NSPCC Repository – October 2019

In October 2019 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Kent LSCB: Child H

Death of a 5-year-old boy in June 2018. Mother killed herself and Child H during planned unsupervised contact outside the family home.

Parents had separated following incidents of domestic violence by mother against father and Child H's adult half siblings. Maternal history of sexual abuse by her father and mental health problems from 1998; she was treated for depression with anti-depressants up to 2014. Family known only to universal services until April 2018. The family are white British.

Findings: information about the mother's mental health history was not passed on to the health visitor so her initial assessment did not take this into account; most professionals did not immediately consider the issue of the mother's employment when assessing risk following the incident of domestic abuse; the DASH risk assessment tool has insufficient focus on emotional abuse and mental health issues and too much focus on physical harm; male victims of domestic abuse do not see themselves as victims; mother's relationship with Child H could be described as enmeshed which may explain the homicide-suicide incident.

Recommendations to the LSCB: to require Kent Police to resolve difficulties causing delays in providing CAFCASS with relevant information when they are undertaking safeguarding checks; to ensure when Police Officers take a person to hospital it is possible to pass on relevant information confidentially to a clinician in a speedy time-frame; to develop an increased understanding of the needs of men as victims of domestic abuse and what this means about the nature of services provided.

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Unnamed LSCB: Child A19

Death by suicide of a teenage girl in January 2019.

A19 started self-harming in 2017 and in September 2018 mother contacted the school with concerns about A19's self-harm and suicidal thoughts. In October 2018, A19 disclosed that she had been sexually assaulted by a distant family member; school reported this to the police; A19 did not wish to support a prosecution. Towards the end of term, A19 disclosed to a teacher urges to self-harm or worse; information shared with mother who agreed to take her to a GP. In the new term, A19 messaged a former teacher disclosing self-harm the previous day and referred to the sexual assault. School was alerted; lessons included the issue of suicide that day. A19 taken to hospital later that day and died six days later. Ethnicity or nationality of A19 not stated.

Learning: early help for young people suffering self-harm and/or suicidal tendencies needs development to promote multi-agency working; responses to a young person disclosing sexual abuse may be more effective if they feel included in discussions regarding decisions and potential outcomes; training required to assist social workers exercise their right to disclose information confidentially.

Recommendations: to enhance the use of the self-harm referral pathway and refer young people when support is needed; to ensure similar enquiries are managed by the police in a sensitive manner when a young person feels unable to proceed with a prosecution and victims better informed if there is no intention to speak to the alleged perpetrator.

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Unnamed LSCB: Child K

Death of a young boy as a result of injuries sustained as a consequence of his mother's actions. Mother arrested and charged with Child K's murder; she pleaded guilty to manslaughter on the grounds of diminished responsibility. Psychiatrists concluded that she was suffering from an acute mental disorder at the time of the incident. Father was a registered sex offender following conviction at age 16 and was subject to an indefinite Sexual Offences Prevention Order.

Child K was subject to a Child Protection Plan when a few months old and his sister from birth due to risk of sexual abuse and neglect. Ethnicity or nationality of Child K is not stated.

Learning: a more thorough assessment of mother's background would have identified high risk factors including a family history of mental illness and childhood abuse; no-one knew the mother used illegal drugs and parents were not challenged regarding their lack of engagement with the drug project; the risk the father posed to his child was not assessed by the time Child K was born; concerns about the family were not discussed at the multi-disciplinary team meetings held at the GP practice; parents were often not present for planned visits.

Recommendations: practitioners must be provided with appropriate knowledge and skills to identify those at risk of developing mental health problems; relevant learning is disseminated to organisations, such as faith establishments, that are likely to encounter people at times of crisis; provide information to be used by GPs when referring women for terminations.

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Gwent Safeguarding: SEWSCB 1/2017

Death of an adolescent girl by suicide in January 2017. The young person had experienced physical, emotional and possible sexual abuse as a child. Parents had separated and the young person moved in with her father from the age of 9 years old.

Struggled with school transition and from school year 8-to-9 began self-harming and had suicidal thoughts. Referred to School Inclusion Centre in October 2015. Excluded from school and referred for Home Tuition after an incident with a blade in April 2016. Referred to Child and Adolescent Mental Health Services (CAMHS) in October 2015 and was regularly seen by the service with her father.

Between May 2016 and December 2016 four serious attempts at self-harm resulted in hospital admissions. Ethnicity and nationality not stated.

Learning points include: CAMHS to review its use of "texting" contact and develop guidance on use to ensure it meets required governance standards; consider the development of a multi-agency locally agreed policy/protocol for the management of high risk cases of self-harm and potential suicide; signpost and make accessible information and guidance for young people and their families/carers experiencing difficulties in managing social media and the internet; CAMHS service to review how they communicate with families about the outcomes of their psychiatric assessments and ongoing formulation of the young person's mental health; explore opportunities for practitioners to gain broader experience and knowledge to promote and deliver collaborative and multi-agency approaches to the prevention of suicide and self-harm.

Makes no recommendations except those included in the learning points.

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Wakefield District LSCB: 'Madison'

Death of a 6-day-old baby girl in July 2017. Father was sentenced to life imprisonment for murder.

On the third day after birth father contacted emergency services reporting that Baby Madison had breathing difficulties after falling off the sofa. Madison was transported to hospital and was found to have a brain injury considered to be non-accidental, and extensive bruising and injuries. She died in hospital three days later.

Family had been known to Children's Social Care since September 2015 due to concerns about poor home conditions and neglect in relation to Madison's sibling. Evidence of domestic abuse but no indicators of either parents presented a risk of harm. Death of maternal grandmother two months before the birth of Madison had a significant impact on the parents. Ethnicity or nationality of family not stated.

Learning includes: in cases of concerns about long-term neglect it is important to understand the child's lived experience, and assess the totality of the child's care; importance of reflective and challenging supervision in cases where there are concerns about long- term neglect to guard against the rule of optimism; importance of recognising a lack of engagement/disguised compliance.

Good practice identified includes: early recognition of the family's need for enhance support by the health visitor.

Uses the Significant Incident Learning Process (SILP) methodology.

Recommendations include: use a standardised, objective approach to the assessment of neglect; need for a shared understanding and common language of levels of needs/thresholds, particularly following a referral to Children's Social care.

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Western Bay LSCB: WB S36 2017

Death of an 8-month-old baby boy in the spring of 2017. Mother had been sharing her bed with baby and his older sister. Mother reported she had found him unresponsive. An ambulance was called; no injuries were identified and examining paediatrician stated that he had died prior to arriving at hospital.

Concerns raised that Mother continued to bed share with her older child and that she was drinking alcohol. Baby was the youngest of six siblings. Four older siblings had been removed from parent's care; two adopted, two in foster care.

Mother was psychologically assessed and found to have impulsive sensation seeking and histrionic personality traits. It was suggested she put her own needs before her children's. Family was in contact with services across two local authorities. Ethnicity and nationality not stated.

Learning includes: develop guidance to help Children's Social Care staff work better with colleagues from other Local Authority areas, particularly where members of the same family reside in more than one area; co-sleeping advice should be further reinforced after baby reaches 6 months, particularly with respect to risk factors; practitioners should be clear about family structure and seek information about all adults involved with a child and to consider the type, level and quality of contact and care; all conversations held with Children's Services should be documented in the child's records - even if the outcome of the conversation is no further action.

Makes no further recommendations other than those included in learning points.

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