# NSPCC Repository – June 2021

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

**1. Child O – Local Child Safeguarding Practice Review**

Serious and potentially life-threatening incident to a 4-year-old boy in July 2019. Child O was taken to hospital after accidentally swallowing Gamma-ButryoLactone (GBL) he found in his mother's handbag. Child O lived with extended family under a Special Guardianship Order (SGO). Child O was alone with Mother when the incident happened, contrary to the SGO agreement. Concerns raised about neglect due to parents' misuse of drugs. A Child Protection Plan was made for Child O but was unsuccessful in reducing risks. Father was convicted of child neglect in 2015 when he was found in-charge of Child O under the influence of drugs. Child O was accommodated under section 20 of the Children Act 1989 and placed with his grandmother. A police investigation was underway but not concluded. Care proceedings were initiated for Child O and sibling which concluded in 2020. Ethnicity and nationality not stated.

**Learning looks at:** the support offered to the family under the SGO and the quality of the support plan; robustness of the communication between local authorities (LAs) including how safeguarding referrals were raised; adult mental health; domestic abuse and MARAC involvement; issues arising from management oversight and supervision information.

**Recommendations include:** review training programs about the legislations, governing and meaning of different types of placements such as SGOs, Children Looked After (CLA) and adoptive placements that are open to LAs when considering the future of children who are unable to live with their birth parents; oversee a multi-agency review of current arrangements for Children in Need that are also subject to SGOs.

**Other resources** Read practice review (PDF)

**2. Child Safeguarding Practice Review: 'Child 'James' 03-01-2010 to 16-08-2020**

Death of a 10-year-old boy in August 2020. James died because of restricted airways after his mother gave him an excess does of Melatonin, prescribed to help him settle at night, and put him to bed with a sponge in his mouth. Mother reported to police that she had "killed her son" and subsequently pleaded guilty to manslaughter with diminished responsibility. James was a boy with severe learning disabilities and a complex range of disorders. James had a degenerative visual impairment and hearing loss. In March 2020 Mother decided to keep James at home due to health risks posed by the Covid-19 pandemic. Mother was concerned about stress related to finances and her divorce; she was diagnosed with depression in 2018. Mother and Father divorced in 2017, and Father moved to Spain. Mother was a Russian national, Father English.

**Learning includes:** there was a significant level of contact between the family and agencies, services were maintained and there was multi-agency oversight; during this contact James's mother was inconsistent in her presentation; James's mother refused

offers of support through Children in Need services; there was no contact between agencies and James's father.

**Recommendations include:** collaborate and co-produce with disabled children and their parents, information about and service delivery of child in need services; review information provided to parents about the Direct Payment System and their responsibilities to inform funders of situations where family members or partners are employed; review the approach to engagement of fathers as single agencies and as a partnership.

**Other resources** Read practice review (PDF)

### 3. Response to significant incident notification: (anonymous victims of FC1)

Sexual abuse of several children by their foster carer between 2007 and 2019. Foster carer (FC1) and his wife (FC2) were registered with a private fostering agency and had fostered forty children from five different local authorities between 2007 and 2020, usually as mother and baby placements. They had never been approved as local authority foster carers but had worked for three private fostering agencies. Early in 2020 FC1 told police that he was a paedophile and had sexually abused several children in his care. FC1 was charged with offences of oral rape and sexual assault on children under 13-years-old relating to four of the children, and sexual activity in the presence of a child which covered unidentified victims. He received a lengthy prison sentence. Ethnicity or nationality not stated.

**Learning includes:** while there were no obvious physical injuries to the young children victimised by FC1 there will be potential long-term impacts on their health and wellbeing; training about the "invisible male" should also be used to consider situations where foster carers and other professionals are providing care and support in their own homes; the identification of child sexual abuse in particular with regard to children who are pre-language or have significant language or communication difficulties.

**Makes no recommendations but sets out actions including: regional** event to be developed to share learning on: understanding and avoiding the impact of professional bias; ensuring neither foster carer is an "invisible party"; understanding perpetrator profiles; and sexual abuse of babies and pre-verbal infants.

**Other resources** Read review (PDF)

### 4. Serious case review: Child A1

Death of a 4-month-old infant in May 2018 whilst in the care of a family member overnight. Police initiated an investigation but no charges were made. Child A1 lived with her parents; Mother and Father were known to Early Help and Health Services in respect of antenatal and postnatal care. At the time of her death, Child A1 was being cared for by her paternal aunt, who placed her on the sofa and then fell asleep after consuming alcohol. When she woke up she found Child A1 lifeless. An ambulance was called, and Child A1 was confirmed dead at hospital. Paternal Aunt had two children; both were made subject to Child Protection Plans in March 2018 under the category of emotional and physical abuse. There were also concerns about alcohol misuse. Ethnicity or nationality not stated.

**Identifies an area of learning** for Children's Services as to the extent to which the Child Protection Plan in respect of Paternal Aunt's household included any risk to other children.

**Recommendations:** ensure that Special Circumstances Forms generated by midwifery services are shared by key agencies, such as general practitioners (GPs) and health visitors; ensure that information sharing and discussion take place routinely between midwifery and GP practices where issues are identified, and concerns are raised in order to understand the holistic family circumstances; where parental alcohol and substance misuse are risk factors, practitioners are able to consider any other caring responsibilities for children including babysitting arrangements.

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

**5. Serious case review: Beatrice (full overview report)**

Injuries to an 8-week-old girl in 2019. Beatrice was taken to a walk-in centre concerning a rash and was found to have unexplained bruising. An ambulance was called and Beatrice was taken to hospital where scans showed 13 fractures to ribs and legs of differing ages. Beatrice's parents did not live together. Father suffered from depression, had anger issues and was diagnosed as having Asperger's Syndrome. Mother had made allegations of sexual abuse against her father, and had a history of self-harm and suicidal ideation. Father had attempted suicide previously and Mother had a history of risk taking. Concerns over both parents not taking prescription medication. Family proceedings and criminal investigation were in progress at the time of writing the review. Ethnicity and nationality not stated.

**Learning includes:** local authorities should liaise around support to care leavers living across boundaries; where there is a history as a care leaver, background information should be sought from the responsible authority; police should take a more holistic view of a person's circumstances and consider information sharing to protect a child, even in cases where the child is not yet born.

**Recommendations include:** agencies working with care leavers must be aware of the right for care leavers for service provision up to the age of 25-years-old; request guidance on information sharing between local authorities where care leavers are not living in the area of the responsible authority; ensure information sharing policies are in place and include all cases, not just those managed under formal child protection procedures.

**Other resources** Read review online: seftonlscb.org.uk/assets/1/sefton_lscb_scr_beatrice_-_report_final.pdf

**6. Report of the serous case review regarding Baby KK**

Death of a 9-month-old infant, from heart failure and chest infection in April 2016. Baby KK was born prematurely and experienced health problems including bronchiolitis, sepsis and injuries requiring nine hospital admissions during his life. Baby KK's 2- year-old sibling

was born when mother was 17 and father was 20 years of age. The family lived in supported accommodation. Mother frequently accessed hospital ante-natal services during her pregnancy with Baby KK. Evidence of domestic abuse which was not disclosed. Involvement of children's social care and concerns, including two referrals to the NSPCC, about unhygienic home conditions and child neglect. Both children were made the subject of child protection plans when Baby KK was 3-months-old. Uses the SCIE Learning Together model for case reviews, a systems approach which provides a theory and method for understanding why good and poor practice occur.

**Key findings:** need for understanding of roles in partnership working relationships so that opportunities for review and assessment of a child needs are not missed; tendency for hospital professionals to focus on the presenting illness or injury and not to consider other explanations; limited involvement of hospital professionals in safeguarding work; reluctance of general practitioners to refer directly to children's social care; and the fluctuating nature of neglect and the inconsistent ability of parents may undermine professionals' ability to see and respond to neglectful parenting.

Makes no recommendations but poses several considerations for the safeguarding board and partner agencies for the eight findings identified.

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

**7. Report of the serious case review regarding Baby LL**

Death of a 4-month-old boy in May 2016. Baby LL was found dead by his father. The post mortem identified the cause of death as acute pneumonia. Baby LL had lived with his father, mother and sibling. Baby LL and sibling were the subject of child protection plans under the category of neglect, and children's services worked with the family due to concerns around the care of both children. The family had been in contact with the police, accident and emergency services and children's services following referrals due to concerns around the children, and due to injuries to Baby LL's sibling. Father had previously been in prison for failing to protect another of his children from physical abuse, and mother had an older child in care due to emotional abuse and neglect. Child LL's ethnicity or nationality are not stated. Uses the SCIE Learning Together systems model.

**Findings include:** issues of professional psychiatric opinion undermining social workers' views on the risks posed by parents; the need for consistent safeguarding practices in paediatric and accident and emergency teams, so that opportunities to identify hidden injuries are not missed; professionals sharing information on the presenting evidence, but not always clearly communicating underlying concerns and relevant historical information; GPs should have access to the records of family members, to understand a family's history and be aware of risk factors and past child protection concerns; the importance of professionals understanding financial challenges faced by families, and identifying risks that financial pressures may pose to children.

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

**8. Serious case review report regarding a child to be known as Child K (full overview report)**

Injury of a 12-week-old girl, taken to hospital in January 2017 with a skull fracture. Parents stated that Mother dropped Child K during a domestic abuse incident. Police attended the family home one day prior to Child K's hospitalisation, where Sibling disclosed physical and domestic abuse by Father. Parents and Sibling were interviewed by police and children's services. Following Child K's injury, parents were convicted of 'causing injury to a child' and given community sentences; Child K and her Sibling were made the subject of care proceedings. Parents had a history of contact with children's services and police due to domestic abuse and physical abuse by the Father. Child K's ethnicity or nationality are not stated.

**Learning includes:** although guidance and procedures do not differentiate between day time and out of hours child protection situations, in practice out of hours services cannot fully replicate daytime services; inter-agency strategy discussions should be held whatever the circumstances for child protection enquiries; clarify in emergency situations if children are protected and accommodated under Section 20 or Section 46 of the Children Act 1989; written agreements, asking that one parent ensures there is no contact between another parent and their children, may not be realistic and may provide false assurance in cases of domestic abuse.

**Recommendations include:** consider how effective current police structure is in ensuring that Warwickshire Police can fulfil their roles as stated in Working Together 2015; Warwickshire Police to consider whether officers involved in child protection investigations have sufficient participation in interagency safeguarding training.

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