NSPCC Repository – May 2021

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

1. Serious case review: Child D (executive summary)

Death of a 13-month-old child in February 2019. Child CD was found head down in a fabric toy box at the bottom of the bed, cold to the touch. Ambulance services were called but Child CD did not show signs of life and resuscitation was not attempted. Ambulance crew expressed concerns regarding the home environment and circumstances in which Child CD was found. Parents were arrested on suspicion of murder/neglect but no charges were levied against them. Family had re-located three times during the review's timeframe. Mother had experienced adverse childhood trauma at home and in school. Both parents had a history of alcohol and drug misuse, depression, and could be non-compliant with their medication regimes. Father had a history of homelessness and Mother did not always engage with services. Ethnicity and nationality not stated.

Learning includes: maternity services should provide assurance that routine domestic abuse enquiry is effective, and not a widespread issue; Early Help may be indicated when families move frequently; there should be a robust assessment of family needs when women with a significant history of mental/emotional instability are pregnant and in the post-natal period to support them in caring for infant and their other children.

Recommendations include: safer sleep and the risks to mobile infants/toddlers should remain a focus of local multiagency activity; a focussed response and co-ordinated multiagency working with adolescents with complex health and social needs on the edge of statutory intervention; assessing and working with young fathers (the hidden male) who have or assume childcare responsibilities is crucial.

Other resources Read executive summary (PDF)

2. Serious Case Review: Child B (full overview report)

Neglect of a 10-year-old child over a number of years. Child B was born with a disability and needed significant support from health specialists. They lived with mother, father and older siblings. In May 2015, Child B was admitted to hospital to have a toe amputated. Concerns were raised that the infection that led to the amputation was preventable. Child B was not brought to a significant number of health appointments. Further concerns were raised and formally escalated in 2018. In February 2019, Child B was made subject of a child protection plan. Nationality or ethnicity not stated.

Learning includes: children not being brought to appointments is an indicator of potential neglect; effective and child focused safeguarding practice with disabled children ensures they are seen, heard and helped; the focus on engaging parents and carers to support disabled children is key, but this should not dilute professional challenge; multi-agency

working, information sharing and understanding the responsibilities of others can be complex; the need for professionals to think family and think fathers.

Recommendations include: ensure that all services have access to and use a 'Was Not Brought" policy across the local health system; the Disabled Children's Service should ensure that meetings that they convene include an analysis of a child's attendance at appointments; ensure that recording systems are sufficient to identify repeating patterns of children not being brought to appointments; ensure that guidance for safeguarding children with disabilities is sufficient in terms of setting out the importance of communication and hearing the voice of the child.

Other resources Read full overview (PDF)

3. Serious Case Review "Faith": (full overview report)

Historical sexual abuse of an adolescent girl. In 2016, prior to Faith's 18th birthday, Faith disclosed that she had been sexually abused for several years by a neighbour, and that her mother had been aware this was happening. There were several domestic incidents involving police and neighbours at the family home. Faith's step-father was violent and Mother had issues with alcohol. Faith was excluded from school and looked after by two foster parents, before moving to residential care. A retrospective health review identified that as a child Faith had been seen by health practitioners with symptoms suggestive of sexual abuse. Ethnicity and nationality not stated.

Findings include: over many years the signs and indicators that Faith had been sexually abused were not recognised and acted upon and her voice was not heard; assessments and plans were limited in their analysis of the history of both parents, the dynamics of relationships within the family and relevant health information; there was no clear plan to give Faith a permanent safe home and the legal framework was not used effectively.

Recommendations include: develop a multi-agency whole family approach to work with complex families; seek evidence from Children's Services that the cause of placement breakdown is analysed and that findings are incorporated into ongoing planning for the child; ensure that all practitioners have the required knowledge and skills and confidence to recognise and respond to child sexual abuse within the family including hearing the "voice" and lived experience of the child.

Other resources Read full overview (PDF)

4. Serious Case Review: Child D (full overview report)

Death of a 7-year-old girl in November 2017. Child D was murdered by her father in the family home. Father then rang the police and reported what he had done; Child D was resuscitated at the scene but died in hospital the following day. Father pleaded guilty to Child D's murder and was sentenced to life imprisonment. Family was known to numerous agencies. Father and Mother were experiencing a breakdown in their relationship. Father had attempted suicide on several previous occasions due to stress and depression. Mother was not a fluent English speaker and there were concerns about Father's coercive control of Mother and his continual disguised compliance and

deception. Post-mortem discovered semen in Child D's vagina but investigation was unable to establish how it got there. Father denied sexual assault. Child D's father was White British and mother was from South East Asia.

Learning points relate to: mental health risk assessments; multi-agency assessments; thresholds and 'step-up' and 'step-down'; the use of interpreters and cultural sensitivity in assessments where English is not the first language; considering and assessing coercive control and disguised compliance; information sharing; sexual abuse.

Recommendations include: seek assurance that in mental health assessments following attempted suicide where the adult has responsibility for children, that risks to them and partners are considered, including where the dependent is seen as part of the patient's perceived 'problem' or 'protective element'; review multi-agency approaches to assessing for the possibility of sexual abuse of children.

Other resources Read full overview (PDF)

5. Serious Case Review 'Laura' (full overview report)

Sexual abuse of a girl aged between 11-19-years-old. Laura disclosed a history of sexual abuse by her mother's partner in 2017 at 19-years-old. Mother's partner was a registered sex offender, which was unknown to the family and professionals until Laura's disclosure. In 2019 mother's partner was convicted of 20 sexual offences against Laura and received a custodial sentence of 23 years. Laura had ADHD, a learning disability, speech and language difficulties and behavioural difficulties. Family received various services in response to Laura's special educational needs. Children's social care undertook three assessments with the family; two assessments followed reports by Laura that she had been physically abused by her mother and mother's partner. Uses a systems methodology. Ethnicity or nationality is not stated.

Findings include: lack of professional awareness of Laura being at heightened risk of sexual abuse due to her learning difficulties and disabilities; unchecked assumptions can inhibit professionals from exploring what may be happening to a child in their family; professionals in contact with children should regularly update records about family members and seek out information about significant males in a child's life; professionals may not always consider the possibility of child sexual abuse, unless there is a disclosure or the presence of recognisable signs and symptoms.

Recommendations include: an authority wide, multi-disciplinary strategy for prevention, identification and response to familial child sexual abuse; ensure that professionals understand that concerns about the behaviour, health, well-being or safety of children with disabilities may be attributable to familial sexual abuse, even if this is later discounted.

Other resources Read full overview (PDF)

6. Serious Case Review: Baby F: (full overview report)

Life-changing head injury of an 11-week-old boy in September 2016. Parents were subsequently charged in connection to injuries. Over the first few visits from health

visitors after Baby F was born, Mother reported low mood, relationship tensions and issues bonding with the baby. She was receiving workplace counselling and the health visitor offered the maternal early childhood sustained home-visiting (MECSH) programme. Both Mother and Father were diagnosed with post-natal depression. Baby F was seen at hospital twice prior to his life-changing injuries. On the second occasion, he was not seen by a senior doctor and was discharged with advice to Father. On the day of Baby F's life-changing injuries, Mother reported that Father had accidentally banged Baby F's head to workplace counsellor. The counsellor discussed this with a supervisor but no further action was taken. Baby F was taken to hospital where he was found to have life-threatening head injuries, intra-cranial haemorrhage and rib fracture. Baby F is of African/European heritage. Uses Partnership Learning Review model.

Findings include: it is important to seek engagement with both parents to assess their mental health; supervisors need to be vigilant to ensure the most vulnerable families are discussed at supervision; and when parents have their own needs, there is a risk that focus on the child will be lost.

Identifies considerations including: guidance on the detection and management of unusual medical presentations in non-mobile babies should be applied consistently by all agencies and counsellors should follow guidelines on safeguarding children.

Other resources **Read full overview (PDF)**

7. Serious case review: Baby G (full overview report)

Death of a 6-month-old baby boy due to a significant head injury attributed to shaking in May 2017. Father was charged with manslaughter and received a prison sentence. Mother was 18-years-old when she became pregnant with Baby G. Maternal history of troubled childhood, being subject a Child Protection Plan, and depression. Father diagnosed with depression; had an older child who lived with their mother. Baby G's parents lived separately; Mother moved into supported accommodation for young parents before the birth. Mother attended antenatal appointments together with Father; no concerns identified. Frequent attendance at GP practice and three attendances at hospital emergency department. Baby G spent regular nights with Father, and following a brief incident of Mother being unwell, the arrangement became more frequent. Ethnicity or nationality not stated.

Learning includes: the need for clear and accurate information sharing and for all agencies to seek information if they believe an assessment is being conducted; importance of professional curiosity for clinicians when presented with unusual signs and symptoms.

Recommendations include: ensure that partner agencies recognise that minor presentations can represent injuries which may be a sign of serious abusive trauma; promote awareness among parents and professionals of the "crying curve" ("purple crying") and the impact on parents of coping with inconsolable crying; reflect on the diagnosis and treatment of depression in new and prospective parents and how this can impact on parenting capacity; develop a programme of intervention to engage fathers

and prospective fathers; engage, reassure and educate parents about infant crying and strategies for coping and impulse control.

Other resources Read full overview (PDF)

8. Serious case review executive summary: Child NS

Death of a 2-month-old child due to asphyxiation. Mother found Child NS lifeless in the bed beside her after waking up following a night out. At the time of Child NS' death, children's social care were not aware that there was a new baby in the family. The family had older siblings, some of whom had additional needs, who lived with Mother and Child NS. Father lived nearby. In 2018, school staff made a referral to children's services because of changes in the presentation and behaviour of two of the siblings. A subsequent child and family assessment resulted in no further action. Later that year, the eldest sibling received a serious injury and was made subject to a child in need plan following a section 47 enquiry and child protection conference. The needs of Child NS were not considered as part of this process because the parents had only disclosed the pregnancy to the services necessary to receive antenatal care.

Learning includes: information about all members of the family should be sought from GPs during assessments and conferences; assessments of a child's needs should consider any additional needs of siblings; and practitioners need to bear in mind that parents might not disclose key information.

Recommendations include: improve the effectiveness of informing parents about the dangers of co-sleeping; consider how to promote the wellbeing of all immediate family members who have experienced a neonatal death; and consider how to ensure the needs of siblings are considered collectively as well as individually.

Other resources Read executive summary (PDF)