NSPCC Repository – March 2021

In March 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: Sam and Kyle: overview report

Death at home of Sam, a 2-year-old boy in January 2018. Cause of death was unascertained. Sam's older sibling Kyle was placed on a Child Protection Plan after Sam's death, and subsequently placed in foster care. Sam and Kyle's mother was a looked after child, placed in foster care at 10-years-old following sexual abuse by her father. She was 18-years-old when Kyle was born. Father was known to social services when a child. Kyle was registered as a child in need until May 2015 when the case was stepped down to early offer of help. Concerns about home conditions, the maturity of mother, and father's offending, alcohol misuse and incidents of domestic violence. Evidence of cuts and bruises on Kyle. Kyle's behaviour was seen to be aggressive and destructive at nursery and at school. Family identified as white British.

Learning includes: the impression is of agencies working in silos rather than developing a shared understanding of the case; professionals concentrated on their own engagement with parents and their compliance, rather than attempting to place the child at the centre.

Recommendations include: review procedure for the escalation of concerns and for resolving differences of view between professional and agencies; explore better co-operation between agencies when handling complex or persistent cases; review interagency procedures for establishing agreement with families of written care plans.

Other resources Read full overview (PDF)

2. Serious Case Review: BSCB 2015-16/03 (full overview report)

Serious injury to a 4-month-old baby consistent with shaking and an impact to the head in November 2015, resulting in permanent impairment. Mother was convicted of child cruelty to the baby and their sibling in March 2020. Both baby and older sibling were taken into care and adopted. Family were known to multiple agencies, including Children's social care. Concerns that neither parent seemed to have bonded with the baby. Parental history of: refusal to accept support or engage with services; social care interventions; teenage pregnancies; adverse childhood experiences; violence and crime (father), mental health issues (mother). Ethnicity or nationality of the baby is not stated.

Lessons: if families do not want or refuse early help it, concerns should be escalated; intervention pathways need to be clear; new birth visitors should have all the information before the first visit; need to remain focused on all family members and their needs; information should be linked, shared proportionately and well-recorded; assessments should identify risks and vulnerabilities; referrals should be seen in context; engage with fathers. Blended approach based on Root Cause Analysis.

Recommendations include: improved provision and organisation of early help services including how new birth visits are carried out; develop operational guidance to enable triggers where there are multiple referrals/contacts including using chronologies; fast decision-making when there is an open case and another referral is made.

Other resources Read full overview (PDF)

3. Multi agency local learning review: Child D: learning theme: repeat missing episodes between 2017 and 2019: "if you take me home, I'll just go missing again".

Placement of a 12-year-old girl in secure accommodation in May 2019. Child D and her family were well-known to services and there was a history of criminality, mental health issues and drug and alcohol misuse in the family. There were concerns about previous neglect and non-protective behaviour from her mother and sexualised behaviour from her sibling and a section 47 enquiry was undertaken in respect of both children. Children's social care received a multi-agency referral form in May 2017 raising concerns that Child D was a victim of child sexual exploitation. By March 2019, Child D was frequently going missing, was involved in criminality and reported misusing substances. Throughout her life, Child D disclosed several instances of rape and sexual abuse. In May 2019, Child D was found almost unconscious and intoxicated in a local park. She was admitted to hospital and children's social care were informed. Following this, Child D was accommodated in a secure residential placement where she remains under section 20. Ethnicity and nationality not stated.

Findings include: Child D's aggressive behaviour may have impacted on professionals' perspective and response to the case; despite being on a child protection plan, outcomes did not improve for Child D; and there appears to have been a lack of cohesion in care planning.

Recommendations include: analyse themes and trends from return home interviews to inform service provision; consider developing a strategy to manage highly complex and high-risk cases; review escalation around the legal gateway process.

Other resources Read learning review (PDF)

4. Serious Case Review: Child L (full overview report)

Death of an infant girl aged under 3-months-old in September 2018. Cause of death was attributed to airways obstruction in the context of co-sleeping. Parents were cautioned for child neglect and drug possession offences. Child L was born prematurely and lived with her mother, father and older sibling, Emily. Her older sibling, Beth, lived with maternal grandmother; there was a lack of information about the reasons for this. Child L's father had history of depression and anxiety. Home conditions were reported to be cluttered, chaotic and dirty and subsequently deemed to constitute criminal neglect. Both siblings underwent child protection medicals; Emily was found to be dirty and unkempt. On the day of Child L's death parents provided different accounts in relation to where she had slept the night before.

Learning includes: importance of enquiries about sleeping arrangements and the number of bedrooms in general. This can provide a clearer indication of where family members are sleeping and counteract disguised compliance when speaking with professionals; lack of professional curiosity about older sibling living with grandmother; information about paternal and maternal mental health and substance misuse. Ethnicity or nationality not stated.

Recommendations include: ensure the Graded Care Profile 2 (GCP2) tool is utilised in every case where concerns are raised regarding home conditions and potential neglect; ensure that the Clutter Image Rating Scale (CIRC) is utilised where clutter is identified as a factor; review multi-agency training to ensure that training on neglect includes professional curiosity, disguised parental compliance, and the avoidance of normalising poor conditions is embedded.

Other resources Read full overview (PDF)

5. Local Child Safeguarding Practice Review: Child RN19

Death of a 15-year-old child in 2019. Child R became unresponsive at home and died after being taken to hospital. Child R was found to be emaciated but otherwise well cared for. Concerns from school about poor attendance. Child R had been removed from school and commenced Elective Home Education (EHE) in 2018. Initially planned to be short-term with a place at grammar school which subsequently fell through. Several GP appointments were attended for chest pain from eating fatty food. Contacted NHS 111 and eating disorder charity counselling services days before death. Coroner's inquest returned a narrative verdict which indicated that Child R died of natural causes with Anorexia Nervosa as a causative factor. No criminal charges made by police. Family is White British/Russian.

Learning includes: parents and professionals should remain curious about what their children are thinking, feeling and accessing on mobile devices; social isolation can have a negative impact on emotional and psychological health; school staff should act on healthcare concerns by offering referral to appropriate services; GPs should use tools to recognise faltering growth and eating disorders are part of the differential diagnosis for this.

Recommendations include: review material available to parents to help them recognise the signs of Anorexia Nervosa and the importance of early diagnosis in children; consider requesting a National Review on EHE to change non-statutory guidance to improve opportunity to promote the welfare of children receiving EHE; raise awareness across the partnership of early recognition of children with eating disorders and professional curiosity and how to promote this within systems.

Other resources Read practice review (PDF)

6. Child B

Disclosure by a 14-year-old girl in January 2019 of four offences of rape by an adult male. Concerns that Child B was at risk of sexual exploitation had arisen a year earlier when Child B had travelled to a hotel to meet a man she had been in contact with over Facebook. Child B had been supported as a Child in Need and was later the subject of a Child Protection Plan, as well as being referred to CAMHS, Catch-22, and Barnardo's. There were concerns at school about bullying and Child B had moved to an Alternative Education placement. Further concerns about disguised compliance from Mother and Father's lack of engagement. Child B made several disclosures of grooming and sexual exploitation which resulted in Section 47 enquiries, and was accommodated under Section 20. Ethnicity and nationality not stated.

Findings relate to: the multi-agency sexual exploitation process; child in need/child protection; the significance of neglect as a factor which underlies adolescent vulnerability; bullying; early intervention to prevent child sexual exploitation; information sharing; school nurse involvement; safeguarding roles and responsibilities; public awareness of child exploitation; the voice of Child B.

Recommendations include: ensure that children and young people assessed as at high or medium risk of sexual exploitation are immediately flagged on the information systems of all agencies who are in contact with the child or young person; ensure that the support provided to children and young people at risk of sexual exploitation also considers the current and future needs of younger siblings living in the same household.

Other resources **Read summary online (PDF)**