**NSPCC Repository – August 2020**

***In August 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 [Children] [full overview report].**   Serious sexual abuse of eight children, several of whom have disabilities including one child with serious physical and learning difficulties, by members of Family S. Review covers abuse during the period August 2010 - May 2016. Criminal proceedings resulted in several adults receiving custodial sentences from four years to life imprisonment. The children had all come to the attention of statutory services over a number of years due to neglect by their carers. Evidence of indirect or incomplete disclosures, both verbal and non-verbal. A police investigation into disclosure of sexual abuse made to a foster carer in 2015 was closed within a matter of weeks with no further action. A second police investigation, triggered by information emerging out of Family Court procedures, uncovered repeated abuse of a number of children by members of Family S, a family where sexual abuse of children had become normalised over at least three generations. All of the children are white British. Issues identified include: the need to hear the voice of the child, and not the louder voice of adults; need to develop knowledge of sexual abuse in relation to disabled children and ways to provide opportunities for non-verbal children to communicate; and the impact of gender on the on the response of services. The review followed a systems-based methodology.  **Recommendations to the Safeguarding Board include:** develop skills and knowledge in communicating with children who disclose sexual abuse; embed understanding of grooming and sexual offending in practice; and ensure a clear pathway is in place for identifying and working with complex intra familial sexual abuse.  **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020CoventryChildrenOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9267AE52FA62B9447C714E57523F054D8822FEE4AEAD558BC2F7C37DAB1120B56CF746F9890080A833B813380E9CC72CAAAAB8AF8&DataSetName=LIVEDATA) |
| 1. **Serious case review Child K [full overview report].**   Death of a 16-year-old boy by suicide. Case review covers the period from January 2012 to December 2017. There were no services involved with Child K at the time of his death apart from school. An initial child protection conference was triggered due to Child K's plans to run away to his family's country of origin and his threats to teachers and other pupils. School made a referral to the Channel Panel and he was made the subject of a child protection plan. After this, his engagement with professionals declined. Concerns about the effects of domestic abuse in the household. Father was controlling and there were sporadic acts of violence. Child K was diagnosed with an autistic spectrum disorder. Shortly before his death, Child K made a report to the police which suggested his actions may result in risk to himself. Ethnicity/nationality not stated.  **Findings include:** Child K was seen differently by different people; Child K's needs in relation to his autism rarely featured in multi-agency meetings; and Child K felt that the involvement of professionals in his family's life was a significant disruption.  **Recommendations include:** consider a trauma-informed relational approach; consider whether practice and service provision is sensitive to the cultural, historic and gender context of families, including those outside of the main Black and Minority Ethnic groups; and review cases of domestic abuse before closure to confirm that couples and children have been signposted to counselling or meditation services.  **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020HertfordshireChildKOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92D70E13EAE30945AF714E56B22C159DFA13DC077EAD94FBD686924922CA8DF50D21AD5E51D9209B6D78EA927C60DB6B7177D9CD6F387BA&DataSetName=LIVEDATA) |
| 1. Serious case review: SCR Child I: Carys [full overview report].   Death of a 16-year-old girl in 2017 by suicide. Carys and her sister lived with their mother and stepfather and his two children. Carys experienced anxiety and was in receipt of mental health services. Early in 2017 Carys and her sister disclosed to their mother that their stepfather had been sexually abusing them; he was arrested and has subsequently been convicted for the offences. Following the disclosure and investigation, but before the criminal trial, Carys took her own life. Ethnicity or nationality not stated.  **Learning focuses on issues around**: initial responses to disclosures of child sexual abuse; use of child sexual abuse pathways and associated support; responses to the mental health needs of Carys; education settings being identified as key safeguarding partners; sharing of adult safeguarding information and concerns; accurate record-keeping by professionals; follow-up for children not brought to health appointments.  **Recommendations to the Safeguarding Children Board include:** to require an audit of strategy meetings to ensure participation from partners is sufficiently inclusive, follow up is occurring as necessary and effective information gathering and sharing is taking place; ensure rigorous promotion of the role of the Sexual Assault Referral Centre to ensure victims of sexual abuse, including nonrecent abuse, are being offered holistic support; explore ways to widely promote existing pathways and opportunities to respond to mental health issues in children and young people, including the policy to manage self-harming and suicidal behaviour; request assurance from health partners that missed health appointments for children are subject to robust and consistent follow up.  Other resources [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020KentChildIOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92E70FD3E8B378F52E035C36F22F047DFA82EA548F8DACDE7A26D6E6FAC8C0A96DE7913EDA6F3D2D1BB960066D8F7&DataSetName=LIVEDATA) |
| 1. **Serious case review overview report in respect of Child G.**   Abstract Neglect and sexual abuse of secondary-school-age child. Legal proceedings took several years, and Child G is now an adult. Child G's school made referral to social work team about Child G's angry behaviours, self-harming and allegations about abuse at home. Strategy meeting and interview with Child G by a police officer and a social worker; core assessment and medical assessment were not carried out. An Interim Care Order made and Child G was placed with a foster carer. Ethnicity or nationality not stated.  **Learning includes:** missed opportunities for a holistic and multi-agency assessment and response to Child G's emotional needs; no evidence of chronologies being maintained or information being collated to enable a wider understanding of Child G's history; there was a need for better management and supervision; ensure appropriate use of specialists to provide advice on how to engage with the child/adult if they have learning needs; practitioners need to be curious about the causal nature of behaviour and seek to explore alternative reasons.  **Recommendations to the Safeguarding Children Board include**: ensure that agencies have in place and follow effective safeguarding supervision and management oversight procedures, and remind agencies of the importance of appropriate challenge and escalation; establish clear self-harm procedures and pathways; ensure that effective support is provided to disabled children and their families to enable them to communicate and effectively participate in plans; ensure compliance with the procedures for child protection medicals and the inclusion of consultant paediatricians in strategy discussions or meetings.  **Other resources** [**Read full overview (PDF)**](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020LutonChildGOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E92960E725A61C8E57E818CB5631E743C0A43CFC16ECD85BA0AE1423818F3CF907100145A3969C94DE36616C3984234E&DataSetName=LIVEDATA) |
| 1. **Extended child practice review: re: C and VRSCB 02/2016.**   Abstract Life-threatening injuries to a 3-year-old child in March 2016. The child was found lifeless by an older sibling, hanging from a soft toy trapped on the top rail of a bunk bed. Ambulance services were called three times before enough information enabled paramedics to attend and take the child to hospital, where they recovered. Concerns recorded by Police related to home environment, particularly lack of food and toiletries, and poor cleanliness. History of substance abuse, child supervision concerns, and domestic abuse in the family home. Children were subject to child protection plans for emotional abuse and neglect. Reports to Police from neighbours and Mother relating to anti-social behaviour and domestic incidents prior to the incident.  **Learning includes:** children's behaviour can be a means of communication and lively and unpredictable conduct could be indicative of exposure to domestic violence; clearer case management with specific advice regarding interventions may have prevented more incidents occurring and triggered further child protection enquiries; provide training for frontline staff in relation to recognising and implementing strategies for disguised compliance at an early stage. Ethnicity and nationality not stated.  **Recommendations include**: consider alternative approaches to capturing the child's voice forms part of any 'direct work with children' training and part of the mentoring process for social workers in their first year of practice; consider if letters or other more suitable forms of communication depending on their particular needs, advising families of the decision to conduct a Child Practice Review are delivered by the most appropriate person.  **Other resources Read report online:** [**www.cardiffandvalersb.co.uk/wp-content/uploads/CPR-022016-Final-Report.pdf**](https://www.cardiffandvalersb.co.uk/wp-content/uploads/CPR-022016-Final-Report.pdf) |
| 1. **Serious case review: Baby Eliza [full overview report].**   Abstract Non-accidental injuries to a 4-month old girl in 2015. Child AA (Baby Eliza) was taken to hospital by ambulance where examination revealed unexplained cerebral bleeding thought to have occurred more than once. Mother was a single parent; had been in care when she was 15. Maternal history of: mental health problems; drug abuse; domestic abuse; reluctance to engage with services; sexual abuse and exploitation; multiple pregnancies. Wider family known to multiple agencies. A previous child had been removed because of parental neglect. Pre-and post-birth assessments had not raised serious concerns; plan to support Child AA as a child in need. Child AA is Black British.  **Learning includes:** need for thorough assessment of mother's and wider family history, including trauma when assessing parenting capacity rather than depending only upon presentation and observations; need to avoid misplaced sympathy; need to consider correlation between animal cruelty and child abuse; importance of following best practice and compliance with established procedures; need for professional curiosity and mutual challenge; need for full, precise and accurate information recording and sharing; persistence in encouraging GP involvement; professional enquiry about men (resident or not) whose relationship and conduct had an impact on the case; need for an effective system for identifying safeguarding supervision cases. Makes specific recommendations to all agencies involved including changes in policy and procedures as well as steps to ensure sharing, accurate, up-to-date information.  **Recommendations to the Safeguarding Board include:** use the case for multi-agency training; urge NHS England to ensure clinics inform GPs of terminations.  Other resources [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019WandsworthBabyElizaOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE03274FD2EBB28894CF014CE7825FB74DAA423EA77EAD94FBD686924922CA8DF6A176EE0E51D920965727E1BFBD22F6D22B7516B03CC2E64&DataSetName=LIVEDATA) |
| 1. **Serious case review: Child KS [full overview report].**   Abstract Death of an 8-week-old baby in 2017. KS was placed in bed next to Mother where they both fell asleep. Mother's partner awoke to find KS still in bed lying on their back and not breathing. Ambulance services were called and attempts to resuscitate KS were made, but KS was declared deceased at hospital. Parents were arrested and a police investigation was conducted and concluded with no further action. Mother had seven children including KS and twin, with some the subject of child protection plans, care proceedings and child in need plans. History of domestic abuse between Mother and children's fathers. Mother had failed to attend and bring KS to many health appointments and had a history of substance misuse. Methodology based on the 'Welsh Model'.  **Key findings include:** KS died from an unascertained cause and there was no known action that professionals in Sandwell could have taken to prevent this death; if agencies had better shared information and complied with both national and local procedures, the level of support to Mother and her family could have been more effective but would not have affected the final tragic outcome for KS. Ethnicity or nationality not stated.  **Recommendations include:** undertake a review of safeguarding training to ensure that pre-birth procedures are understood and implemented appropriately; seek assurance that health professionals engaged in antenatal and post-natal work are trained in the appropriate use and application of escalation procedures, issues of disguised compliance and over optimistic assessments.  Other resources [Read full overview (PDF)](http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2019SandwellChildKSOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776135EAAAAFFECACF7BE03674FD2EBF3A8A52C714E57523C962F9BB3CF94EF5D94AE57168354BBAEFC02D2157DF093D5F16E3E72C0A892D8485FE5A3F8C&DataSetName=LIVEDATA) |