NSPCC Repository – February 2021

In February 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 C (full overview report)

Death of a 15-year-old boy in May 2019 as a result of being stabbed. A 15-year-old boy was found guilty of Child C's murder, and a 16-year-old boy and 18-year-old male were convicted of manslaughter. Child C had been permanently excluded from school, and had been injured in another stabbing three months before his death. Increasing police contacts and concerns about behaviour and escalating risk prior to incident. Child C was going missing with concerns about criminal exploitation and county lines involvement. Parents had separated and Mother lived with new partner. Two referrals to children's services and concerns over Child C's cannabis use.

Findings include: exclusion from mainstream school can heighten risk; education settings need access to local intelligence; clarity is needed about interventions to mitigate extra-familial risk; involving and supporting parents is essential to effective safety planning; inconsistent judgements about risk creates uncertainty; poor case recording can directly impact on practice. Child C was from a Black and minority ethnic background.

Recommendations include: review processes that involve the application of risk gradings for young people at risk of serious youth violence; exhaust all kinship options as part of a safety plan for children who are at risk of serious youth violence; schools ensure they have a detailed understanding of the potential safeguarding needs of any child at risk of permanent exclusion; ensure that policy, procedure and guidance is sufficient to ensure the active consideration of racial and cultural identity as part of the safety planning process involving extra familial risks.

Other resources Read full overview (PDF)

2. Serious Case Review: Child A (full overview report)

Death of a boy aged under 3-months-old in June 2019. Child A was found unconscious on the sofa at home in the morning by Mother; Father was asleep on the sofa. Child A was taken to hospital by ambulance where he was confirmed dead. Child A was born prematurely and spent time on the neonatal unit prior to being discharged home. Mother is a care leaver and had disclosed cannabis usage; Father also known to use cannabis. Concerns that both parents were using cannabis when visiting Child A on the neonatal unit. On the day of Child A's death police and lead nurse for child death visited family home; concerns noted about home environment.

Learning includes: Mother received consistent support from the Care Leavers Team, but insufficient consideration was given to how she would manage living independently with Father of Child A and her unborn child; parents should have been challenged about their use of cannabis and they should have been offered Early Help; there were opportunities

for professionals to have visited the family home prior to the discharge of Child A, which may have identified the need for more support. Ethnicity or nationality not stated.

Recommendations include: ensure that training of professionals includes the impact which cannabis use can have on parents' ability to care for their children; promote the feasibility of conducting the antenatal and postnatal visits jointly, and ensure that the Graded Care Profile 2 (GCP2) tool is utilised where concerns are raised regarding home conditions and potential neglect.

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3. Serious case review: Baby B (full overview report)

Serious non-accidental head injury and bite marks to Baby B, a 20-week-old baby who was taken to hospital on 23 December 2016. Baby B's father was found guilty of grievous bodily harm and received a 12-month prison sentence. Baby B was born prematurely at 28 weeks and remained in a neonatal intensive care unit for 14 weeks prior to discharge. Baby B was the first child born to their mother who was 17-years-old and the second child of their father who was 20-years-old. Baby B was identified as a Child in Need while in hospital.

Issues of concern included: the relationship between the parents; their ability to parent safely due to low level maturity; concern about Father's use of cannabis and history of violent and aggressive behaviour. Evidence of domestic violence. Baby B's mother engaged with all ante-natal services and had a high number of medical presentations during her pregnancy, but did not disclose domestic abuse. Ethnicity or nationality is not stated.

Key learning: maintaining a focus on fathers of children to establish more clearly the implications of their needs and role in the family; need to ensure that the Local Safeguarding Children Board escalation policy is disseminated across the whole safeguarding partnership to ensure practitioners and managers challenge when there is a difference of opinion. Recommendations: children's social care to ensure that multi-agency Child in Need plans are in place for children in need; partner agencies to brief their staff on their responsibility to ensure child in need plans are in place.

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4. Serious Case Review Family M

Serious harm and sexual abuse of children whilst living with a relative under a Special Guardianship Order. The review concerns six children, of whom four were removed from one situation where they were likely to suffer significant harm to another where they experienced severe abuse. The children had moved from another local authority area and were placed with the perpetrator and his wife. Behavioural problems were attributed to early trauma; this was magnified by the perpetrator's ability to create a narrative that he and his wife were "courageous and brave" in taking on the children.

Findings include: the need to share information across the multi-agency network; practitioners need to be equipped to undertake assessments which include hearing the

voice of the child, understanding the meaning of a child's behaviour, and maintaining professional curiosity; friends and family assessments should always include consideration of the impact of placement on all children in the household.

Recommendations include: ensure that there is a focus on the voice and lived experience of children in assessments and interventions; consider the child's history, the history of their care givers and the motivation underlying their application to look after the child; the Safeguarding Children Partnership should work with partner agencies to develop a strategy on recognising and working with child sexual abuse within the family; and agencies should evaluate their supervision systems and provide an opportunity for practitioners to analyse in complex family situations.

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5. Serious case review: Chid O (full overview report)

Serious harm suffered by a 11-week-old baby boy in October 2016. Child O was taken to hospital by his parents where he was found to have injuries indicative of abusive head trauma. Child O was seen as vulnerable but no safeguarding concerns were identified. Sibling S had previously been subject to a Child in Need plan. Following hospital discharge, both Child O and Sibling S were placed in foster care. Family are White British (former travellers), and known to multiple agencies. Maternal history of: mental health problems; severe adverse childhood experiences; persistent non-engagement; teenage pregnancies; subject to Child Protection Plan.

Learning focuses on the following themes: importance of: timely record keeping and information sharing, including relevant past histories; engagement with fathers, young people and hard to reach individuals, including at or below the Child in Need threshold; high quality, reflective, restorative supervision and management oversight; planning to achieve outcomes; professional scepticism/challenge; adherence to agency and multi-agency policy, procedures and good practice in a timely way, especially when dealing with new born babies; consider the impact of adverse childhood experiences; incorporate family culture and context into assessments; quality assurance of supervision for health providers.

Recommendations include: ensure the needs and risks of new born babies are given sufficient attention in their own right; promote restorative practice; seek multi-agency involvement before closing a in Child in Need case.

Other resources Read full overview (PDF)

6. Serious case review; Frankie (overview report)

Death of a 15-year-old boy in the summer of 2018. Frankie was fatally stabbed when attacked by a group of adolescent males in London. One young person was convicted of murder and four were convicted of conspiracy to cause grievous bodily harm. Frankie lived with his mother and two siblings; his father was in prison from 2016. Family was supported by a Child in Need Plan, following a social work assessment that identified concerns around involvement in crime. Frankie had a Referral Order for theft and knife

possession and was permanently excluded from school in 2018. Frankie's social worker had concerns about his associations with gang culture. No evidence to indicate that Frankie's murder was gang related. Ethnicity or nationality are not stated.

Learning and recommendations are integrated and include: ensure timely notifications to relevant persons when a child dies outside of the area in which they reside; improve notification processes for agencies when a child becomes the subject of a Child in Need Plan; review permanent exclusion processes within schools to reduce the potential for safeguarding risks to children at risk of exclusion; understand how to incorporate the concept of contextual safeguarding in the assessment of risk to children in the future; evaluate how partner agencies support families affected by gang association; assess how partner agencies share intelligence related to gang affiliations.

Recommendation made to the National Child Safeguarding Practice Review Panel to consider a national thematic review because of the prevalence of similar incidents across the country.

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