NSPCC Repository – July 2021

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

1. Child Safeguarding Practice Review concerning Emily: overview report

Potentially life-threatening non-accidental head injuries to a 6-week-old girl in August 2019. A criminal investigation into the injuries was ongoing at the time of this review. Emily lived with her mother and her five siblings and half-siblings. Her mother and father separated in April 2019. Throughout the period covered by this review, there were several referrals to children's social care expressing concerns about the care the mother was providing. There were also a number of domestic abuse incidents between Emily's mother and father. The children in this family were the subjects of child in need plans from June 2018 for 12 months and child protection plans from June 2019. Between July and August 2019, when Emily sustained her injuries, there were regular visits from social workers and health visitors, who reported that children appeared happy and settled. Ethnicity/nationality of family not stated.

Learning includes: inconsistencies around attendance at meetings meant that there was never a clear, shared understanding of the children's lived experiences; key people were missing from child in need meetings, child protection conferences and core group meetings; and possible indications of neglect were missed.

Makes recommendations including: child in need plans should clearly describe areas of concern, actions to be taken and measures of success; changes in the composition of a household where there is a child in need or child protection plan should lead to an updated social work assessment; and schools should put arrangements in place so they can contribute to conferences and meetings during school holidays.

Other resources Read full overview (PDF)

2. Joint domestic homicide review and serious case review: overview report. Maria aged 47, Luis aged 10, Carlos aged 7. Found murdered by Juan aged 57 who also took his own life

Death of 10-year-old and 7-year-old boys and their mother and father in March 2018. The children, Luis and Carlos, and their father, Juan, were found dead at the foot of cliffs in Sussex; their mother, Maria, was found dead at the family home in London. The coroner certified that Luis, Carlos and Maria were unlawfully killed, and that Juan had committed suicide. The family emigrated from Venezuela to the UK in 2016. Prior to the deaths, Juan wrote a document in which he claimed that Luis and Carlos had been sexually and physically abused while at school in Venezuela. The family did not come to the attention of agencies while in the UK, and the review panel were unable to find sources to support the claims of abuse. The review panel concluded that financial issues were a potential motivation for the murders and suicide. The family were Venezuelan with Portuguese heritage.

Learning includes: consideration of the financial and homelessness support available to migrant families; and ensuring the link between financial difficulty and suicide is incorporated into safeguarding adults and suicide prevention.

Recommends that: the London Borough of Richmond upon Thames addresses issues of financial and homelessness difficulties for all communities; links to domestic abuse are addressed in the development of the borough's violence against women and girls strategy; the borough ensures that issues of financial difficulty and links to suicide are incorporated into public health and suicide prevention work.

Other resources Read full overview (PDF)

3. Serious Case Review: Child R (full overview report)

Serious injuries to a 6-year-old child in 2018. History of domestic abuse between Child R's parents, resulting in a Child in Need Plan and Child Protection Plans until parents separated. Child R had experienced 13 injuries over a nine-month period, mainly in the form of bruises to his face. In 2017 and 2018 Child R made disclosures about being hurt by mother's partner. Child protection medical examination found that one injury was non-accidental and caused by someone hurting him but no protective action was not taken. Injuries were attributed to poor parental supervision, but this was not in line with the medical findings. In October 2018, Child R attended the emergency department with a serious head injury and significant bruising, which later required neurosurgery. Mother's partner was sentenced to nine years for grievous bodily harm against Child R; Mother charged with neglect. Ethnicity or nationality not stated.

Learning focuses on compliance with child protection procedures and the arrangements for the child protection medical examinations; assessment of risk, the impact of confirmatory bias and misunderstanding of terminology; the transfer of cases.

Recommendations include: ensure that multiagency child protection procedures are effective in respect of strategy discussions and child protection medicals; chronologies should be completed as part of the referral to Social Care to highlight patterns of physical injury; consider an awareness raising campaign within the wider children's workforce focused on physical harm in children and consider whether the terminology around non-accidental injuries should be changed.

Other resources Read full overview (PDF)

4. Child Safeguarding Practice Review: PS

Serious assault of a child in care by an adult in 2019, resulting in life-changing injuries. The perpetrator was the son of a member of the residential unit staff where PS lived. PS experienced many adverse childhood experiences (ACEs), including physical and emotional abuse. At 7-years-old he was removed from Mother's care and lived with his paternal grandparents under a Special Guardianship Order (SGO). PS was described as a troubled child, and in 2017 his grandparents felt unable to cope with his aggressive behaviour. Following several placements in foster care and in a residential care home, PS

was placed in the residential unit where he stayed until the assault. Ethnicity or nationality not stated.

Learning includes: it's critical that families involved in SGO placements receive information, advice and training on ACEs and the strategies they need to adopt to maintain the placement; agencies should have acted as responsible adults and asked for a previous assault of PS to be investigated. Victims of crime often are fearful of retribution.

Recommendations include: ensure that the 'voice of the child' is routinely captured during assessments; ensure that measures used to determine suitability of residential settings for placing children are fit for purpose; ensure that newly-qualified social workers and practitioners working directly with children and families receive formal monthly supervision; staff working with children such as PS should be trained to spot and respond to early signs of exploitation, such as cash in hand work; staff and managers should know and be able to apply the principles of trauma-informed practice.

Other resources Read practice review (PDF)

5. 'Jason': the overview report

Death of a 3-month-old infant in August 2019. Jason had been co-sleeping with a sibling and his mother. Jason had already died when Mother contacted emergency services and he was taken to hospital. Skeletal surveys found no injuries beyond evidence of attempted resuscitation. Siblings were subject to child protection plans and children in need plans at different points from 2008. Parents had been looked after children and experienced adverse childhoods. Mother had a history of self-harm, low mood and domestic abuse and was subject of a child protection plan for several years. Mother had difficulties regulating emotions and could be very hostile and aggressive with practitioners and the public. Father was remanded in prison at the time of Jason's death. Parents are White British.

Learning includes: some parents have difficulty assimilating and consistently following advice and the circumstances under which children's needs are neglected; the way parents respond to their children's needs is influenced by their own childhood experiences; parents who have experienced unstable or adverse childhoods can learn to just focus on their own needs because they have learnt not to depend on others.

Recommendations include: ensure multi-agency training includes curiosity about where children are sleeping as part of assessments; develop safe sleeping procedures emphasising the importance of ongoing risk assessment about safer sleeping for all services; consider how the use of the neglect toolkit is used routinely by services; encourage every GP practice to have a written protocol for discussing safeguarding concerns and follow-up.

Other resources Read full overview (PDF)

6. JS: serious case review: final report (full overview report)

Serious physical harm and neglect of a 6-month-old baby by their parents in January 2017. JS was born prematurely to teenage parents supported through the Family Nurse

Programme. Pre-birth, Mother moved to independent living with Father when JS was nearly 3-months-old. Concerns about neglect and parents disengaged with services; no referral was made. JS had five hospital admissions; at the last admission morphine was found in J's system. Maternal history of: involvement with safeguarding services; depression; missed appointments. Father was convicted of wilful neglect in January 2019. Ethnicity or nationality not stated. Uses a systems review methodology.

Lessons include: need for all professionals to: recognise when a multi-agency approach is needed and what support may be needed; consider whether their service is best placed to deal with the presenting issue; follow guidance, protocols and procedures; share information; be able to recognise a safeguarding concern and access supervision from safeguarding lead; challenge robustly when parents do not listen to advice and instructions or administer medication not approved for a child; consider whether all children who attend A&E with excessive drowsiness without an immediately identifiable cause should have their urines sent for toxicology.

Recommendations include: ensure that pre-birth protocol is embedded and used in all appropriate cases; ensure that thresholds are properly understood; ensure that health partners have in place robust provisions for supervision and "Did not attend' (DNA) policies; roll out a neglect identification tool; launch a prevention campaign aimed at parents/carers about the safe handling and storage of drugs.

Other resources Read full overview (PDF)

7. Report of the serious case review regarding Child G (full overview report)

Review of the support received by Child G in the period 2014-2019 including her allegation of sexual abuse in August 2018. In 2018. Child G lived with Mr A, her maternal great uncle, and his wife, who were Child G's Special Guardians. Child G alleged she was sexually abused by Mr A. A police investigation concluded there was not sufficient evidence to proceed with a prosecution. Mr A had historical allegations of sexual abuse made against him. Child G was born in 2011; parents separated during the pregnancy. She has two older and one younger half siblings. Child G's mother had mental health needs and was inconsistent in engaging with professionals. Evidence of incidents of domestic abuse. Children's social care were involved with the family since 1995. In October 2015 Child G was subject to a Child Protection Plan under the category of neglect before moving to live with special guardians in February 2018. Subsequent evidence of distressing and sexualised behaviour led to an urgent GP referral to Child and Adolescent Mental Health Services (CAMHS) in August 2018. Family is White British.

Learning includes: communication challenges across partnerships working with a family with multi-faceted needs; the Special Guardianship Order report and recommendation was not subject to sufficient scrutiny; the need for professionals to be aware of the possibility of trauma and current abuse, in children presenting with distress and high levels of disturbance; and delays to accessing of therapeutic support.

Recommendations include: ensure that family support is consistently applied and not stepped back due to resource pressures; ensure there are mechanisms to review caseload

size, and social work shortages; review of processes for undertaking Special Guardianship assessments; review training on trauma informed practice and sexual abuse.

Other resources Read full overview (PDF)

8. Report of the serious case review regarding Child A: executive summary

Death of a 4-week-old infant in April 2017. Child A was found unresponsive by their mother. Cause of death was identified as sudden unexpected death in infancy (SUDI) associated with co-sleeping. Police conducted enquiries and passed the case on to the Crown Prosecution Service. No charges were made. Child A lived with their mother and two siblings (Sibling 1 and Sibling 2). The relationship between Mother and Father 1 ended within days of Child A's birth, and Father 2 was absent from the children's lives. The siblings' school had referred the family to children's services, due to concerns around Mother's alcohol use. Children's services had conducted a child and family assessment, which resulted in a child in need plan for support around Sibling 1's behaviours. Child A's ethnicity or nationality are not stated.

Learning includes: services thinking about children within the context of their family, and being mindful of repeat patterns of behaviour within families; professionals recognising when parental deflection may create risk for a child; professionals being aware of indicators of abuse, and understanding when to share information about these indicators.

Recommendations include: ensure school staff have training on indicators of abuse, and have the competencies to safeguard children; information sharing training should include the directive that when parents do not give permission to share information staff consider if a child is at risk of harm, before a decision to not share information is made; when there is disparity between parent's views and those of their children, professionals should maintain focus on the child.

Other resources Read executive summary (PDF)