving with excess alcohol. Both parents were arrested the following day for neglect.

Learning includes: practitioners working with families should take every opportunity to remind parents of key safe sleeping messages tailored to their needs; health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims; good practice was shown by the neonatal doctor in following-up after Child I was not brought for a repeat blood test. Ethnicity and nationality not stated. Recommendations include: support professionals working with universal and high risk families to identify safe-sleep risks, emphasising 'out of routine' events such as going to a party or on holiday; support professionals in discussing alcohol consumption with parents and highlighting what happens on those occasions when they may binge/drink more than usual; Portsmouth hospital should review and improve continuity of carer arrangements, especially when there is staff sickness.

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

4. Serious case review: Family G review report (full overview report)

Death of two children by their parents in May 2019 as a result of strangulation. Four surviving siblings are in local authority care subject to care proceedings. Mother and uncle (later known to be father) convicted of two charges of murder, four charges of attempted murder and six charges of conspiracy to murder; in November 2019 both sentenced to life imprisonment. Parental history of: neglect; child protection plans; being in care; child sexual abuse; separation and loss. Family known to multiple agencies. Family are white British. Issues identified include: need to recognise and respond to harmful sexual behaviour by professionals; professional optimism and the need to be more professionally curious and take a holistic view; invisible male carers/fathers; eligibility to services; impact of delays to provision of services and the need to meet needs in a more timely way; need for a more integrated offer to families with children with Attention

Deficit Disorder; need to align special educational needs and disabilities (SEND) processes; need to understand the impact of lived experience, especially trauma, on parenting.

Recommendations include: streamline specialist support; consider how professional optimism impacts on assessments; consider fathers in assessment; develop an integrated offer for harmful sexual behaviour; Child and Adolescent Mental Health Services to consider the impact of delays to service provision and how to meet needs in a more timely way.

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

5. Child T: Child safeguarding practice review

Death by suicide of a 17-year-old child in November 2019. Child T was diagnosed with autistic spectrum disorder (ASD) in 2012. Child T's behaviour deteriorated at secondary school and they were permanently excluded and transferred to a pupil referral unit (PRU) in 2016. Child T displayed aggressive behaviour on several occasions and admitted to drug misuse. Child T attempted suicide four times and was admitted to hospital twice between December 2017 and September 2018. In the eight months leading up to their death, the only services involved with Child T were a special college and an adult sleep clinic. Family are Catholic but Child T did not hold any faith. Ethnicity/nationality not stated.

Findings include: education, health and care (EHC) plans and safeguarding of those with special educational needs and disabilities (SEND) need to be more aligned to ensure safeguarding issues aren't minimised due to SEND; the emergency provision for young people following a suicide does not aid recovery for the young person or the family; and when a young person has highly complex needs, the focus can be entirely on the young person without consideration of the impact of issues on the wider family.
Recommendations include: review the offers of post-diagnostic support for autistic spectrum disorder; challenge agencies and partnerships in how they listen to young people around the transition to adult services; and ensure a review by the SEND board takes place to address issues holistically before consideration of school exclusion.

Other resources Read practice review (PDF)

6. Serious case review: Child N (full overview report)

Injuries to a 4-week-old infant in 2016. Civil court found that the injuries were caused by Father and that Mother failed to protect Child N. A criminal investigation in respect of Mother, Father and Paternal Uncle concluded with no further action in 2020. Child N lived with their mother, father and older sibling, Sibling 2. Both siblings were subject of a Child in Need plan at the time of the injuries. Another older sibling, Sibling 1, died when aged 5-months-old. Mother was a teenage parent with a history of self-harm, mental health problems and personality disorder, and substance misuse. Father had experienced a difficult childhood and had anger control issues. Ethnicity or nationality not stated.
Learning includes: when one parent has mental health issues affecting their ability to care for the children, the assessment and plan needs to consider the impact on the other

parent/carer; supervision for professionals needs to ensure they are focused on the child and not by the parent's histories and situations; professionals should seek to understand the nature of parenting relationships from the point of view of both parents/adults and the child, and not focus only on the mother. Uses the Significant Incident Learning Process (SILP) methodology.

Recommendations include: confirm if formal pre-birth assessments are being undertaken in cases where a new baby will be the subject of a child in need or child protection plan at birth; consider the benefits and practicalities of requesting that the information that a child is on a child in need plan is shared with all professionals working with the family.

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

7. Alice and Beth: Serious case review report (full overview report)

Death of two sisters aged 3- and 1-years-old in 2018. Alice and Beth died within two weeks of each other. Police investigation revealed the cause of death to be interference with the normal mechanics of breathing. Mother was convicted of murder and imprisoned. Alice and Beth's parents had separated before Beth was born. Mother was in a new relationship before Beth's birth. Alice had attended A&E previously for injuries and seizures. Several accusations of alleged abuse were made by both parents and mother's partner, as well as arguments over contact with Alice and Beth. Numerous reports to children's services, the police and the NSPCC were also made.

Learning includes: where a family moves between areas, the new authority and relevant partners need to be informed; where possible more information should be achieved and explored when referrals come to the multi-agency safeguarding hub (MASH) to better understand the nuances of the referral; when concerns raised about parents can be easily refuted there is a danger that professionals can be prone to dismiss other information in the same vein. Ethnicity and nationality not stated. Recommendations include: encourage professionals to adopt an investigative, questioning and professionally curious approach when considering the history of a case; seek reassurance that the West Midland Regional Safeguarding Network policy on 'Protecting Children who move across Local Authority borders' is understood and adhered to; be assured that GPs are clear on the pathways and procedures for making timely referrals to Children services.

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