NSPCC Respository – December 2016 / January 2017

In December 2016/ January 2017 one combined DHR/SCR and six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

City and Hackney LSCB: Combined domestic homicide review and serious case review: Ms AB aged 45 years: Child D aged 22 months: each killed in Hackney in March 2014

Death of 22-month-old Child D and her mother, Ms AB, in March 2014. Child D's father and Ms AB's ex-partner, Mr YZ, was convicted of their murder and sentenced to life imprisonment. In February 2014, Ms AB reported serious domestic abuse to the police. Prior to this, there were no records of Ms AB and Child D having contact with any agencies other than universal health services. Father had a previous conviction for drug offences and was known to drug and alcohol services and the Probation Service.

Issues identified include: Ms AB's disclosure to the police of Mr YZ's threat to kill her and her three children (Child D's siblings aged 14 and 15) did not result in a thorough investigation and action to protect them; there were missed opportunities to refer the case to children's services who could have made their own risk assessment of potential harm to the children.

Single and multi-agency recommendations include: the Metropolitan Police Service should review its electronic crime reporting system to ensure that: any threat to life in a domestic abuse case is reviewed by an inspector who will be responsible for implementing and directing actions; and when children are named as victims or witnesses in a domestic abuse case, a pre-assessment checklist is shared with children's services. The College of Policing should commission research to identify a model of safe exit planning for adults and children who are victims of domestic abuse.

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Lancashire LSCB: Child O

Death of 22-month-old Child O at the hands of their mother who also killed herself in summer 2014. A post-mortem concluded mother and child died of carbon monoxide poisoning. Parents were separated, and mother and Child O had since moved to a number of areas around the country. At the time of their death in Lancashire, they were not known to any statutory or other agencies within the county. Father had made an application for contact with Child O and a Cafcass children's guardian was working with the family. Mother had made unsubstantiated allegations to Devon and Cornwall police of domestic violence and sexual abuse against Child O's father.

The coroner's inquest concluded there was no substance to the mother's belief that she was being pursued by Child O's father and he had acted appropriately throughout. Mother had a history of possible post-natal depression and personality problems; and giving misleading information to statutory services to conceal the whereabouts of herself and Child O.

Findings include: there were organisational weaknesses in the approach to working constructively and proactively with fathers; professionals need to be encouraged to balance respect for women who talk about domestic abuse with appropriate scepticism and curiosity where allegations are denied. Makes multi-agency recommendations including developing knowledge and awareness of the nature of homicide in the context of parental conflict

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Sunderland LSCB: Baby E

Death of a 4-month-old girl in September 2013 whilst sleeping in her parents' bed. The Inquest concluded there was no evidence that drugs caused or contributed to the death and the medical cause was recorded as unascertained. Parents were convicted of Child Cruelty and received a six month custodial sentence suspended for two years. Family had been referred to children's services by health professionals and the police due to concerns around parental substance misuse and the behaviour of the two eldest siblings. Initial assessments were undertaken, but did not result in any child protection intervention. Mother had a history of: non-engagement with professionals, substance misuse and a violent relationship with the father of her first three children. The role the mother's new partner, the father of Baby E, played in her children's lives had not been assessed by professionals.

Identifies findings, including: failure to engage effectively with fathers or significant males; concerns not given high enough priority; professionals were too parent-focused and wishes of older children were not considered; lack of multi-agency collaboration and risk assessment tools; and conflicting professional views about the impact of illegal substances on parenting capacity. Sets out key findings using a systems model based typology. Sets out issues for the Local Safeguarding Board to consider in light of these findings.

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Sunderland LSCB: Baby W and Child Z

Head injury to 11-week-old baby boy admitted to hospital in November 2012. The injury was later found to be a skull fracture believed to be due to a non-accidental head injury. Baby W and his 3-year-old brother Child Z were taken in to care, and later adopted, following the incident. Child Z had previously been identified as a Child in Need due to concerns about neglect. A decision for this case review was sought retrospectively since Sunderland Children Safeguarding Board was not notified in 2012 about the incident. Mother, who was 17-years-old when she first became a parent had been living with her grandparents, who were seen by professionals as a supportive factor. She moved into her own accommodation following the birth of Baby W. Mother had a history of: concealment of pregnancies, lack of engagement with professionals and neglectful parenting. The father was not known to any services.

Issues identified include: lack of detailed awareness of Unborn Baby Procedures and their relationship to Child Protection Procedures; limitation to professionals' understanding of the impact of neglect on children's development; poor record keeping; and a lack of supportive opportunities to reflect on practice.

Recommendations include: practitioners should have access to information about the tools to use in assessment; partner agencies should ensure chronologies of 'significant events' are used and maintained; and a Multi-Agency Neglect Strategy should be developed.

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Bournemouth and Poole LSCB: Baby N

Death of a 17-week-old boy in summer 2015 from “sudden unexplained death in infancy” (SUDI). Baby Nathan died whilst co-sleeping with his mother and the Coroner's report indicated overheating through being over wrapped as a contributory factor. Baby Nathan had been subject to a child protection plan due to neglect at the time of his death. Mother had been in care during her childhood and became pregnant at 16-years-old. Father had Attention Deficit Hyperactivity Disorder (ADHD), a history of drug abuse and violent behaviour and was known to the Youth Offending Service (YOS). Father's violence towards his own mother had led to two Multi Agency Risk Assessment Conferences (MARAC) before baby Nathan's birth. Maternal grandmother had a history of hoarding behaviour, leading to cluttered home conditions in which Baby Nathan slept. Issues include: contact with social workers and health professionals were problematic and a pre-birth risk assessment was not completed due to parental resistance; MARAC did not share information about father's violent behaviour with the mother; the baby's living and sleeping arrangements were not reviewed by health professionals.

Learning points identified for the Local Safeguarding Children's Board (LSCB) include: the LSCB should satisfy itself that all agencies share information; protocols for the Protection of the Unborn Child need to be fully understood by practitioners; the LSCB should consider including risk of SUDI in Child Protection Planning for under ones at risk for neglect; and the LSCB should ensure clarity about health visitor's role in safeguarding babies with regard to baby's sleeping arrangements.

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Sunderland LSCB: Baby O

Non-accidental injuries to a six-month-old baby girl in August 2013 who was admitted to hospital a fractured femur and bruises. Mother became seriously ill following the birth and parents struggled to care for Baby O. History of: missed health appointments and poor home conditions. Baby O and her older sister were removed to the care of their paternal grandmother in May 2013. Grandmother already cared for two children under four years and struggled to look after the two siblings. Following her hospital admission in August 2013, Baby O and her sister became subject of care proceedings. Paternal grandmother was convicted of child cruelty and neglect in 2015. Mother died in 2014 from complex medical condition. Maternal history of: domestic violence; depression, non-engagement with services; and missing own health appointments. Father had history of anxiety and depression. There was a delay in the initiation and completion of the serious case review.

Issues identified include: pattern of neglectful parenting not consistently monitored; threshold for Children's Services intervention was high; some positive examples of escalation but also failure to escalate and challenge inaction by Children's Services; lack of clarity about legal and safeguarding issues related to placement with grandmother; mother's vulnerability and health condition and father's involvement not sufficiently shared or considered. Uses a systems methodology.

Recommendations include: implementation of Graded Care Profile (GCP) for interagency use in cases of neglect; regular multi-agency workshops; audit of Section 47 enquiries. Highlights some examples of good practice by professionals, in keeping the children as the central focus.

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Unnamed LSCB: Child BS

Death of a 2-year-1-month-old girl in 2016 in hospital as the result of multiple injuries. Child died from a serious brain injury sustained whilst in the sole care of mother's new partner. The partner was charged with murder and was sentenced to nine years' imprisonment. The mother was placed on police bail. Family were known to universal services only. Child had a bruise to the face the week before the incident which was recorded by the nursery.

Issues identified include: the significant impact of the change in the mother's relationship on her children's safety, a lack of robust recording by the nursery following an injury to Child BS and a lack of robust evidence behind Ofsted's positive rating of the nursery's safeguarding provision leading to a misplaced confidence in their procedures. Also identifies examples of good practice including: supportive and timely postnatal contacts with child health services and contact from the local Children's Centre to offer a range of community services following the birth of both children.

Recommendations include: develop common guidance and supporting documentation for local nursery providers; develop public awareness of domestic abuse and the risks to children at the points of parental separation and newly formed relationships; and get assurance from Ofsted that the lessons of the review have been acted on and disseminated throughout the organisation.

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