Torbay Safeguarding Children Partnership

NSPCC Repository – September 2021

In September 2021 nine case reviews were published to the NSPCC Repository featuring a number of issues including sudden infant death and suicide.

1. Local Child Safeguarding Practice Review: Ryan, Nathan and Amelia

Serious persistent neglect of three siblings over a number of years by their mother. Child in need plans for Ryan and Nathan opened and then closed due to non-cooperation from the mother; all three children later had child protection plans due to neglect subsequently stepped down to child in need. Ryan and Nathan both had learning disabilities and autism. Ryan was referred to Child and Adolescent Mental Health Services (CAMHS) due to low mood and behavioural problems. Mother made several requests to have Nathan placed in residential care due to his aggressive behaviour which was later agreed. Concerns over Amelia due to developmental delay and inappropriate feeding by the mother; concerns over the home environment and safety of the children. Intensive family support provided by multiple agencies but no improvements achieved. Maternal history of: depression, sexual assault and domestic abuse; child neglect (own children). Ethnicity or nationality not stated.

Learning includes: lack of access to the family home can prevent agencies fully appreciating the extent of child neglect.

Recommendations include: resolve professional differences; child protection proceedings should not preclude pre-birth assessments; staff working with children with complex and additional needs should be trained and skilled; tools such as the Graded Care Profile 2 and local strategies and procedures should be followed; health, education and care plans should be robust; parenting assessments should be repeated or updated when necessary; consider filling gaps in service provision.

Other resources Read practice review (PDF)

2. Sudden unexpected death in infancy, a thematic review 2014 - 2020

Thematic review of sudden unexpected deaths in infancy (SUDI) between April 2014 and March 2020 in Surrey. Twenty babies met the case definition for the thematic review of probable SUDI; 12 females and eight males. Analysis shows that: 80 per cent of babies were either in unsafe sleeping positions or environments with particular high-risk circumstances; 60 per cent of parents smoked; 65 per cent of babies were exclusively formula fed; 45 per cent of parents were suspected to have taken alcohol or drugs in the 24 hours prior to the death of the infant; 30 per cent of babies were born at less than 37 weeks gestation; 20 per cent of babies were over-wrapped. Ethnicity and nationality not stated.

Learning includes: along with greater risk associated with placing a baby on the front or side to sleep, there is also a greater risk to babies who are in a room alone; rather than co-sleeping alone, it is co-sleeping when a particular high-risk circumstance is present

which increases the risk to the baby; there is extensive data to show that breastfeeding has a protective factor in reducing SUDI.

Recommendations include: ensure partners adopt a practice model encompassing reducing the risk of SUDI within wider strategies for promoting infant health, safety and wellbeing; fully implement the NICE guidance - Smoking: stopping in pregnancy and after childbirth; ensure that alcohol awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.

Other resources Read thematic review (PDF)

3. Learning review: Child B

Death of a 15-year-old boy in June 2017. Child B's father found him unconscious in woodland near their family home. Child B died at hospital having suffered severe brain damage. Child B had reported anxiety and admitted self-harming behaviour and was referred by his GP to the child and adolescent mental health service (CAMHS). Multiple agencies were involved with Child B over the previous eight months before his death. Child B had a history of going missing and had four overdoses between November 2016 and February 2017 resulting in hospitalisation. Child B reported an inexplicable and implausible incident of assault which lead to professional concerns of possible psychotic presentation. Police called out several times to the family home and school. Ethnicity and nationality not stated.

Learning includes: practitioners across the multi-agency network face challenges when charged with responsibility for safeguarding children in mid-adolescence; effective plans for risk-taking, tolerating uncertainty, risk-minimisation and promoting safety rely on robust risk analysis; the principle of understanding behaviour as communication is as relevant for children in mid-adolescence as for younger children.

Recommendations include: ensure that specialist mental health services engage in effective collaboration and co-working with the team around the child, the child's parents, and the child's informal network of care throughout their involvement with children; ensure that staff throughout the service are aware of and consider a range of potential sources of early help for children and families while waiting for specialist assessment or input.

Other resources Read learning review (PDF)

4. Child safeguarding practice review: siblings from Family H

Sexual and physical abuse of a small sibling group over a two-and-a-half-year period. In 2020 the siblings were staying with their extended family and disclosed that their father had sexually and physically abused them, as well as subjected them to harsh and critical treatment. Father was found guilty of several offences for which he received a custodial sentence. Siblings' mother had died some years earlier and Father had taken

responsibility for home educating the siblings as a single parent. Siblings were not registered with the local authority Elective Home Education Service. Siblings were seen by the GP for minor ailments and were not known to any other agencies. Housing department had concerns about Father's responses to requests for information and an investigation was started by the corporate anti-fraud team. Siblings are from a minority ethnic group.

Learning relates to: the home education of children and young people; identification of home educated children; ensuring a stable education; safeguarding home educated children; social, pastoral and leisure needs as the foundation of child development; and bereavement support.

Recommendations include: raise awareness of the importance of the identification of elected home educated children and the need for them to be registered across all agencies; make a recommendation to the National Panel to complete a thematic review of serious case reviews, rapid reviews and child safeguarding practice reviews (CSPRs) that relate to home educated children; consider the existing pathways to bereavement support for the children of terminally ill parents.

Other resources Read full overview (PDF)

5. Review of a cluster of four apparent suicides of children

Death of four children aged 16-and-17-years-old between May 2017 and February 2018. Child 1, 2, 3 and 4 apparently took their own lives. Child 1 was a child in care at the time of his death and had been removed from the care of his mother and stepfather at the age of 10-years-old. After nearly five years in foster care Child 1 returned to his mother and stepfather. Child 2 was staying with her maternal grandparents at the time of her death. Child 3 lived with her mother and stepfather. Child 4 lived with his mother, stepfather and adult step-sibling. Child 2, 3 and 4 had made previous suicide attempts and Child 1, 2 and 3 self-harmed. Each child had at least one parent with a history of mental health problems. Ethnicity and nationality not stated.

Learning relates to: antecedents of suicide; primary care; child and adolescent mental health services (CAMHS); secondary education; school nurse services; transition post 16 college education; transition to adulthood; young carer responsibilities; Early Help; communication and information sharing; impact of child suicide on the family; and multi-agency response to suicides of children and young people.

Recommendations include: CAMHS should undertake an audit to review the children and young people on their waiting list to ensure appropriate support, advice and action is considered; school nurse service should be reviewed to clarify how best to utilise this service, focusing on suicide prevention in children and young people; a two-stage approach to addressing communication and information sharing.

Other resources Read review (PDF)

6. Child safeguarding practice review: Child A

Death of a 15-year-old boy in September 2019. Child A was fatally stabbed after responding to a message on social media to meet some friends. Child A had an Education Health and Care Plan due to having moderate learning difficulties. Family was known to services from 2005, mainly in relation to issues around housing, Mother's immigration status and Father's mental health. Children's Social Care conducted family assessments in 2012 and 2014. Child A moved schools in 2017 and there were concerns about his affiliations to gangs and being groomed for criminal exploitation. Police investigation resulted in the convictions of two defendants for Child A's death, who were sentenced in July 2020. Ethnicity and nationality not stated.

Learning includes: this review mirrors other national and local reviews, studies and case reviews that show the disproportionality of Black boys of African Caribbean heritage who are more likely to be susceptible to risks of criminal exploitation; housing services were not engaged in multi-agency discussions about how agencies were seeking to reduce the risks to Child A; frequent moves between boroughs hampers and delays services to children and their families.

Recommendations include: ensure practitioners in Early Help services are equipped to work with children and families affected by criminal exploitation; ensure staff are equipped to identify, assess and make plans for children whose learning disability increases their susceptibility to criminal exploitation, where contextual safeguarding is an issue; ensure that guidance, best practice and training around multi agency safeguarding discussion and meetings involves housing services.

Other resources Read practice review (PDF)

7. Child safeguarding practice review regarding Child AI

Significant burns to a 5-and-a-half-year-old child in August 2019. Child AI suffered burns to 26 per cent of her body while in the care of her mother. Child AI was taken to the regional burn centre and underwent surgery. Following discharge, the family were placed in a family assessment unit, with Child AI and her sibling subsequently being placed in foster care. Child AI had been managed under Section 47 and a child in need plan for neglect. Reports from neighbours about anti-social behaviour (ASB) at Mother's flat. Child AI presented with injuries on several occasions at nursery at school. Ambulance services attended the family home on two occasions before the incident. There was no contact with Child AI's father. Ethnicity and nationality not stated.

Learning includes: staff should consider when families use emergency departments, whether it is because they do not want professionals to visit the family home; ASB officers should consider the impact of ASB in a safeguarding context when a child is present and share with appropriate agencies; the number of perceived minor injuries to a child should be viewed in relation to parenting capacity and the ability to keep children safe.

Recommendations include: equip frontline staff with the skills to work with clients who may have a 'learning difficulty'; promote the Family Network programme, to build relationships with the wider family and support families when services are no longer

needed; develop guidance for transferring safeguarding records from Early Years to schools to facilitate appropriate information sharing at the point of transition.

Other resources Read practice review (PDF)

8. Serious case review: Child D (full overview report)

Unexplained death of a 4-month-old baby boy in November 2018. Mother had experienced domestic abuse prior to her pregnancy and had to flee from her abuser, father of Child D. Before Child D was born Mother moved from one local authority area to another, where she lived in a refuge for women experiencing domestic abuse. Mother was isolated with limited social support, and no family; concerns about her alcohol consumption. Following eviction from the refuge, Mother and Child D were housed in temporary accommodation in the neighbouring local authority. The accommodation did not contain a cot, and none was provided. Initially Police treated Child D's death as a Sudden Unexplained Infant Death however because of Mother's demeanour and behaviour she was arrested on suspicion of neglect, due to alcohol abuse whilst in charge of a child. Coroner noted cause of death as unexplained and that there were signs consistent with asphyxiation. Ethnicity and nationality not stated. Learning includes: assessing the needs and risks of families experiencing domestic abuse is a complex task; some practitioners are still not confident about using escalation; practitioners do not always record important information which results in significant information not being shared when required; there is a tendency for some practitioners to minimise the significance of parents using alcohol and being over optimistic about reports by parents of their alcohol consumption. Makes no recommendations but raises questions to Newham Safeguarding Children Partnership and Waltham Forest Safeguarding Children Board.

Other resources Read full overview (PDF)

9. Serious case review Child V (full overview report

Concerns that an infant was seriously harmed due to fabricated or induced illness (FII) in 2017. Child V was admitted to hospital for observation. On the day of admission Mother was observed to physically abuse Child V, following which Child V became looked after by the local authority. Child V was the subject of a child in need plan, and was subject to multiple medical investigations and treatments. There were a large number of practitioners involved with the family and a high level of multi-agency activity. Concerns around physical abuse and neglect due to presentations of injuries and bruising. Uses the Significant Incident Learning Process (SILP) methodology. Child V's ethnicity or nationality are not stated.

Learning includes: the potential for parents to act as conduits for information between professionals, which may become a route for misinformation; where a child has been identified as a 'child in need', a child in need plan should be the overarching planning and review process; professionals should maintain focus on the needs of the child; the need for professional curiosity and scepticism with regard to possible neglect and abuse.

Recommendations include: the need to deal with FII as robustly as other forms of abuse and neglect, following local and national guidance; early recognition and action in respect of perplexing presentations; practitioners have a basic understanding of the features of perplexing presentations and FII; when there are unexplained concerns about feeding and weight gain, the parent-child relationship should be considered, as well as possible medical causes.

Other resources Read full overview (PDF)