Torbay Safeguarding Children Partnership

# NSPCC Repository – January 2021

***In January 2021 six case reviews were published to the NSPCC Repository. A summary of each of these cases can be found below:***

## 1. Serious case review: Child X (full overview report)

Death of a 7-year-old boy in December 2016. Emergency services found Child X and Mother deceased at Mother's home address. Inquest concluded Child X was unlawfully killed, and Mother died by suicide. Family moved to England in 2011 for work. Mother worked as a nurse; history of alcohol dependency and mental health problems. Had contact with Police following a rape allegation in 2015. Mother's hospital employment terminated in 2015. School concerned about Child X's appearance and attendance; referrals made by family and school about Mother's wellbeing. Mother reported to cousin that she was going to take her own life and that of Child X. Father reported Child X as missing after he did not attend school, and being unable to contact Mother. Family are Irish.

**Learning includes:** information sharing within police did not always work well and information about Mother and Child X was lost; information held by friends and family should be taken seriously and support given to help them share information; lack of focus on the potential impact of Mother's alcohol use and mental health on her role as a parent and a nurse.

**Recommendations include:** guidance from the College of Policing should be unambiguous that, in cases of sexual assault, a victim care plan should be delivered by the police force where the victim resides; GPs should always ask patients whether they have any dependants when alcohol misuse is a problem; consider with national organisations whether a helpline for families concerned that a child is at risk could be developed.

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

## 2. Child Safeguarding Practice Review: Helen

Delay in responding to potential trafficking of a female child in May-June 2019. Aaron and Helen, both African, presented as homeless; Aaron applied for accommodation. Housing raised concerns with children's social care and police that Helen, 24-years-old according to Aaron, was a child. Helen was removed under Police Protection Powers and placed in foster care in June 2019. An age assessment of Helen resulted in an age of 12-years-old assigned to her. Aaron was arrested for trafficking offences.

**Learning includes:** immigration identification documents are not evidence-based; need for professional curiosity; need for professional advice in a timely manner and to escalate concerns to enable a multi-agency approach; need for a multi-agency approach to age assessment and to have a pathway to resolve disputes on the presenting age of an individual; consider the child's views at all times.

**Recommendations include:** Local Safeguarding Partnership to develop effective multi-agency pathway and deal with risk of child trafficking; UK Visas and Immigration to ensure robust identification procedures and have a consistent approach to directing practitioners with concerns if someone with an adult ID is thought to be a child.

**Other resources** **Read practice review (PDF)**

**3. Serious case review: Freddie (full overview report)**

Examines the quality and effectiveness of statutory agency involvement with Freddie, a child under 8-years-old, from January 2014 through to his being made the subject of a final Care Order in October 2016. Freddie lived with his mother and two older half-siblings who were known to children's services due to concerns including neglect and physical abuse. Evidence of sexual abuse of Freddie's half siblings by their father. Freddie's mother started a relationship with a person posing a risk to children. The children were made subjects of Child Protection Plans under the category of sexual abuse in June 2014. Accounts of Freddie displaying sexually inappropriate behaviours at pre-school; excluded from school in June 2015 for displaying aggressive and sexualised behaviours. In March 2016, Mother reported that she no longer felt able to manage Freddie and he was taken into local authority care due to neglectful parenting. Whilst in care Freddie made statements about sexual abuse that had taken place within the family.

**Learning includes:** importance of management support and supervision when working with intra-familial child sexual abuse; the value of seeking additional input from specialised services in helping professionals remain objective and child focused; not letting biases of professionals towards parents hamper judgements and undermine decision making.

**Recommendations:** ensure that the plans for children subject to Child Protection Plans are fit for purpose and have pace; to examine blocks and barriers to effective multi-agency work around the issue of child sexual abuse; and increase the knowledge and confidence of practitioners in assessing and working with cases involving child sexual abuse.

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

**4. Multi-agency Learning Review: Child Sam**

Serious, non-life threatening injuries to an adolescent in 2019. Sam was the victim of a targeted attack and admitted to hospital. Sam had been known to services from an early age. Parents had separated; history of domestic abuse, some of which Sam witnessed. Father is in prison custody. Mother had two further children with new partner, one of whom died of natural causes. Police involvement with Sam on several occasions, including being arrested predominately for drug misuse. Sam left education aged 15-years-old with signs he was associating with people involved in organised crime. In 2017 a friend of Sam's was the victim of homicide. Sam was arrested for suspected involvement in a separate murder, for which he remains under investigation. In 2018 Sam was suspected in county lines drug supply. Ethnicity and nationality not stated.

**Learning includes:** following any high-profile local incident community tensions and anxiety are likely to be heightened; safeguarding partners need to be assured that they are sharing key information and that they are doing so securely in compliance with regulations; there are potential implications for children and vulnerable people who are 'released under investigation' especially when this is for an extended period.

**Recommendations include:** local police should review its 'Released Under Investigation Framework' to ensure that professionals conducting reviews take cognisance of a suspect's age, vulnerabilities and safeguarding risks; review the 'Step Up & Step Down' procedure to ensure that a multi-agency approach is taken when making decisions relating to levels of need.

**Other resources** **Read learning report (PDF)**

**5. Serious case review: BR19: Review Report**

Child sexual exploitation and neglect of an adolescent girl. An incident of rape and sexual abuse of a 15-year-old girl by teenage males in February 2019 involved other children as victims, perpetrators or witnesses. Review focuses on one child, BR19. Criminal proceedings ongoing at the time of the review; BR19 and her sibling have been taken into care. Maternal history of Adverse Childhood Experiences (ACEs) including sexual exploitation; being in care; and domestic abuse. Mother had BR19 as a teenager; was imprisoned when BR19 was young. BR19 lived with Father until aged 10-years-old, when she returned to Mother. Both BR19 and her sibling were made subject to Child Protection Plan in 2013 for neglect. BR19 was not in school throughout most of an 18-month period; concerns expressed by Mother of possible child sexual exploitation (CSE) of BR19; became subject to a Child Protection Plan in September 2017 and 2019 due to ongoing concerns around CSE and Mother's ability to protect BR19. Ethnicity or nationality of family not stated.

**Learning includes:** multi-agency planning and analysis of risk; impact of CSE and services for survivors of CSE who are parents; parental engagement and consent; professional challenge and escalation; professional curiosity of the child's lived experience; contextual safeguarding and perception of sexual activity between teenagers being consensual. Identifies good practice from professionals.

**Recommendations include:** strengthening multiagency decision making and practice in relation to child protection processes; understanding and responding to the link between adolescent neglect, CSE and contextual safeguarding; understanding the impact of traumatic adverse life experiences on parenting through partnership assessments.

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

**6. Serious case review report Child Ap (overview report)**

Death of a 1-year-old girl in April 2018 due to a suspected non-accidental head injury. Child Ap was in the care of Mother's partner, Mr X, on the day of the incident. Mr X called Mother reporting that Child Ap was unresponsive having fallen off the bed and an ambulance was called. A CT scan at hospital suggested that Child Ap had suffered

bleeding and swelling of the brain. Subsequently discovered that Child Ap had suffered an earlier brain injury and concerns were raised at hospital as to the possibility of non-accidental injury. Mr X was convicted of Child Ap's murder and sentenced to life imprisonment. Child Ap's siblings had presented with several injuries over previous years and had also missed many health appointments. Mr X had been in care as a child and had a history of violence and substance misuse, as well as allegations of drug dealing. Child Ap's father was serving a prison sentence at the time of her birth.

**Learning includes:** there is a need for information sharing to support holistic assessment; professional intervention was adult focused and the children's voices were not fully sought or captured; it is important to assess significant male adults in the lives of children. Ethnicity and nationality not stated.

**Recommendations include:** ensure that agencies involved in child protection processes work together and focus on the needs and wellbeing of children; ensure agencies share all information known to them in order that a holistic assessment of the family can be undertaken.

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