NSPCC Respository – July 2018

In July 2018 five SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Barking and Dagenham LSCB: Child C

Death of Child C, a 3-month-old Black British/Caribbean girl, in September 2016 from cardiac arrest, while in the care of her mother. After her death, Child C was found to have multiple fractures consistent with non accidental injuries. Parents received custodial sentences.

Child C was born prematurely at 28 weeks and admitted to neonatal unit. Hospital staff made referral to children's services regarding mother's limited visits during her baby's stay and engagement with staff. A child protection plan was made for Child C and her sibling. Mother and children moved in with maternal grandmother, to avoid children being taken into care. Previously, mother of Child C lived between family and friends and turned down offers of housing. Mother of Child C denied a relationship with the father of children but said he was supportive.

Child C was travelling in a sling on the bus with her mother. Mother asked passengers for help, saying her baby had stopped breathing. Child C presented at hospital with cardiac arrest and bruising and swelling to her head and eyes.

Maternal history of: domestic abuse; abuse as a child; homelessness; and reluctance to engage with services.

Findings include: impact of poverty and homelessness on the child (including pre-birth) should always be considered; and investigations of fathers must be pursued even when resistance from mothers.

Recommendations include: training for staff working with avoidant and hard to engage families should include identifying disguised compliance; and the relevant LSCB's must get assurance that agencies demonstrate how fathers or absent parents are included in any assessments.

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Bristol LSCB: Aya

Death of Aya, a six-month-old baby who died after suffering non-accidental head injuries whilst in the care of her father on 25 December 2016. Aya's father pleaded guilty to her murder and received a life sentence. Aya's mother moved to the UK from Eastern Europe. Her pregnancy was unplanned; Aya's father did not want to continue with the relationship but wanted to remain in Aya's life; her parents lived together in a platonic relationship.

Both parents attended the hospital booking appointment with the midwife. Aya's mother reported a history of depression, feeling isolated and previous cannabis use. Aya's father said he was smoking cannabis. Both were noted to have low mood. Aya's mother was not asked about domestic abuse as her partner was present, and she was identified as a low risk pregnancy. Aya's birth was uncomplicated and routine care was provided. Aya's father appeared supportive towards Aya's mother and helped in her care.

Findings include: there is currently no specific universal programme of work with fathers either in the antenatal or postnatal period; the need to routinely question all mothers about domestic violence.

The methodology used was based on a broad systems approach.

Recommendations include: ensure that routine questioning about domestic abuse is embedded within all agencies working with women and children; that updated guidance will include within it that all members of the primary health care team who work with parents and children receive notification of any childhood injury; the need to implement aspects of the Healthy Child Programme that relate to fathers' engagement.

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Croydon LSCB: Child J and Child K

Severe malnutrition of a 4-year-old child in 2015. Child J was admitted to hospital with severe acute malnutrition, diagnosed as a condition most usually found in developing countries, which could have been fatal if treatment had been delayed by 24 hours .

Child K is Child J's 16-year-old half sibling. Mother and maternal grandmother were arrested; a police investigation concluded that no further action should be taken in respect of any criminal offences. Child J was placed in foster care; Child J's condition deteriorated again and, following a further episode in hospital, was placed with another set of carers and now lives in a permanent home away from their family. Parents' relationship had broken down and father had applied for contact. There were allegations of domestic abuse.

Lessons learned include: the impact of parental disputes, allegations of domestic abuse and conflict on children is not well understood, Child J did not reach the threshold for ongoing services from children's social care and there was little focus on the impact of these issues on Child J or Child K; the child abuse investigation system in Croydon lacks effective joint planning between police and social workers particularly when there is another sibling in the home.

Recommendations include: health visitor resources should be sufficient to carry out recommended checks to identify potentially vulnerable children; disseminate information on the importance of considering weight and height measurements to identify children with faltering growth; focus on identifying the best way to make sure placement planning focuses on all the child's needs.

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Derbyshire LSCB: Child Practice Review ADS13

Death of a 9-week-old infant in June 2013 due to a head injury. The cause of the injury and the circumstances in which it occurred were still under investigation at the time of the report.

The child lived with both parents, and prior to the incident the family had only been involved with universal services. Parents were regarded as competent and caring. At the time of the incident the father was providing sole care. He had consulted with the GP earlier in the day, and when the child's condition deteriorated he called emergency services. Hospital examinations indicated traumatic head injury and child protection procedures were invoked. The child died three days following hospital admission. The review of the case did not find that additional services should have been offered or that alternative action should have been taken.

However, some wider learning was identified, including: importance of joint working and reciprocal information sharing between members of the primary health care team; to explore ways in which new fathers may be better engaged and supported by services; importance of providing health protection messages in relation to protecting infants' heads, including the message that it is never safe to shake a baby.

Uses the Child Practice Review process that was introduced in Wales in 2013 to replace the serious case review process.

Recommendations include: health commissioners and providers of health visiting services should work together to ensure that the vulnerability of new fathers providing a primary care role to infants is considered in the assessment and provision of services.

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Unnamed LSCB: Child G

Death of Child G, a teenage girl, in spring 2015 by suicide. Child G experienced problems at home and at school which escalated in the weeks preceding her death. She suffered from depression and had feelings of worthlessness and being unloved; there was conflict between herself, her mother and her siblings. She self-harmed and had one episode in hospital following an overdose. She was excluded from school when she and two friends stole craft knives from a classroom. Two days later she hanged herself in the garden shed.

Lessons learned: the need for a coordinated approach to children and young people who self-harm; sufficiently robust safeguarding responses to self-harm and suicide ideation in teenagers; assessment as a dynamic process that should be updated as circumstances change; guidance around exclusion and vulnerable pupils in school.

Recommendations include: to launch a campaign to raise awareness of self-harm and suicide ideation in children and young people; that agencies and CAMHS have sufficient tools, education and knowledge to assess risk and implement risk management plans for children and young people who self-harm; to ensure that the TAF/CAF model that supports early help for children is provided for families whose needs do not reach the threshold for statutory services; the LSCB should be assured that NHS England has informed all pharmacies in NHS England regarding selling of medication (Nytol) to children; to review processes for communicating available help to bereaved parents and their families.

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