**NSPCC Repository – September 2020**

***In September 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 into the care of Jack [full overview report].**

Abstract Serious harm suffered by a 3-month-old baby boy because of multiple injuries including fractures and bruising of the brain in May 2017. Jack lived with his parents; had been subject to a child protection plan because of risk of neglect before birth. At the time of the injuries, he was subject to both a child protection plan and Interim Supervision Order (ISO). Family were known to multiple agencies; older sibling had been taken into care and adopted. Maternal history of: depression, being a looked-after-child, learning disabilities. Following the identification of the injuries, Jack was made the subject of an Interim Care Order (ICO). Ethnicity or nationality of Jack is not stated. Identifies lessons in relation to effectiveness of assessments; consideration and management of risk; injuries to pre-mobile babies need to be viewed from a perspective of potential risk; consider risk of neglect where a child's weight is varying; need to involve and support fathers; need to share information to allow robust discussion of concerns.**Recommendations include:** ensure that procedures on pre-birth assessments are consistent, contain guidance on timescales and ensure sufficient challenge; ensure that all agencies understand legal orders and their implications; child protection plans are SMART using tools to measure progress; review and reissue guidance for parents with mental health problems, joint working, and bruising in pre-mobile babies. **Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020CambridgeshireAndPeterboroughJackOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92674FE28BA368259E10FE47035E770D8A909EE4CF9CE5FA4736326DB3486D87399E8E9BDBC14200231B0BF94456CECAC7E7B494AC94C75E1AFE0DBAC0A80EE6674A3245D58&DataSetName=LIVEDATA) |
| 1. **Serious case review: overview report: Baby B.**

Abstract Life-changing injuries to a 10-and-a-half-month-old infant in November 2013 due to shaking. Mother's partner was convicted of causing grievous bodily harm and was imprisoned. Mother was convicted for neglect and received a suspended sentence. Baby B was the second child in the family. Baby B's parents had separated and both children were living with their mother and her partner. Anonymous report about neglect made to the NSPCC in June 2013; Children's Social Care found no concerns. Baby B was not brought to several health appointments; sibling had high rate of school absenteeism. Concerns about domestic violence; mother's partner's child had been subject to a child protection plan due to domestic violence in earlier relationship. Family is White British. Case review conducted following an investigation in December 2018 by the Local Government and Social Care Ombudsman into complaints made by Baby B's father against East Riding Council.**Learning includes:** concerns made anonymously should be treated as seriously as those that are not anonymous; health visitors and school nurses provide a useful link between schools and health services; where professionals have personal or professional relationships with a service user or someone closely involved with the service user there is the potential for professionals' boundaries to become blurred. Recommendations include: practitioners must ensure that they are complying with current legislation, statutory guidance and agency polices relating to information; ensure that the minutes of strategy discussions are included within the case record of all agencies involved in the meeting and include the arrangements for review. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020EastRidingBabyBOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92074E03E9A368257EA1BCE7825FB73F9BB3CF94EF5D94AE5716835A6C417B96D2757DF3AD7E53A9E3681576E797CDF8D345A46&DataSetName=LIVEDATA) |
| 1. **A serious case review overview report: Megan.**

Abstract Neglect and abuse of a 6-year-old girl over a number of years. Megan was placed in the care of her paternal grandmother in 2012 via a Special Guardianship Order (SGO). Megan was neglected and physically abused by her father, her paternal grandmother and her grandmother's partner. Megan was brought to hospital 'acutely unwell' and staff found her covered in bruises. Megan was removed from her grandmother's care in 2015. Her father, grandmother and partner received substantial custodial sentences. An initial case review was carried out by the Social Care Institute for Excellence (SCIE) in 2017. This review reassesses the 2017 report. Ethnicity or nationality not stated.**Learning includes:** need for practitioners to improve their awareness and personal knowledge in being able recognise and identify the signs and symptoms of all child abuse; the voice of the child was not effectively captured at the time considering the subsequent disclosures Megan made; agencies should have robust record keeping and management systems in place; a consistent lack of professional curiosity and scrutiny displayed in the assessment of child protection concerns; too much optimism when conducting the SGO application of parental grandmother's capacity to care. Recommendations: Gloucestershire County Council Children Social Care to develop a safeguarding pathway for the application of family members for Special Guardianship Orders. The process will include utilising a Family Group Conference and to apply for an interim Kinship Foster Placement to allow safeguarding to remain in place whilst a detailed viability assessment of the prospective guardians' capabilities is conducted. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020GloucestershireMeganOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92279FC3FAB3A954AE10EFF712EF054FBA83EEA56D3CA58B9776536CB72BCDD76EAC4EBC8B3B7B92757613DFCB8CB9852FEDEA0B26BC6104F&DataSetName=LIVEDATA) |
| 1. **Child U1 serious case review [full overview report].**

Abstract Death of child under 3-years-old (Child U1) in January 2018. A post mortem concluded that the death was a result of internal bleeding caused by significant trauma impact to the abdomen. Partner of Child U1's childminder was found guilty of the child's murder, and the childminder was found guilty of causing or allowing the death of a child. Both received prison sentences. Child U1 was born in March 2016, and had an older sibling who was under 4-years-old at the time of their death. Child U1's father had no contact with the family. Child U1 first attended hospital with an episode of minor gastro-intestinal bleeding in April 2016. There were frequent hospital visits in 2016/17 including surgery; initial concern regarding non-accidental injury (NAI) but this was discounted and a medical cause was thought to be responsible. A strategy meeting concluded that there were no safeguarding concerns in relation to Child U1. Family are Mixed Race British. Key findings: a decision that the injuries were due to a medical cause rather than NAI meant professionals did not query an alternative diagnosis; deference to the medical clinicians involved made challenging medical professionals difficult.**Recommendations highlight the need for:** professional curiosity, professional challenge and information sharing within and between agencies; assessments to include an understanding of care arrangements and an assessment of the carers; and an understanding of differential diagnosis, and when bruising is present where NAI should be considered. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020ManchesterChildU1Overview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92874FD29A03A954AE10ECF712EEE55E3FC16FD5DEECA54AE762223D83A12EB19EBDA4A288EEBC7ED4002A5BFE279A131264D81D3CC&DataSetName=LIVEDATA) |
| 1. **Summary report: serious case review: Young Person B.**

Abstract Self-harm of a young female in June 2018. Young Person B took a significant overdose of her prescription medication, alongside over the counter medication, which caused a brain injury. Young Person B was subject to periods of abuse and neglect from an early age. She lived with her family until October 2017, when she moved in with the mother of her boyfriend in an informal arrangement. Disengaged from education early in 2017; prior to the overdose some instances of less serious self-harming. Ethnicity or nationality not stated. Learning includes: importance of ensuring representation from schools at child protection conferences and in core groups even when the child or young person is not attending school; importance of reviewing the impact of child protection plans; the need to risk assess access to prescribed medication for children and young people who self-harm; importance of understanding the potential adverse impact of private fostering arrangements not being assessed on the young foster person and on other children in the family; persistent fear and anxiety caused by childhood neglect impacts on children's ability to learn, solve problems and relate to others, which undermines their ability to manage further adversity in adolescence.**Recommendations include:** ensure practitioners understand the features of adolescent neglect and review the effectiveness of local approaches in addressing both chronic and acute factors; ensure that the voice of the child is more consistently acted upon; ensure private fostering is more effectively publicised across the partnership and children are identified, assessed and supported in their private fostering arrangement. **Other resources** [**Read summary (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousYoungPersonBSummary.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF725E36C29E561D3BF2AE456DEEF48A66C6D21C572BCDD7683C470FCB3B7B927653133BD176AE240F817E6B69B8A257E&DataSetName=LIVEDATA) |
| 1. **Serious case review in respect of Family W: executive summary.**

Abstract Significant neglect of two siblings, including neglect of their physical, emotional, social developmental, health and medical needs. Both children had been the subject of child in need plans since October 2016 and child protection plans under the category of neglect since June 2017. Alcohol use and abuse were present in this family but was not identified as a risk factor and addressed. Ethnicity or nationality of family not stated. Learning includes: at times, the focus was on the adults rather than the lived experiences of the children; information sharing within and between agencies was not always consistent; over-optimism about the likelihood of the adult carers improving their care of the children; a lack of challenge to adult family members which led to gaps in information. Identifies good practice, including: direct work carried out by the school nurse, which allowed the child's voice to be heard and shared; recognition by dentist that one of the children's decayed teeth and bleeding gums were indicative of neglect.**Recommendations:** highlights the improved outcomes that have been identified and should be addressed, including: multi-agency partners can evidence a shared responsibility for the safeguarding and protection of children; multi-agency assessments, risk assessments and effective safety plans are secured and monitored within the child protection conference process, to ensure the best outcomes for children; amending the pathway for capacity assessments of carers with learning difficulties so that they can be undertaken at an earlier stage. **Other resources** [**Read executive summary (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020WestSussexFamilyWExecutiveSummary.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93270E03E9B2A954DE104CA782AEB5DCF9A1CF35DFFC949A2776900C931A1D8628B89EFBCA8A35CD57DE31A0063906A5B5F672EEB0E8AD02CF84D2B04FA&DataSetName=LIVEDATA) |
| 1. **Serious case review: overview report: Child LK.**

Abstract Death of an 8-month-old girl in 2017. Rose was transported to hospital by ambulance and shown to have a subdural bleed reflecting severe brain trauma. Two days later life support was withdrawn due to the severe brain injury. Mother charged with her murder as well as offences from 2004. Mother known to services since 2015 when pregnant with Daisy, Rose's sister. Father had a learning difficulty. Rose born in 2016 after a concealed pregnancy. Mother was suspected of serious injuries to a child in 2004, but after police investigation Mother was not prosecuted for any criminal offences at the time.**Learning includes:** consider opportunities to ensure disguised compliance and focus on children to be examined regularly in staff supervision meetings and reviewing desired outcomes for children; develop and implement guidance relating to looked after children who sustain injuries, including who should be informed and what action should be taken; consider options for ensuring continued and meaningful engagement of GP services throughout safeguarding processes; consider how non-statutory voluntary organisations can be identified and included in safeguarding processes; consider requiring the local authority to complete and share the outcome of an analysis of children placed at home, the circumstances and decisions which led to placements being initiated and how compliance is monitored, to ensure the safety of all children who are subject to home placement agreements. Ethnicity and nationality not stated. Review does not include any recommendations. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019LancashireChildLKOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02974FD29A92C8E57F619CF712EEE55FA8616FD5DEECA54AE762223D83A55BD1CB3DA4A288E56064244A8E15EF1C4A886A77A296942&DataSetName=LIVEDATA) |
| 1. **Overview report: serious case review:  Child A**

Abstract Non-accidental head injury to a 2-year-old boy, Child A, in February 2016. The injury was discovered during an unannounced visit by a social worker. His mother had no explanation for the injury and had not sought medical help. Child A lived with his mother and older brother (Child A1) who was born in 2007. Both children were subject to Child Protection Plans under the category of risk of emotional harm on two separate occasions. Reports of incidents of domestic abuse as well as the physical abuse of older brother by mother. Evidence of mother's complex mental health issues, drug and alcohol abuse and series of abusive relationships. Child A1 is described as a young carer for his mother and younger brother. Ethnicity or nationality of Child A is not stated. Lessons learned include: the seriousness of the concerns and risks to the children were not effectively communicated, shared or addressed; professionals need to retain open minded curiosity and consider all potential risks to children; and professionals should be supported in considering the impact on them of working with people who present as aggressive or with challenging behaviour.**Recommendations include:** conduct a multi-agency review of the use of the category of emotional harm in child protection plans; ensure that professionals understand the purpose of the Core Group and Child Protection Conference; and recognise the impact on practice when working with adults with violent and aggressive behaviour or disguised compliance. Other resources [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019LeicestershireAndRutlandCaseAOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02970FA29AD2C925BF60FE47035E770D8A90BFE4CF0DD53AF426D20D91D83CF7580D1F6BDB94C390320A09F20692D52EBCB4913D5B11292BBDCD4E968C5EC0E9074&DataSetName=LIVEDATA) |