NSPCC Repository – December 2020

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

1. Serious case review for Family K (full overview report)

Severe knife injuries of an infant boy in June 2018. Father subsequently pleaded guilty to the attempted murder of Child R and his mother. Child R's mother and her family had moved several times and were known to 20 organisations across four local authorities. During her separation from her first husband, against whom she had made allegations of domestic abuse, Mother became pregnant with Child R. Following low level concerns about Mother's mental health, there were referrals to social care and a social worker was allocated. Child R's Father assaulted Mother in August 2017 and threatened to kill Child R in December that year. In March 2018, Child R's father again assaulted Mother and a children's social care assessment concluded that there was no risk to the children. After being convicted for the assault, Child R's father stabbed Child R and Mother. Family is Muslim and from a Pakistani background.

Learning points include: focus on children's daily lives and the emotional impact of domestic abuse; recognise the importance of previous episodes in assessment; and recognising the importance of families that move frequently.

Makes recommendations including: ensure that all agencies promote a culture and competence to enable staff to evaluate the risks of domestic abuse in full; ensure that staff take full account of race, religion and other characteristics that may shape domestic abuse and its impact; highlight the importance of compiling and sharing information when a family leaves or arrives in an area.

Other resources Read full overview (PDF)

2. Safeguarding practice review (complimentary learning): Child E: Version 7 (full overview report)

Death of a 4-month-old boy in August 2018. Steven's death was initially suspected to be an overlay but inquest concluded a verdict of accidental death due to co-sleeping. Steven had been subject to a pre-birth assessment due to Mother's children from a previous relationship being taken to live with their father. Assessment concluded that support for the family was needed via a Child in Need plan which ceased in July 2018. Both Steven's parents had mental health difficulties and there were concerns about alcohol misuse. In July 2017 Mother attempted suicide. Several domestic incidents occurred between Mother and Father, even after bail conditions for Father stated that he should not go within 100m of Mother's house and not to contact her.

Learning includes: victims of domestic abuse are given responsibility of keeping their children safe from the perpetrators of abuse without an assessment of their capacity to do so; perpetrators of violence, though identified as the source of risk to children, are not

directly worked with to address concerns; relationships characterised by domestic abuse and between people with alcohol, substance and mental health issues rarely end without periods of reconciliation and contact; clear up-to-date records and effective, comprehensive information sharing are the foundations on which effective child safeguarding practice are built; workforce understanding of the risks of domestic abuse, particularly the risks associated with post separation are poorly understood. Ethnicity and nationality not stated. Review does not make any recommendations.

Other resources Read full overview (PDF)

3. Serious case review concerning the young person 'Clare' (full overview report)

Death of a 17-year-old girl in March 2017 whilst a patient in a mental health unit. Clare was her mother's only child. Parents separated before she was 1-year-old. Father met a new partner, and had two children. Mother also met a new partner who had a child - both joined the mother's household. Clare remained with her mother but had contact with her father and his new family. In June 2015 Clare moved to a new area to live her father and his family. Evidence that the parental separation had a significant impact on Clare's emotional and mental wellbeing, and that her mother experienced bonding and attachment issues. Clare and her mother were first referred to child and adolescent mental health services in December 2009. Moving schools in 2015 gave rise to challenging behaviour, truanting and going missing. Evidence of increased incidence of self-harm, reported anxiety and attempted suicide lead to hospital admissions and detention under the Mental Health Act on several occasions during 2016. Clare's ethnicity or nationality is not stated.

Key lessons: the need for early intervention based multi-agency approach that includes the school, Children's Services and relevant agencies; the need for schools to be aware of their students emotional and mental health needs and to share any concerns with the school's designated safeguarding lead.

Recommendations: agencies should consider how best to maximise the voices of young people and their parents in decision making processes; and have awareness of the importance of early recognition, intervention and treatment of children and young people with mental health issues.

Other resources Read full overview (PDF)

4. Serious case review: Baby Darryll: anonymised review report (full overview report)

Death of a 20-day-old infant in 2018. Baby Darryll was admitted to hospital and died five days later. Mother was a care leaver, had experienced a difficult childhood, and was known to Children's Social Care from the age of nine-years-old due to domestic abuse between her parents. Mother moved into care at 13-years-old, and had episodes of going missing, child sexual exploitation, and drug and alcohol use. Concerns about Mother entering abusive relationships. Pre-birth risk assessment highlighted concerns over housing arrangements and Mother's cannabis use. Coroner's Court concluded an outcome

of death by misadventure, with the post-mortem stating cause of death as hypoxia. Ethnicity and nationality not stated.

Learning includes: recognising adverse events that have happened in a person's earlier life can provide important context to understanding their current circumstances and behaviours; in cases where an adult is judged to have their own vulnerabilities, and they already have a named worker to support these needs it is important that for any child living in the same household there is consideration to them having their own allocated worker.

Recommendations include: inform the Family Nurse Partnership National Unit to allow them to consider the learning; promote learning, as a public health message to the wider population, about the importance of avoiding co-sleeping and unsafe sleeping arrangements with babies; seek assurance about the quality and effectiveness of joint working arrangements for those services who work with care leavers who are pregnant and who require housing support.

Other resources Read full overview (PDF)

5. Serious case review: Grace and Georgina (full overview report)

Physical abuse of a 3-year-old girl, Grace, and her 10-month-old sibling, Georgina. In February 2018 Georgina was taken to hospital with severely infected chicken pox; examinations revealed non-accidental fractures. Siblings were placed in foster care. A Finding of Fact concluded that Mother had physically abused Grace. Parental history of adverse childhood experiences; ADHD and mental health problems; Mother had partial deafness. In 2013, Father convicted for assault on Mother, and Grace was made subject to Child Protection plan; closed in 2015 due to Mother seeking non-molestation order on Father's release from prison and proactively seeking support; later found to be disguised compliance. Pre-birth Child Protection Plan for Georgina attributed greater risks to Grace's Father than to Mother's parenting; stepped down to a Child in Need Plan in September 2017. Grace is White British; Georgina is White British/Palestinian.

Learning focuses on: understanding and working with carers who have complex histories; communicating with and responding to the children; responding to physical abuse in infants; management of risks after stepping down from child protection; and consideration of multiple forms of abuse.

Recommendations include: consider raising awareness and refreshing understanding of the risks to infants of physical abuse for children at all levels of intervention; consider how well the reality that children can be harmed in different ways by more than one perpetrator is understood within the multi-agency partnership and what can be done to develop best practice; review the way that the category of emotional abuse is used for children subject to Child Protection Plans.

Other resources Read full overview (PDF)

6. Serious case review report Child Ak (full review report)

Death of a 2-year-old boy in December 2017. Child Ak was taken to hospital on life support but died of cardiac arrest. Was found to have several drugs in his body and multiple unexplained injuries and bruises. Father was arrested, charged and convicted of Child Ak's murder. Father was known to services and had prior convictions involving drugs and a history of domestic violence. Child Ak's paternity only established in late September 2017. Agencies agreed pre-birth that Child Ak would be subject of a child protection plan for emotional abuse. In October 2017 police found Child Ak in father's care with drugs present and an understanding that Child Ak was left alone in the premises for periods of time. Ethnicity and nationality not stated.

Learning includes: develop organisational culture that enables professional curiosity and that is child centred and child focused, ensuring that the child/young person is 'seen' or considered, when working with parents, even if absent; ensure that the child's 'voice' is heard; ensure that expectations regarding multi-agency information sharing are clearly understood across all levels of involvement.

Recommendations include: develop procedures for effective work with young people who are parents where safeguarding is required for both a young parent and their child; identify and promote approaches to engagement and effective work with fathers or partners of parents; develop strategies to enhance practitioners' capacity to work effectively where there may be complex parenting arrangements, for example involving different parents - especially fathers/father figures - for several children within a single household.

Other resources Read full overview (PDF)