**NSPCC Repository – July 2020**

***In July 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 CE: review report [full overview report].**

Abstract Death of a 10-week-old infant in March 2019. Cause of death was confirmed as overlay due to unsafe sleeping arrangements; Police investigation concluded with no further action taken. Child CE lived with their mother, father and siblings. No concerns were observed or identified by professionals during the pregnancy or following the birth; only a small number of universal level services involved with the family. National Probation Service were involved with an adult male who lived with the family but no association was found with this and the circumstances of Child CE's death. Ethnicity or nationality not stated. Learning includes: it is important that all professionals understand, and follow, agreed policy and procedures. Failure to do so may place a child or vulnerable adult at risk; being actively curious about members of the household, family dynamics and actual, or potential, risks to children is an important consideration for practitioners; contemporaneous record keeping is an essential requirement following all appointments and contacts; ensuring fathers are given the same advice and support as mothers is important; ensuring new parents think about safer sleeping arrangements for the baby is a core task for all professionals. **Recommendations include:** to review the current strategies and initiatives around safer sleeping advice, support and promotional materials and consider any changes which may promote knowledge and understanding.**Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020BlackpoolChildCEOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92779F229A32F8951E83FE4702BE672F3822FEE4AEAD558BC2F7C37DA0C2CAAFB0B766F98CBE282FCB1C714858BC046298C26EDB6&DataSetName=LIVEDATA) |
| 1. **Serious case review: Sasha [full overview report].**

Abstract Death of a 17-year-old girl by suicide in August 2017. Sasha was the third of three children in her family. Her mother had poor health and was unable to care for her. As a young child she had been made subject of a child protection plan, and she was in foster care between 2006 and 2007. Sasha received services from many agencies, including Children's Social Care, Child and Adolescent Mental Health Services (CAMHS), Police, Youth Offending Services, and services in relation to possible child sexual exploitation between late 2015 to August 2017. In the period January 2016 to March 2017, there were three Child and Family Assessments; decision made to accommodate Sasha in care in March 2017. Ethnicity or nationality not stated. Learning includes: assessing competence, resilience and emotional attachment disorder in adolescents and considering the impact of adverse childhood experiences (ACEs) and impact of cannabis use; using a holistic family approach to assessing children and young people where their parents have difficulties; recognising when young people are carers; the importance of reflective supervision. **Recommendations include:** to work with the Safeguarding Adults Board to develop a "Think Family Approach"; review how practitioners are supported and trained in assessing adolescents who have complex and unresolved emotional issues, possibly coupled with drug use and impulsivity; promote awareness of and response to Contextual Safeguarding.**Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020HounslowSashaOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92D7AE624BB338949D71DFF7126CD47D3BF2FE25DEB924DAF67D17C1CAC3568E0B2C33662D037E758866F6A0497DFA3144E&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child C: a 14 year old boy [full overview report].**

Abstract Death of a 14-year-old boy in January 2019. Child C was stabbed by four men, one of whom was sentenced to life imprisonment. Child C was the youngest of three children. His parents separated after he was born and he was brought up by his mother. Child C was Black British of African Caribbean heritage. Child C's early life was in the East Midlands. He had a troubled time at secondary school and was home educated by his mother from the age of 12. Evidence of access to and threats to use firearms. His mother felt he was being groomed and the family moved to Waltham Forest in April 2018. Child C was arrested in October 2018 in a flat in Bournemouth in possession of Class A drugs. Evidence that Child C had been a victim of criminal exploitation for a considerable time by the time of his death, and that this became significantly greater in the autumn of 2018. Findings include: time spent out of school constitutes a significant risk to children who are vulnerable, and the current arrangements governing home education contribute to this risk; and a failure to capitalise on a 'reachable' moment for a child who was being criminally exploited.**Recommendations include:** the government to review the guidance on home education; the implementation of a national system for responding to exploitation of children by county lines gangs; and a review of arrangements for recovering children to ensure they are brought back by adults with skills relevant to working with children who are being criminally exploited.**Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020WalthamForestChildCOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E93274FF3EA03E8B78EB0EE96A33C159DFA13DC877EAD94FBD686924922CA8DFF2277269211F92091166EE51042FF2BF203A32A3E8AC052E&DataSetName=LIVEDATA) |
| 1. **Child A: serious case review: final report [full overview report].**

Abstract Serious physical harm of a 10-week-old child in September 2016. Both parents were arrested. Child A's parents were both teenagers and received support from the family nurse partnership (FNP). Mother had type 1 diabetes and there were concerns about her care of her health. Mother had a difficult relationship with her own mother. In August 2016, Mother and Father moved to supported housing. There was a domestic incident, during which Father caused damage to the property. Children's social care had been involved during pregnancy and closed the case in February 2016. In September 2016 Child A attended the emergency department and was admitted to the paediatric ward with marks on back, leg and cheek; additional bruises were noted the following day and a referral to children's social care was made. The duty social worker advised there be no contact from the parents and a joint Section 47 investigation was commenced. Child A was transferred to foster care. Ethnicity and nationality not stated.**Findings include:** assessments are biased towards assessing mothers, rather than assessing both partners equally; there was an over reliance on the Family Nurse Partnership (FNP) by all partner agencies involved; and processes designed to safeguard children were not followed when bruises and marks were identified. Recommendations include: consider how to reduce professional anxieties around sharing information with partners; foster a culture where professional curiosity is increased; and assure that professionals' response to indicators of domestic abuse is in line with policies and procedures.**Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019DudleyChildAOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE02160F726AD26A556ED10E85808F454C4BB30EE4FB2CC59ADE1DA5747A51D49506CE4CEF309509E8F45E712543D93047A&DataSetName=LIVEDATA) |
| 1. **Significant case review Child R: executive summary.**

Abstract Emergency admission to hospital of a male under 18-years-old in 2016 with acute severe nutritional failure. Child R was diagnosed with a blood disorder due to dietary deficiency which almost resulted in his death. Child R presented with obesity and urinary wetting before starting primary school, and had difficulties separating from his mother. At secondary school, he had additional difficulties with soiling and refusing to attend school or engage with services, as well as his obesity continuing. Child R was involved with several agencies including universal health and education services. An Adult Protection Concern referral to Adult Wellbeing was made by medical staff on admission to hospital. Ethnicity and nationality of family not stated.**Learning includes:** inability to comply as well as enmeshed relationships should be considered if plans are not progressing as expected; there is a gap in the provision of multi-disciplinary intensive family home support exploring and challenging family dynamics; there is a vulnerability at transition into adulthood, despite Getting it Right for Every Child (GIRFEC) processes applying up to the age of 18, especially for those who leave school or who have complicated or challenging needs which do not fit into a medically defined category. Recommendations include: children with severe obesity affecting functioning should be supported via the GIRFEC pathway; everyone with parental rights and responsibilities should be consulted with and recorded on all agencies' GIRFEC paperwork; the GIRFEC pathway should be followed during transition, especially once a young person who has a child's plan has left school, to ensure ongoing support and planning.**Other resources View report online:** [**emppc.org.uk/file/Child\_Protection/Significant\_Case\_Review\_-\_Executive\_Summary\_Child\_R\_07-01-19.pdf**](https://emppc.org.uk/file/Child_Protection/Significant_Case_Review_-_Executive_Summary_Child_R_07-01-19.pdf) |
| 1. **Significant case review executive summary: Baby A.**

Abstract Death of a 5-month-old baby in 2012. Cause of death unknown at the time but post-mortem examinations over the following three years revealed non-accidental injuries. Father sentenced to seven years and three months imprisonment in 2016. Baby A lived with mother and father; no antenatal or postnatal concerns noted. Ethnicity or nationality not stated. Parents contacted NHS 24 following incident where Baby A was said to have rolled off a stool; this was not noted or communicated. GP referred Baby A to hospital with a rash and a bruise; hospital found injuries to be unexplained and contacted Social Work Services. Parents and Baby A were allowed home with follow-up. No further contact until five weeks later, when father contacted ambulance services because Baby A had breathing difficulties; Baby A died before their arrival.**Learning and recommendations include:** infants under 6 months of age do not generally possess the motor skills to allow them to roll of their own will and they are unable to injure themselves; the 'scripts, algorithm' from which nurse advisors work within NHS 24 results in staff being at risk of missing crucial signs that a child may have been subject to deliberate harm; all agencies should have baseline knowledge and understanding about the risks of non-accidental injury in infants and young children. Review was commenced in late 2016 due to delay in criminal proceedings.**Other resources Read report online:** [**www.southlanarkshire.gov.uk/Childprotection/downloads/file/372/significant\_case\_review\_executive\_summary\_-\_baby\_a**](http://www.southlanarkshire.gov.uk/Childprotection/downloads/file/372/significant_case_review_executive_summary_-_baby_a) |
| 1. Independent significant case review (SCR) report: Woodhead Road Children's Unit.

Abstract Investigation into non-recent institutional child sexual abuse and exploitation by a member of staff at a children's unit from 1990-1996. In 2012 two former residents reported non-recent systematic sexual abuse. Reports were investigated by police leading to the conviction of a former member of staff. In 2015 a former residential care worker was convicted of ten charges of indecency and sexual assault against six boys and sentenced to 13 years' imprisonment. More former residents reported non-recent abuse in May 2016 and four years' imprisonment was added to his sentence, running consecutively. In January 2016, a second former residential care worker was charged with offences against young women, but was not taken to trial. Ongoing criminal proceedings delayed the review process until 2015. Findings include: there is evidence that the concerns of children and young people were not fully heard. This likely impacted on the depth of investigation and the outcome of the then disciplinary process; former residents said they did not raise concerns at the time because they felt they would not be believed; information sharing in and across agencies was not as focused or made as readily available as it should have been. Ethnicity and nationality not stated.**Recommends** five key themes for improvement: person-centred approaches to care and support; listening to the concerns of young people in our care; investigating any concerns raised thoroughly; acting to safeguard young people in our care; working in and across agencies promoting the Getting It Right For Every Child (GIRFEC) principles.**Other resources View report online:** [**www.south-ayrshire.gov.uk/documents/woodhead%20road%20children's%20unit%20scr%20report.pdf**](https://www.south-ayrshire.gov.uk/documents/woodhead%20road%20children%27s%20unit%20scr%20report.pdf) |