NSPCC Repository – February 2020

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

1. Serious case review: Child K (full overview report)

Death of a 5-and-a-half-year-old boy, Child K, in November 2016 following injuries sustained during an assault by his mother's boyfriend. He was convicted of Child K's murder and sentenced to life imprisonment. Child K's mother separated from his father in August 2014 following allegations of domestic violence. Mother had no recourse to public funds. Child K was identified as a child in need in 2015 by Lambeth children's social care; known to housing services before moving to Bromley in 2016. Child K had contact with his father until the summer of 2016. Mother started a new relationship in March 2016; boyfriend had been in prison and had a history of violent behaviour including domestic abuse assaults. Child K's mother was unaware of his past. Child K was a mixed-race child; mother's nationality is Ukranian.

Learning includes: full assessments must be made of accommodation arrangements of offenders when they are known to have been domestically violent to adults and or children; awareness of the vulnerability of victims of domestic abuse whose immigration status is not secure. Uses the Welsh Child Practice Review methodology. Recommendations include: ensure that staff involved in cases involving domestic abuse are aware of arrangements for sharing information about offenders; that the risks to children, including emotional abuse are assessed when assessing incidents of alleged domestic abuse; reviewing how families experiencing domestic abuse with no recourse to public funding are supported.

Other resources **Read full overview report (PDF)**

2. Serious case review concerning "Billy": overview report

Physical abuse of a boy aged under 1-years-old in 2016. Billy was born prematurely and placed in foster care subject to an interim care order at 2-weeks-old; pre-birth assessment had concluded that it was not safe for him to be cared for by his birth mother, who had had previous children removed from her care. Moved into the care of his father and partner, and her child in September 2016. Father had history of substance misuse, domestic abuse, having a child removed from his care; partner had history of a child being removed from her care because of poor parenting capacity. Concerns raised about couple's capacity to parent Billy, who had complex needs due to detoxification from mother's substance misuse during pregnancy. Following a home visit where it was reported that Billy had a swollen leg, medical assessment and x-rays revealed fractures and bruises sustained whilst placed with his father and partner. Ethnicity or nationality not stated.

Learning includes: evidence of good practice with professionals working well together to do the best for Billy; some opportunities missed for professionals from different agencies and disciplines to formulate effective plans together; purposeful professional meetings may have promoted better clarity and more effective ways to have informed decision making. Uses the Welsh model methodology. Challenges to the Local Safeguarding Children Partnership includes: consider how all involved agencies can contribute effectively to the formulation of a child's plan; ensure the inclusion

of hypothetical risks that may be predicted along with risks identified in a comprehensive assessment to better safeguard children.

Other resources **Read full overview (PDF)**

3. Serious case review: Child Y (full overview report)

Death of a premature 9-week-old baby girl in June 2017 from unascertained causes. Mother had fallen asleep with Child Y and when she was awoken by her 7-year-old daughter, Child Y was not breathing. Child Y was of African-Caribbean ethnicity. Mother had history of mental health difficulties, and reported being sexually abused as a child in the West Indies, and learning difficulties due to a childhood accident. Mother and Child Y's four siblings were known to Children's Social Care Services and Police; NSPCC referral in 2016. History of violence within relationships with Fathers 1 and 2, and private law dispute about residence arrangements with Father 1. A Family Assistance Order was made in 2015. Allegations of physical abuse and online sexual exploitation involving Siblings 1 and 2 and Father 1 lead to a Children's Social Care assessment. Social workers concerned about Mother's parenting; risks of co-sleeping with Child Y were discussed on several occasions. Five children (including Child Y) and Mother were living in the two-bedroom flat, which health visitors noted were poorly decorated and sparsely furnished. Police observations at the time of Child Y's death showed that the home environment was dirty and smelly, with no suitable sleeping place for Child Y.

Learning includes: the need for raised and constant professional curiosity; learning about invisible men; a greater willingness to escalate issues if agency responses appear insufficient; effective record keeping. Recommendations include: policies and guidance should be amended to require midwives and health visitors to enquire about, observe and record, where and in what a baby is/is to be sleeping.

Other resources **Read full overview (PDF)**

4. Serious case review: Child K (full overview report)

Death of a 1-year-old boy, Child K, in June 2018. A post mortem revealed injuries including bruises, scratches and a fractured skull. Child K was born 10 weeks prematurely in June 2017; an older sibling was born in October 2016. The family were known to multiple agencies. In December 2017 Care Proceeding were initiated after a paediatric review found Child K had bruising and a suspected broken femur. He was made subject to an interim care order and placed with foster carers. He returned home in February 2018 after the application to court was withdrawn based on contradictory medical evidence. Following Care Proceedings Child K's mother did not co-operate with children's social care, or attend hospital appointments for Child K. Family members expressed concern about mother's parenting including allegations she left him home alone. Evidence of domestic abuse and mother reported to have low mood, financial problems and relationship difficulties.

Lessons learned include: the importance of focusing on the child's experience; remembering that a number of minor injuries, including bruising on a baby, may be an indication that the child is at risk of harm; and ensuring family history, background and contextual information is taken into account during the referral process. Sets out findings using the Partnership Learning Review model. Recommendations include: embedding the Early Help assessment process across the local authority; ensuring that staff are regularly reminded about the significance of bruising in non-

mobile babies; and all agencies should be confident to question medical opinion provided as part of Care Proceedings.

Other resources Read full overview (PDF)

5. Mario (Case A18): serious case review: overview report

Death of a 16-year-old boy by apparent suicide in February 2018. Mario initially lived with mother and maternal grandmother with siblings 1 and 3 and moved in with father and sibling 2 a year later; his parents had divorced in 2010. All four siblings were subject to child protection plans in April 2013 due to emotional abuse arising from parental conflict and domestic abuse, with Mario's case closing in April 2014. School raised concerns over Mario's mood due to defacing school equipment and a teacher overhearing him discussing suicide; referred him to an in-school counselling service. Mario disclosed physical abuse by father on two occasions and the school contacted the multi-agency safeguarding hub (MASH) for advice. Sibling 1 reported that Mario was possibly anorexic to MASH and had seen Mario self-harming at his father's house. Mario used school computers for web searches relating to suicide and self-harm which were blocked but not reported to school. Ethnicity/nationality unknown.

Findings include: practitioners viewed Mario in isolation from concerns about his wider family; advice provided to school by MASH was not consistent with safeguarding policy and practice; Mario was not linked to domestic abuse incidents at his mother's house; and the counselling service's safeguarding policy and practice requires development. Makes recommendations including: increase awareness of the antecedents of suicide amongst children and young people; share learning with schools in the local authority; and ensure assessments consider the needs of siblings not living in the household.

Other resources Read full overview (PDF)

6. Learning report: Case P

Sexual assault of a 14-year-old child. The young person reported in November 2015, at the age of 18, that RS had sexually assaulted them some years previously. Sibling of young person also made a complaint of sexual assault against RS in May 2016. RS had a history of violent offences and imprisonment; recalled twice on being released due to risk he posed to others. Made subject of Multi Agency Public Protection Arrangements (MAPPA). RS groomed parents and carers to gain the trust of young people in their care to commit offences against them. RS arrested and another five young people disclosed that they had also been sexually assaulted by RS. Convicted of numerous serious offences and received a significant period of imprisonment. Ethnicity or nationality of young people not stated. Learning includes: understanding of risk and how that can be managed needs to be better; agencies need to identify persons who present a risk to children and flag those persons within their agencies to enable them to be managed in a multi-agency fashion; parents and carers need to be equipped to identify grooming, especially when a risk is known or perceived.

Recommendations include: ensure that organisations can effectively flag and monitor persons identified as presenting a danger to children; ensure that staff feel confident in identifying and referring persons who present a danger to children; review how effective disclosures can be achieved from children and young persons where there is a lack of verbal disclosure.

Other resources Read learning report (PDF)

7. **(Young person): re: child practice review SILR14B**

Death of a 15-year-old young person. Cause of death attributed to acute morphine poisoning and aspiration of gastric contents. Young Person (YP) lived with their mother, sister and grandfather, and was described as bright and articulate. YP had experienced sleeping difficulties over a number of years, had been self-medicating with cannabis to help them sleep and experimented with other drugs sourced on the internet; engaged with a number of internet drug forums. Known to Child and Adolescent Mental Health Services (CAMHS) since April 2012. Ethnicity or nationality not stated. Practice and organisational issues identified include: the benefits of multi-agency coordination through Early Help processes to support YP and their family; threshold for referral to Children's Social Care; impact of transformational change on services; lack of clarity amongst professionals about interventions that CAMHS could offer; Substance Misuse Services for Young People and CAMHS situated in different providers; importance of communication with fathers; importance of systems that enable communication of risk where more than one professional is involved in an organisation; professional awareness of patterns and sources of young people's drug use; safety when experimenting with drugs.

Areas of good practice identified include: support and commitment by YP's school and GP. Recommendations include: development of an awareness raising and educational campaign about young people who use and supply drugs; guidelines to strengthen professional knowledge about referral thresholds and pathways for young people who abuse or procure drugs.

Other resources **Read child practice review (PDF)**