**NSPCC Repository – March 2020**

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

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| 1. **Serious case review: Child Z Serious Case Review (full overview report)**   Sexual assault and sexual exploitation of an adolescent girl between the ages 14-18-years-old. Child Z lived with mother and older half-brother in Local Authority 1 (LA1). Received services for anorexia. Assaulted by older boy she was in relationship with, resulting in social care assessment, which identified risks of suicidal ideation and sexual exploitation. Case closed; referral to other services. Increasing concerns about her relationships with a number of males; diagnosed with emotional dysregulation. Pregnant at nearly 16-years-old; homelessness resulted in referral to Local Authority 2 (LA2). Detained in psychiatric unit; son made subject of care proceedings. Case transferred back to LA1 on her discharge. Mental health deteriorated; further incidents of sexual assault and exploitation. Placed in mental health supported accommodation at age 18-years-old. Ethnicity or nationality not stated. Uses a hybrid model based on the Welsh Model. Findings include: resource pressures were such that they were manifest in high thresholds; medical focus was necessary but an early consideration of home situation would have been appropriate; local authority transfer requests were not founded on the best interest of the child; lack of understanding of the lived experience of Child Z.  **Recommendations to LA1 Local Safeguarding Children Board includes: children** who themselves have children should have their own social worker and their own separate plan for the avoidance of conflicts of interest; where the child of a child is made the subject of child protection plan, there should always be formal consideration as to whether or not the child-parent should also be the subject of their own child protection plan.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousChildZOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73FE4702BE66BF9BB3CF94EF5D94AE5716835681822023B3B57DF33761D547F5A9B0218417DECB1143100&DataSetName=LIVEDATA) |
| 1. **Baby ‘T’ serious case review (full overview report)**   Death of an 11-month-old girl in October 2017. Female C was babysitting Baby T when she became unwell. Ambulance services were called and Baby T was taken to hospital; was found to have sustained a head injury. Later transferred to Great Ormond Street Hospital, where she died. Female C convicted of manslaughter and sentenced to six years imprisonment. Mother was an asylum seeker and reported imprisonment, religious persecution, physical abuse and rape. Had two other children by a different father in Vietnam and had suffered post-natal depression. Mother had no English language skills and relied on interpreters when meeting professionals. Mother and Baby T were moved accommodation by Home Office several times. Mother began working illegally and paid Female C to babysit Baby T.  **Learning themes include:** decisions made by Home Office about Mother's claim for asylum and asylum support; effectiveness of Home Office asylum seeker support services and 'mainstream' health and social care services; impact of frequent moves of Mother and Baby T; use of interpreting services in supporting Mother and Baby T; 'lived' experience of Baby T; indications of trafficking or exploitation concerns and agency responses; 'hidden males'. Mother and Female C were Vietnamese. Recommendations include: remind practitioners about policy and practice in respect of modern slavery; ensure that advice to parents on caring for crying and sleepless babies is accessible in all community languages; Home Office to ensure pregnant asylum seekers and asylum seekers with young children are referred to local primary care service at the point of first contact.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020RedbridgeBaby'T'Overview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93770F728BA368259E13EED7B3EA56591822FEE4AEAD558BC2F7C37DAA7F91EEBD96E6F988C53EF68DC166D7349CBC900789BE7BF&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child N (full overview report)**   Serious injuries to an adolescent girl in supportive accommodation by her partner in September 2016. N was known to Children's Social Care since 2008; had been in local authority foster care and residential placements because mother stated she was unable to cope with her behaviour. History of self-harm, criminal offences, going missing and possible risk of child sexual exploitation. In September 2015, N became subject of a Care Order just before her 16th birthday. N became pregnant and unborn child made subject to a Child Protection Plan. In February 2016, her son A was born. Father initially believed to be M1 but subsequent DNA testing clarified that M2 was the father. N had been in a relationship with M1 since 2014; history of domestic violence and a violent assault on N in August 2016 when she was pregnant. In September 2016, M1 broke into N's supported living accommodation and stabbed her five times; she received life changing injuries and M1 was arrested, charged and convicted. Ethnicity or nationality not stated.  **Key themes for learning includes:** dealing with domestic abuse in teenage children; dealing with 'missing' episodes with Looked After Children; multi-agency working and working with a group of children who are engaging in abusive behaviour to one another; transition and accommodation issues for Children Looked After; approaches to children who are part of 'intergenerational' need and/or abuse. Recommendations to Safeguarding Children Board include: review of the way in which children who are involved in domestically abusive relationships are assessed in terms of risk of harm.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018DudleyChildNOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12160F726AD26A556ED10E85708F454C4BB30EE4FB2CC59AD60731D9870054950A4BC9093B7C2DFBC88C0C0D1D12B9ED7&DataSetName=LIVEDATA) |
| 1. **Serious case review: Young Person P (full overview report)**   Murder of a 16-year-old girl in May 2017. A male was later found guilty of her murder and sentenced to a minimum of 26 years imprisonment. P was removed from her biological parents' care at 4-years-old due to neglect and was placed in foster care until she was adopted aged 7. At age 14, P was found by an ambulance crew following a suspected sexual assault. P did not disclose a sexual offence at the time. No safeguarding issues were identified by police, social care or health services and P was referred to sexual health services. Following this incident, P's relationship with her family began to break down. She requested assistance finding housing in December 2016 but was issued with an abandonment notice in February 2017. There were three domestic abuse incidents reported between P and her boyfriend. In April 2017, P's mother reported their relationship was improving but P had not been in touch for a week. P's body was found at a hostel for men released from prison in May 2017. Ethnicity/nationality not stated.  **Identifies key findings including:** failure to instigate statutory child protection measures; a lack of assessment of the risks faced by P and a failure to listen to the voice of the child. Makes recommendations including: consider providing advice to adoptive parents on children contacting birth parents through social media and adolescent behaviour; professionals need to understand their responsibilities to homeless 16- and 17-year-olds; seek assurance that procedures and support for children reporting sexual offences is robust and properly resourced.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018DudleyYoungPersonPOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12160F726AD26BF51F112EB4922F042D9A309C44EF9CE4BA2647B7DCC38AA23884A9EB3113E2242E387FC693B41D9C993CD8171F54089&DataSetName=LIVEDATA) |
| 1. **Report of the significant case review carried out by Highland Child Protection Committee in association with Local Safeguarding Children Board: Child T: executive summary**   Life-threatening head injuries and other serious injury to 20-month-old boy in April 2016. Child T was born in Scotland in August 2014, and was named on a child protection register from birth. He was placed with foster carers before moving to the north of England in December 2015 to live with his maternal aunt who was approved as a kinship carer by Highland Council who continued to manage the case. Following Child T's admission to hospital his aunt and her partner were arrested and investigated in relation to his physical abuse. Findings include: the focus on processes in kinship care system to collect information rather than a full analysis of information gathered led to undue optimism about a potential kinship placement at the expense of critical thinking; the decision that Highland Council would retain management responsibilities when Child T moved to England was unrealistic and it was optimistic to expect that supervision could be maintained at this distance. Uses the Social Care Institute of Excellence (SCIE) learning together model.  **Recommendations include:** ensuring that guidance supports staff to lead and contribute to risk assessment generally and specifically in relation to kinship care; discussion at national level with chairs of child protection committees (CPCs)and Social Work Scotland about disclosure/ vetting systems between Scotland and England; the need to value foster carers contributions in the assessment and planning of children moving to kinship care.  **Other resources** [**Read executive summary (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018NorthTynesideChildTExecutiveSummary.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12B7AE13EA00B9F50E10FE57D22C159DFA13DDF7DE4D95EBE756525D90FB9D47D93D5E6F6BE062F46041A88DCEAA0C709C58F7884F8F6B95583D4CDF01E8CBC&DataSetName=LIVEDATA) |
| 1. **Serious Case Review: Baby K: Overview report**   Death of 13-week-old infant due to non-accidental traumatic head injury in March 2017. Father was charged with manslaughter and was subsequently acquitted. Baby K lived with his mother, father and older brother. Baby K and his brother were only known to universal services. Mother had regular interaction with Community Midwife and health visitor, including routine discussions of strategies to cope with a crying baby, prevention of a shaken baby and Sudden Infant Death syndrome (SIDs). Routine domestic abuse enquiries made with disclosures. In November 2016 during a development review with a Nursery Nurse, mother disclosed she had suffered domestic abuse with her previous partner; no record of any report to Police or other agencies of this. No evidence was found to suggest that any agency had the opportunity to foresee or prevent the death of Baby K. Ethnicity or nationality not stated. Learning includes: the intrinsic vulnerability of babies; areas of consistent established practice, e.g. recognising and acknowledging that the absence of any indicators of abuse does not eliminate risk; agencies to consider alternative contacts to accommodate working fathers to be able to attend home visits or appointments; risk assessments to have a reflective review by supervisors; the benefits of having an open, non-incident based approach to all forms of abuse within the family, supported by structured enquiry, professional practice and awareness that a victim may not disclose or even identify the existence of abuse. There are no recommendations.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018NewcastleBabyKOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12B70E429A92C9252E13EED7B3EC97EC0A82BFD51F9CB13BB656A80ED2D8195D902E786FB00EED904CD3BE30E4D33D6EC7B19&DataSetName=LIVEDATA) |
| 1. **Serious case review report: Child E (full overview report)**   Death of a 3-month-old boy in September 2017 whilst in his mother's care. Child E was taken to hospital in cardiac arrest having been left unchecked for 12 hours overnight in a pram with heavy blankets. Mother had a history of drug misuse. An anonymous referral to children's social care raised concerns about mother's drug use and home environment. A common framework assessment (CAF) meeting was held in relation to Child E's siblings. This was closed as professionals felt mother had worked honestly with the service and was no longer misusing drugs. However, mother later disclosed to the midwife that she had used multiple drugs during the pregnancy of Child E. Criminal investigation is ongoing. Ethnicity and nationality of family not stated. Learning includes: the rationale for closure of CAF should identify trigger points to review necessity for further multi-agency sharing of information; understanding multi-agency referral pathways is crucial to professionals' sharing information with purposeful intent; specialist midwives are best placed to support the pregnancy of women with a known drug history; health agencies need to work together in order to ensure that new born babies are registered with a GP practice.  **Recommendations include:** review guidance ascribed to cessation of CAF to include a risk indicator to support single agency identification of risk to initiate further multi-agency consultation; ensure that the role of specialist midwifes is developed and promoted amongst the wider health economy; use this review as an instructive case scenario to support early help services to understand barriers to best practice.  **Other resources** [**Read full overview (PDF)**](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018RochdaleChildEOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE1377AF022AC3E8A5BC714E57523C77EC0A82BFD51F9CB13BB656A976D35A595D902E7D44EEBC54DAD8EDB3479D099CB086E3F&DataSetName=LIVEDATA) |