**NSPCC Repository – May 2020**

***In May 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. **Baby MD: serious case review [full overview report].**

Abstract Death of a 5-week-old infant in August 2018. Baby MD had been placed by mother in the parental bed to sleep during the night and was found lifeless the following morning. Parents had consumed a significant amount of alcohol and there had been a domestic abuse incident. Baby MD, together with siblings, was subject to a Child Protection Plan under the category of neglect. Mother had history of alcohol misuse and mental health difficulties; had experienced Adverse Childhood Experiences (ACEs). Mother had four children prior to relationship with father; all children were in the care of grandmother or birth father. Baby MD's father had alcohol misuse issues and convictions for violent offences. History of domestic abuse. Mother moved across local authority boundaries twice; historical risk factors not fully shared in the first children's social care transfer. Father was a 'hidden male' after the second move. Ethnicity or nationality not stated.**Learning includes:** trauma-informed practice can support service users in forming effective working relationships with practitioners; case transfers should ensure all relevant information including significant historical risk factors and parental ACEs is shared; there is a need to explore more effective safe sleep interventions for vulnerable families. Identifies eight instances of good practice. Recommendations include: consider escalating the trauma-informed practice learning to the Greater Manchester Standards Board; Safeguarding Children Partnership to be assured its multi-agency partners have considered the relevant learning points and developed implementation plans in order to support safeguarding practice when working with complex families with multiple risk factors.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SalfordBabyMDOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93674FF2CA72D827CE51EF55403CD47D3BF2FE25DEB924DAF674144BC866574E0B29F4F973C3C49D8B67D52E69CE7800656&DataSetName=LIVEDATA) |
| 1. **Serious case review: Archie: final report [full overview report]**

Abstract Death of a 15-year old boy in May 2018. Archie was fatally stabbed by another young person. Archie arrived in the UK in 2014 with his mother and lived with his adult sister and three older siblings until mother's return in 2015. Enrolled in a different school to siblings' due to lack of places. Death of adult sister in a house fire had a traumatic impact on Archie. His behaviour in school began to deteriorate and moves to new schools were unsuccessful, resulting in periods where Archie was home educated. Detained for shop lifting; other offending quickly escalated. Frequent episodes of missing from home; involved in gang culture, controlled and exploited by older associates; known to the criminal justice system and youth justice; subject to a Child Protection Plan. Archie was of African Caribbean heritage. Learning is embedded in the recommendations but also includes: impact of bereavement must not be underestimated.**Recommendations include:** when a parent elects to home educate their child, the local authority should seek reassurances that the child is receiving a balanced education, including a home visit for an assessment by a trained professional; local authority must develop and communicate a clear escalation process for children not on school roll; ensure there are structures in place to assess, refer and intervene with vulnerable people who may be exploited by gangs and organised crime groups; clear referral route for vulnerable young offenders; implement Child Protection conferences that assess risk and develop plans in line with increased understanding of contextual safeguarding.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SheffieldArchieOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9367DF62CAE368352E03DFE7A2FEB54F9BB3CF94EF5D94AE5716835A87E2C59B93F57DFF478E76B4B1FC67578407CCCA241FEDC&DataSetName=LIVEDATA) |
| 1. **Serious case review: SC17 Unborn Baby A: review report [full overview report].**

Abstract Death of unborn baby due to suicide of mother, who was 37 weeks pregnant, in April 2019. Mother found hanged and taken to hospital; following emergency caesarean the baby was stillborn. Mother known to substance misuse services, police, community housing, and wider family was known to education services. Midwife placed mother on pathway for substance misusing mothers; social work assessment pending at time of death. Maternal history of attempted overdose, drug abuse, previous partner violence and missed appointments. Ethnicity or nationality is not stated. Does not specify any learning but finds significant evidence of strong practice, particularly in relation to prompt follow up when the mother did not attend or could not be contacted, by the midwife, social worker and housing officer.**Recommendations include:** substance misuse midwifery team should consider informing women on the substance misuse pathway that a positive toxicology result will lead to a referral to social care at the point of testing; conduct a review analysing current referral processes and pathways.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SolihullUnbornBabyAOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9367AFF23A02A8A52D112EE7635EC73D7AF20CA77EAD94FBD686924922CA8DFE254D786720392095FF187A2740B1BCC4DA73701C0D874F0&DataSetName=LIVEDATA) |
| 1. **Serious case review: [Family D] [full overview report].**

Abstract Sexual abuse and neglect of three siblings by their father over many years. Father was convicted of sexual offences and received a substantial term of imprisonment. Mother was a repeat victim of domestic abuse by Father. Anonymous report made to Children's Social Care in 1998 that Ash, one of the siblings, had been sexually abused by Father. In 2007, Ash disclosed to police, but later retracted, that they had been raped by Father. Father was arrested, but no further action taken due to insufficient evidence. In 2016, local authority received information that Casey, Ash's sibling, had been sexually abused by Father; abuse disclosed to Mother in 2015. Ethnicity or nationality of family not stated. Uses the Appreciative Inquiry (AI) methodology. Learning includes: professionals need to act with caution when a victim makes a 'retraction' statement; sexual abuse is a possible cause of vaginal discharge; professionals need to recognise when they come into possession of information concerning historical sexual abuse which should be shared with other agencies; providing the victims of domestic abuse with access to an Independent Domestic Abuse Advisor (IDVA) will help professionals recognise and respond to the impact of coercive and controlling behaviour.**Recommendations include:** partner agencies should ensure their records capture the detail and rationale for actions and decisions and have processes for timely sharing of information about these incidents; when the word 'retraction' is used in connection with an investigation, the reasoning behind that decision is documented in police records and when shared with other agencies.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousFamilyDOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73AED742EEE48F2822FEE4AEAD558BC2F7C37DA2ABA8B30586A6F9864D103F506D30DB1855775D6ED0A678F&DataSetName=LIVEDATA)  |
| 1. **Serious case review Georgia [full overview report].**

Abstract Life-threatening self harm of a 15-year-old girl in May 2019. Georgia was admitted to hospital following a serious and life-threatening overdose. Georgia was subject to child protection plan in both parents' care, and later her mother's care. Taken into care in 2018; no contact with father for 10 years but court ordered assessment regarding Georgia's wish to have contact. Episodes of going missing, using cannabis, and alcohol misuse. Concerns about risk of exploitation. Georgia was in foster care at the time of the incident but was staying with her father and his partner as planned contact. Georgia refused to return to her placement; made allegations about a visitor to the foster home. Delays in Georgia being formally interviewed about allegation, with her ultimately refusing. Three incidents at father's home: overdose and attempt to self-harm; allegation of physical assault by father; serious and life-threatening overdose.**Learning includes:** foster carers require training that is trauma informed; when a child in care moves area it is important for all professionals to share information and for key professionals to speak to their equivalents in the new area; Independent Reviewing Officers (IROs) must focus on a child, regardless of the pressures that professionals working with the child are experiencing. Ethnicity and nationality not stated. Recommendations for the relevant Children's Safeguarding Partnership include: undertake a multi-agency audit to consider practice and processes when a child in care is placed outside of area; seek assurance that professionals in partner agencies are using appropriate formal processes to challenge other professionals if they are concerned about the plan for a child, or do not receive information that is required.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousGeorgiaOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73BE97635E558D7822FEE4AEAD558BC2F7C37DAC8551334586A6F98DBF74A57685822050F0E6692CFF372DC&DataSetName=LIVEDATA) |
| 1. **Child D serious case review [full overview report].**

Abstract Serious assault of a 22-month-old boy in February 2018. Child D was home alone with his mother's partner Adult A at the time of the assault. Subsequent medical exam identified red marks and bruises to Child D's body and head as well as an injury to his mouth. Adult A was arrested on the day of the assault and served a 21-month custodial sentence. Family was known to services since 2013 due to concerns over neglect. Child D lived with four siblings who were subject of a child protection plan at the time of the assault. Mother reported prior traumatic experiences including possible rape in 2017, alcohol misuse, and domestic violence between the four different fathers of the children. Learning includes: mother's parenting capacity was not assessed despite the family being known to agencies for at least 10 years; mother did not appear to recognise her own vulnerability or that her relationships with abusive men put herself and the children at risk. Child D's family were White British.**Recommendations include**: seek assurance from partners that the voice of the child and lived experience of the child is the primary focus of all agency interventions, risk assessments and child protection processes; seek assurance that the views and concerns of family members are listened and responded to and that there is evidence that have contributed to assessments and planning; using validated parenting assessments for parents with vulnerabilities including their own adverse childhood experiences which can indicate that parenting may be compromised.**Other resources** [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019KirkleesChildDOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02E7CE121A43A834DC714E57523C67EC0A82BFD51F9CB13BB656A945CC1AF13DD02E789BDBA2190CD6D0521F7E254CA9DEF05&DataSetName=LIVEDATA) |
| 1. **Serious case review report relating to Child E [full overview report].**

Abstract Murder of a 7-year-old boy by his mother in September 2017. Mother was found guilty of murder and sentenced to life imprisonment. E's parents separated when he was a few months old and he spent time living with both parents. Mother (ME) accessed early help services and saw her GP for mental health problems on several occasions. Several domestic abuse incidents were reported to the police between 2010 and 2017. In 2014, E's father (FE) reported concerns to several agencies about historical bruising and reported that E had made an allegation of sexual abuse by a family member. In June 2017, ME reported to the police that FE had refused to return E home and subsequently decided to stop FE's contact. In August 2017, FE made an application to enforce the contact order and a section 37 report was ordered. In the week before E's death, ME contacted E's school and GP, reporting that E had said he wished he was dead. Ethnicity/nationality not stated. Learning includes: lack of clarity about the safeguarding referral pathway across the professional network; managing allegations and concerns in respect of children of separated parents; lack of engagement with and unconscious bias against fathers.**Recommendations include:** clarify the decision-making process for referrals to early help and children's social care; review the notification process for section 37 reports; and create learning opportunities for reflecting on the approach to providing a whole family focus.**Other resources View report online:** [**www.safeguardingshropshireschildren.org.uk/media/1168/final-scr-child-e.pdf**](http://www.safeguardingshropshireschildren.org.uk/media/1168/final-scr-child-e.pdf) |