**NSPCC Repository – June 2020**

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

|  |
| --- |
| 1. **Serious case review conducted under Working Together 2015: Children's Case W: overview report.**

Abstract Severe neglect and abuse of a large group of siblings by their mother and father over many years. Care proceedings concluded in 2017 and the children are no longer under parents' care. Six of the siblings are now adults. Evidence of the children suffering significant neglect and abuse by their parents between 2007-2017. Home environment was overcrowded, chaotic, dirty and unsafe. Evidence of physical abuse, domination and coercion, and failure to prevent physical and sexual abuse between siblings. Failure to ensure that the children received medical care or attended school regularly. Parents were uncooperative; aggressive to professionals with some disguised compliance and manipulative behaviour. Several of the children made subject to child protection plans for neglect in 2007-2009; in July 2016 police protection was taken on all the children under 18 living with the parents and interim care orders were granted. Learning includes: overwhelming nature of the complexity and scale of the problems and of the oppositional, hostile behaviour of the parents; responses from all agencies to concerns and interventions were generally short-lived and episodic; children's lived experience was not fully appreciated. Ethnicity and nationality not stated.**Recommendations include:** develop a model for interagency practitioner supervision for complex cases where working together closely and consistently is of paramount importance; ensure that the use of the Public Law Outline is being used effectively to give local authority and social workers sufficient leverage with families which are deliberately obstructive by clarifying their concerns in a 'Letter before Proceedings' or further action. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousChildren%27sCaseWOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF73FE4702BE643D3A37EF87BFDCF589C4E7A36CE2AA5DC67DCD7FBBE4B9ACF120E513FB093799C35A8293B71AEF6A8E838986C01&DataSetName=LIVEDATA) |
| 1. **Serious case review: review report: Harry [full overview report].**

Abstract Attempted suicide of a boy aged under 16-years-old in 2019. Harry had experienced significant neglect, trauma, emotional and mental health difficulties whilst living with his mother, step-father and siblings in Scotland; subject to child protection plan in 2016. In 2017, Harry moved to live with his father in England. Incidents of self harm; suicide attempts on five separate occasions prior to the incident in 2019. Harry's recollection of the incident, resulting in him being admitted to Child and Adolescent Mental Health Services (CAMHS) is that someone tried to kill him, however there is no evidence to confirm this. Ethnicity or nationality of Harry is not stated.**Learning includes:** a greater appreciation of the impact of early childhood adversity and trauma and the importance of using this information to inform decision making and safety planning; importance of information sharing across borders and agency boundaries; the need for prompt action to secure the appropriate type of support and intervention when young people experience an acute and serious mental health episode. Identifies areas of good practice. Uses the SILP (Significant Incident Learning Process) methodology. Recommendations for the Safeguarding Partnership include: to inform the Child Safeguarding Practice Review Panel about the apparent lack of explicit guidance about the transfer of school records across borders in Scotland and England; to review and amend guidance and procedures on the management and information sharing practices between local community based child mental health services, acute health settings and community health services for situations where children re-present to an acute setting. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020AnonymousHarryOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9247BFC24B132894BF734ED6B35FB7EC0A82BFD51F9CB13BB656A61ED7D5DF1DF02E75EE5EF2582C8A735A2BB2499912B0674&DataSetName=LIVEDATA) |
| 1. **Serious case review report: Baby T [full overview report].**

Abstract Death of a 10-week old boy in 2017 as the result of non-accidental head injuries. Forensic post-mortem found two injuries: one several days prior to death and another closer to time of death. Father convicted of manslaughter and grievous bodily harm; custodial sentence. Family known to universal services only; no vulnerabilities in family background. Ethnicity or nationality not stated.**Lessons:** preparation for parenthood needs to involve: both parents learning practical and emotional aspects of caring for a new born baby; managing crying; access to advice and support when needed; when a baby is taken to hospital with symptoms indicating potential harm, consider the possibility of non-accidental injury. Recommendations include: Safeguarding Partnership should continue to use ICON: Babies Cry, You Can Cope! and DadPad (prevention of abusive head trauma tools) and evaluate these programmes; medical professionals should provide documented analysis of any symptoms of non-accidental head injury. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020WestSussexBabyTOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93270E03E9B2A954DE104CE7825FB65F9BB3CF94EF5D94AE5716835192C2320583D57DFD1F780874E13B3E7DA53ED7D6F32B018&DataSetName=LIVEDATA) |
| 1. **Serious case review: BSCB 2017-18/01 [full overview report].**

Abstract Death of a 2-month-old baby girl in January 2017. A post-mortem found eight rib fractures sustained over a 24-hour to twenty-day period. Baby's mother was found guilty of manslaughter and received a custodial sentence. Baby lived with her mother and was the subject of a Child Protection Plan from birth due to concerns based on her mother's past parenting difficulties, alcohol and substance misuse and previous abusive relationships. Mother chose not to say who the father was. An older sibling born in 2008 was cared for by the maternal grandparents who obtained a Special Guardianship Order. The family is of white British heritage. Baby was born pre-term and was seen frequently by health and social work professionals from two local authority areas - she was viewed as making good progress and being well cared for. Evidence of mother drinking and taking drugs during her pregnancy; continued use of alcohol and cocaine after the baby's birth was successfully hidden from professionals.**Lessons learnt include:** the need for effective liaison and communication between local authority social care teams; professionals should understand the addictive nature of drug and alcohol dependency and that non-attendance at substance misuse appointments could be an indicator of abuse; professionals need to be mindful of disguised compliance and an over optimistic mind set. Recommends that an appropriate action and implementation plan should be devised to ensure lasting improvements to practice and services aimed at safeguarding and promoting the welfare of children. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019BirminghamBSCB2017-18-01Overview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102172D08A780A14959D3BCE5747137B3B2A935011CB8EC3068664FF481AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE0277CE127A1318156E511CE4A04C00386FC6EA609A4910DFA4E7A36CE2AA5DC67DCD7FBBE000230C60E513FB0BD975505E6F1EAC7B0BEAB6C36794203&DataSetName=LIVEDATA) |
| 1. **Extended child practice review: re: CPR 03/2016.**

Abstract Neglect and possible sexual abuse of a 6-year-old child. Child was made the subject of a care order in January 2016 and is now in foster care. Mother had longstanding substance misuse problems and the child was exposed to criminal activity and domestic abuse. Three child protection referrals between 2009 and 2012 which were investigated but identified no further concerns. An initial assessment was completed in December 2013 and enquiries to the child's school revealed there were concerns about attendance, presentation, dental health and communication. A section 47 enquiry was undertaken and completed in May 2014 which identified significant concerns around neglect and parental substance misuse. Child disclosed sexual abuse by mother's partner to mother's aunt and made further disclosures when interviewed by police. Crown Prosecution Service decided not to initiate criminal proceedings. Child was placed in foster care in August 2015 due to mother's imprisonment for shoplifting. Throughout the period under review, mother did not co-operate with professionals and refused consent to share information. Ethnicity or nationality not stated. Learning includes: little evidence that the child's views were gathered and supported; child protection conferences became focused on helping mother rather than the child; and delayed decisions can mean that children experience lengthy exposure to abuse and neglect.**Recommendations include:** update protocol on working with families who are not cooperating; ensure training on information sharing for safeguarding children is available to staff in partner agencies; and ensure that there is meaningful engagement from schools across the region. **Other resources View report online:** [**www.cardiffandvalersb.co.uk/wp-content/uploads/CV-RSCB-CPR-032016-Report.pdf**](https://www.cardiffandvalersb.co.uk/wp-content/uploads/CV-RSCB-CPR-032016-Report.pdf) |
| 1. **Serious case review: Child K [full overview report].**

Abstract Death of an 11-week-4-day old boy after sharing a bed with his parents. An ambulance was called for Child K but medical professionals could not resuscitate him. Mother and father were arrested on suspicion of neglect by overlaying, but no charges were brought due to insufficient evidence. Mother had prolonged involvement with ante-natal services and had suffered from depression. She refused numerous meetings and check-ups from health visitors and maternity staff. Mother and father also failed to take Child K to several medical appointments. Siblings KS1 and KS2 had been on child protection plans for associated risks of significant harm linked to alcohol and domestic violence. Ethnicity and nationality of family not stated. Learning includes: it is important to explore and confirm the exact circumstances of previous children's services involvement and use that and other information to inform care planning; transferring information when children move to another area - especially if there has been statutory involvement with a child identified as a child in need or a child in need of protection should be required.**Recommendations include:** review the guidance and information about 'safe-sleeping' arrangements (including known risk factors, for example alcohol consumption) provided to all prospective and new parents (including fathers or partners) and to the practitioners who may work with them; and consider promoting public awareness through a media campaign; share historic information about a child, young person or family with relevant practitioners and services (where appropriate) and include this in all assessments. **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2018HampshireChildKOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EBAAAFFECACF7BE12D74FE3ABB378F4CE13FE4702BE67AF9BB3CF94EF5D94AE57168355EA30514583D57DF9992F9D5D65B7C166BE13D3BB6132F9A&DataSetName=LIVEDATA) |