NSPCC Repository – April 2021

In April 2021 eight case reviews were published to the NSPCC Repository. A summary of each of these cases can be found below:

1. Serious case review: Child A (full overview report)

Review relating to Child A, following concerns about suspected fabricated or induced illness including the prescription of opioids for pain management, covering the period from birth to the age of 11-years-old. Child A was born by emergency caesarean section at 27- weeks-old and was diagnosed with a condition found in premature babies. Child A underwent a wide range of medical and surgical investigations, suffering from an increasing number of conditions leading to more health professional involvement. Evidence of mother declining heath visiting support and cancelling and postponing appointments. Child A attended a school for children with physical disabilities and additional sensory needs, before parents opted for home tutoring. Poor health and authorised absences requested by mother impacted on educational progress.

Findings: practitioners did not listen to the voice of child; acceptance of what mother said, and responding without any objective assessment led to unnecessary and inappropriate medical intervention; lack of professional challenge and curiosity culminated in the ongoing medicalisation; an insufficient response in meeting educational needs.

Recommendations: embedding the voice of the child in procedures and training and ensuring that children are involved at each stage of their care; review practice guidance on fabricated and induced illness to ensure it takes account of children who are coming to harm through excessive medical intervention; training should include the potential safeguarding impact on children not being brought for health appointments; ensure escalation policy incorporates supporting professionals being able to challenge colleagues.

Other resources Read full overview (PDF)

2. Serious Case Review: Baby Harris (full overview report)

Death of a 15-day-old boy in June 2019. Baby Harris was found dead in the family home, after having been asleep in his parent's bed. Baby Harris had lived with his mother, father and half-sibling (Child A). Family were known to children's services and the police due to concerns around potential parental drug misuse and issues around Child A's school attendance. Family had two social work assessments, and police had intervened in domestic abuse incidents between the father and mother. Father had a history of mental health issues, violence, and alcohol and drug misuse. Family was White British and European.

Learning includes: lack of professional understanding around Child A's lived experience, which could have alerted professionals to risks and harm; invisibility of unborn Baby Harris and Child A, partly due to inconsistent parental engagement with services; a lack of

access to and understanding of the family's history by agencies resulting in parental risk factors not being identified; issues around multi-agency responses to domestic abuse, including issues with information sharing; safer sleep messages provided to the family were difficult to put into practice, due to the family's living arrangements.

Recommendations include: improving the engagement of children, and an understanding of the lived experience of children; improving the quality of assessments where children and unborn children are experiencing neglect; improving the understanding of the cumulative effects of neglect; ensuring that there is sufficient staff capacity in social work services to offer the conditions for good social work practice.

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3. Child Safeguarding Practice Review: Jacob

Death of a 16-year-old boy, who was found dead in his bedroom in April 2019. There was insufficient evidence that Jacob had intended to end his life. Jacob had been criminally exploited by adults operating county lines, and exposed to serious levels of youth violence. Support for Jacob included: early help pathways, nine inter-agency strategy discussions, a child protection plan under the category of neglect. Jacob was placed in residential care in 2018, eventually returning home under a supervision order. Jacob repeatedly went missing from home and care. There were several police reports and recorded offences against Jacob, mainly relating to violent crimes; there were no investigations or convictions. Jacob missed education for 22 months. Jacob was White British.

Findings include: issues with professional knowledge, skills and safeguarding systems for children at risk of criminal exploitation; a single agency approach instead of multi-agency coordination that could have identified contextual risks; focus on responding to Jacob's behaviours, without enough focus on reducing risks to Jacob in the community; issues of unconscious gender bias in relation to criminal exploitation; missing education playing a significant role in levels of risk not being identified; importance of agencies responding quickly at critical times in a child's life to keep them safe.

Recommendations include: a review of the effectiveness of the National Referral Mechanism; statute and guidance on schools who cannot be mandated to accept children on roll; a national review of placement sufficiency for children who need to be in care or placed under secure arrangements.

Other resources Read practice review (PDF)

4. Serious Case Review Overview Report: Child E

Death of a 6-year-old girl in June 2019. Cause of death is unknown. Child E had a chromosomal abnormality, a history of having regular epileptic seizures, and significant learning difficulties. On the morning of her death she had suffered two seizures and was kept home from school. Mother left Child E and three younger siblings locked in a bedroom while she went to collect another sibling from school. On her return, she found Child E face down on the bed and unresponsive. Mother called an ambulance and Child E

was pronounced dead at the hospital. Family lived in temporary and overcrowded accommodation. Ethnicity or nationality not stated.

Learning includes: the practice was insufficiently child focused and tended to be governed by parents' wishes and views; there was a need for more focus on the quality of Child E's lived experience and on her parents' refusal to consent to potentially lifesaving treatment; there was insufficient professional curiosity and response about understanding and investigating the children's experience of living in overcrowded accommodation.

Recommendations include: ensure that professional practice is child focused and considers the lived experience of all children in a family; review the process and procedure for identifying risks and harm to children when parents or carers are not complying with medical advice; professionals need to establish whether fathers have parental responsibility for children; consider the options for improving the coordination of services and information sharing to address the needs of children with disabilities.

Other resources Read full overview (PDF)

5. Serious Case Review: Anonymous Family: Review Report

Chronic neglect, physical and sexual abuse of eight siblings and three older half siblings perpetrated by their parents and one sibling. Both parents and the oldest sibling of their relationship were convicted and sentenced for sexual offences and neglect. Initial case review commissioned in 2016 and covered a period of 26 years involving six Local Authority areas; reviewed in 2019 to focus on home area partner agencies and services responsible for the family from 2005-2015. Children were removed on Care Orders in 2007 but sexual abuse continued to be perpetrated by their parents and an older sibling. Two criminal investigations - the first in 2007 did not progress; the second concluded with charges and a trial in 2017. Ethnicity or nationality not stated.

Learning includes: the impact of securing evidence in criminal proceedings and safeguarding children; mothers as sexual abusers of their children and the impact of disguised compliance by parents; the level of knowledge, skills and training available to practitioners on child sexual abuse within the family; the continuing need for escalation and professional challenge by practitioners; the historical and current issues around the retention of records; the central role of the Independent Reviewing Officer (IRO) needs to be recognised when there are a number of children within a family in different placements; and children “not brought” to medical appointments.

Recommendations are provided under the following themes: child sexual abuse investigation processes and management oversight; professional escalation and challenge; training and professional development for front line practitioners; and information sharing.

Other resources Read full overview (PDF)

6. Serious Case Review ‘George’ (full overview report)

Death of a 3-year-old boy in February 2018 in Croydon. George had been in the rear passenger foot well of a car when the front passenger (Mother's partner, 'A') pushed his seat back twice and crushed George. 'A' was imprisoned for manslaughter, perverting the course of justice and witness intimidation, and George's Mother received a custodial sentence for child cruelty, perverting the course of justice and assault.

Actions by Children's services for George and Mother included: supported accommodation; a child protection plan on grounds of neglect; a child in need plan and child and family assessments. Mother was considered vulnerable to abuse and exploitation due to adverse childhood experiences, and there were concerns about her cognitive ability. Mother was involved with two men, 'A' and 'B', both of whom were involved in multiple incidents of domestic abuse and criminal activity. When George was 18-months-old he was taken to hospital twice with head injuries, which Mother claimed to be accidental. Mother and George moved address several times. George was White British.

Learning includes: the impact on George of witnessing domestic abuse and unpredictable changes of residence was underestimated; George's presence was not adequately recorded during some incidents; the need for professionals to record and assess incidents considering information on all individuals present; the need for professionals to define demonstrable change in the situation of a child at risk or vulnerable adult before concluding sufficient improvement.

Recommendations include: Medway agencies to improve methods of reporting and responding to incidents involving safeguarding issues and vulnerable adults.

Other resources Read full overview (PDF)

7. Serious Case Review: Child H: Review Report (full overview report)

Death of a 9-year-old boy in August 2018. Child H was found unresponsive in the family home and later pronounced dead. A police investigation concluded there was insufficient evidence to pursue a prosecution. Child H had epilepsy and significant disabilities. Family was in receipt of various services in response to Child H's needs. Child H was subject to Child Protection Plans in 2010 and 2018 due to concerns around neglect. Child H's father and mother were known to the police for involvement in drug use and supply and other criminal offences. Ethnicity or nationality is not stated. Uses a model of learning based on a Soft Systems Methodology.

Learning points include: a professional focus on managing Child H's disabilities, rather than seeing a child who was disabled and neglected; the need for information sharing between appropriate agencies when a child has a Child in Need plan; importance of professionals escalating concerns about parental capacity in a timely manner, particularly when a child has complex needs; family medicine management should be checked by professionals on a regular basis, when prescribed medicines form part of a child's health and safety plan.

Recommendations include: increasing knowledge across services on how concerns about a child's welfare might be managed; children's social care review their local policy on Child in Need cases, to ensure policy clearly reflects the need to involve partner agencies,

particularly in cases involving children with disabilities; local NHS Trusts review their policies and procedures on recognising and responding to medical neglect.

Other resources Read full overview (PDF)

8. Frankie: Serious Case Review (full overview report)

Death of a 3-year-old boy in July 2016. Frankie was a hospital inpatient for life threatening asthma leading up to his death, and died within 24 hours of discharge. Parents were professionals and Frankie was cared for by a nanny; his older sibling was home educated. Frankie was seen at home twice post birth but was not immunised and did not attend the two-year developmental check. Frankie had twelve hospital admissions associated with severe asthma from the age of 20-months, until his death. Parents were reluctant to fully comply with medical advice and prescribed medication for Frankie; they feared steroids and declined or reduced numerous medications over various hospital admissions. Ethnicity or nationality not stated.

Learning includes: medical neglect is less understood across all agencies and within the health system, which is a weakness in the multiagency children safeguarding system; impact of parents' social class upon the relationship with health professionals; parental challenge around medication is common but there is a lack of robust strategies to manage this in the hospital; absence of other categories of neglect appear to have reassured practitioners.

Recommendations include: hospitals to explore how clinical teams manage parent consent for emergency treatment; hospitals must review how they manage severe illness in children when a parent favours alternative therapy; GPs and Health Visitors must have an agreed plan when following up issues of concern with families; all services must be able to evidence how their workforce participates in reflective safeguarding supervision which supports their learning and development.

Other resources Read full overview (PDF)