Torbay Safeguarding Children Partnership

NSPCC Repository – January 2020

In January 2020 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

1. A serious case review under Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006: 'Child 1': the overview report.

Life threatening injuries to a child attributed to physical abuse. Child 1's sibling was referred for paediatric assessment, which also identified abuse. Mother and partner were arrested and prosecuted. Child 1 and sibling lived with mother and her partner. Partner controlled mother, prohibited her from having contact with children's father, subjected her to domestic violence and abuse, and abused the children when they began cohabiting. He isolated mother from her family; and was issued a harassment warning by police following threats to relative. Mother sought support for low mood and self-harm from GP. Child 1 had been observed with bruising and other injuries at nursery but this was not evaluated as a potential safeguarding concern. Child of partner's previous partner (Partner 2) disclosed to teacher that partner was abusive and violent towards their mother, leading to charges for domestic violence and abuse. Police and Crown Prosecution Service applied for him to be remanded into custody and informed that partner was living with two young children with serious child protection concerns; application rejected by magistrates.

Learning includes: risk and harm from control and coercion represents a different threat to other forms of domestic violence and abuse; intimidated adults and children are unlikely to disclose information; prior history of domestic violence and abuse is a significant indicator of higher risk in subsequent relationships. Issues for national policy considerations include: guidance on coercion and control as a safeguarding issue and the implications for practice; guidance and arrangements for training for magistrates in regard to domestic violence and abuse.

Other resources [Read full overview (PDF)]

2. Baby C: Serious case review (full overview report)

Abstract Death of a baby within a week of birth. Both parents concealed the birth, death and burial of Baby C. No agencies were involved until after Baby C's death when mother disclosed to her mother (maternal grandmother), prompting a police investigation. Older sibling had been removed from parents care and adopted. Father was violent and controlling of mother in their relationship. Mother claimed that Baby C had been born with a deformity and would not take breast milk. Mother and father were charged with murder but the judge ruled that a murder conviction would not be safe, as cause of death was unascertained. Parents pleaded guilty to concealment of birth and were sentenced. Baby C was White British. As the deliberate concealment from all agencies of the pregnancy and subsequent death of Baby C could neither have been predicted nor prevented, this review only looks at potential interventions which could support practice and lessen the likelihood of similar events happening in the future.

Recommendations include: consider developing a system of notification letters to the GPs of parents who have experienced the traumatic loss of a child through adoption; explore the possibility of whether, under the General Data Protection Regulation (GDPR), notification outlining the information the GPs will need to know could be legitimately sent, in the interests of the parents,

when consent cannot be obtained; seek reassurance that suitable provision is available to support women who want to break the cycle of repeat pregnancy and care proceedings.

Other resources [Read full overview (PDF)]

3. Serious Case Review: Child X (full overview report)

Abstract Death of an 11-year-old boy in May 2017. Parents called an ambulance because Child X was suffering with a chest infection. Paramedics attempted to take him to the nearest hospital but parents refused and he was taken to a hospital further away. Child X suffered cardiac arrest en route and died. Child X had complex health needs since birth including cerebral palsy and epilepsy. His parents cared for him full time. He was admitted to hospital twice in May 2015 and Father questioned treatment. A Section 17 assessment was triggered in July 2015. Section 47 enquiries were initiated in January 2016 which led to Child X being made subject of a Child Protection Plan for neglect, later stepped down to a Child in Need plan. Several professionals reported aggressive behaviour by Father and parents were difficult to contact and displayed challenging behaviour. Family are Black/African Caribbean and Jehovah's Witnesses.

Lessons learned include: the threshold for intervention due to neglect was too high; emergency contingency planning should be given more attention when working with families with children with life limiting conditions; and professionals would have benefited from a unified approach to working with a family they found hard to engage. Makes recommendations including: there should be clear guidance for staff where parents are reluctant to engage; ensure a system for identifying a Lead Professional for all children with complex needs is in place; and the ambulance service should review guidance on how police assistance can be used to ensure the welfare of patients.

Other resources [Read full overview (PDF)]

4. Serious Case Review: Services provided for Child M and his mother

Abstract Death of a 5-year-old boy in March 2017. Child M died of stab wounds while in the family home with his mother. Child M's mother had suffered from mental illness and been a patient of mental health services or treated by her GP for at least five years. In 2015, Child M had been placed in foster care by another local authority at the request of his mother, telling professionals she had thoughts about harming him which were understood to be part of her psychotic thinking. In the weeks before the death, Child M's mother showed no signs of serious mental illness. Ethnicity or nationality of Child M is not stated. Findings: those working with Child M and his mother had a limited understanding of possible risks to Child M; after the family moved to Oxfordshire no professional had a comprehensive knowledge of the mother's mental health history as case transfer and closure summaries did not contain full details; there was no coordinated transfer with agreed objectives and plan.

Recommendations include: to consider whether the LSCB's current threshold of need document places sufficient emphasis on the need to consider previous and historical concerns; that mental health service providers and GPs have adequate arrangements in place to identify and assess the needs of children of patients being treated for psychiatric illnesses; to ensure staff have clear expectations for obtaining and reading case histories; to seek reassurance that implementation of GDPR has not led to inappropriate limitations on information sharing.

Other resources [Read full overview (PDF)]

5. Learning review: Child G: review report

Abstract Neglect of an adolescent boy over several years by his mother. Child G was diagnosed with a degenerative and limiting illness which required full-time care. Was regularly assessed by professionals as malnourished and under-weight. Mother continually failed to take Child G to health appointments and did not engage with many of the 24 agencies and numerous professionals involved with Child G, including Children's Services. Home environment was deemed to be cold, smelly and untidy. Child G was subject of a Child Protection Plan (CPP) under neglect in June 2015, and was subsequently made subject of a Child in Need Plan in March 2016 after the CPP had limited success. Ethnicity and nationality of family not stated. Uses a model of learning based on a Soft Systems Methodology. Learning includes: when assessing risk of harm to children with disabilities, it is important that the care of the disability does not distract, or mask, any actual or potential harm being caused; children with multiple and complex needs should always be offered an advocate when there is an expectation that they express their views and contribute to their own care arrangements.

Recommendations include: promote greater understanding across the safeguarding partnership about mental capacity, decision making and implications for safeguarding of children aged 16-18 years old; seek clarification about the role of the MASH for when professionals from all agencies refer concerns about a child's welfare or safety, and it is an open case to Children's Services.

Other resources Read review (PDF)

6. Serious Case Review case 7: Charlie (assigned pseudonym): Overview report.

Abstract Death of an infant in November 2017 from injuries linked to being shaken three months earlier. Father was convicted of murder. Charlie was the youngest of three children and lived with mother and father. Father had history of significant domestic abuse in a previous relationship and violence towards his sister and partner. GP records showed that he sought support for anger issues in 2004. Father suffered a significant brain injury from a fall at work in December 2015; he was supported by various services; Mother became his primary carer. In June 2017 Sibling 1 made disclosures at school about Father being angry and rough play indicative of risk to injury. Call made to Multi Agency Safeguarding Hub; children's social care stated that threshold was not met for a Family and Child Assessment. Mother declined Early Help support. On the day of the incident Charlie was left in the care of Father along with Sibling 2; he suffered significant injuries linked to being shaken.

Learning includes: professional curiosity may lead to a fuller understanding of the lived experiences of children; accurate recording of assessments is vital for understanding risk; when children talk about their lived experience there should be adequate credence given; information held by agencies that indicate risk to children should be shared regardless of how or why that information is known. Recommendations include: specific programmes of activities to improve and embed a culture where Think Family and authoritative practice and supervision become the norm in practice considerations.

Other resources Read full overview (PDF)