Lessons Learnt Research Digest
Serious Case Reviews

Issue 1, March 2016

Welcome to the first edition of the Board's Research Digest bulletin. The bulletin has been produced to share messages from recent published Serious Case Reviews. The cases identify any lessons to be learnt to improve learning and develop practice across multi-agencies to safeguard children and young people. The information in this bulletin has been obtained from the NSPCC national repository for Case Reviews published in 2015.
www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2015

Please cascade to staff within your settings.

Physical and Emotional Abuse

Nottingham – Child H - Death of a 4-month-old girl in December 2012.
Child H died of unknown causes but had a number of injuries which were thought to be non-accidental.
Background: the family was known to a number of agencies due to the serious domestic abuse the mother had experienced with her previous partner, who was the father of Child H and her sibling. Mother had a history of mental health problems, abusive relationships and alcohol misuse.
Learning: holding a common assessment framework (CAF) meeting earlier would have helped clarify concerns, responsibilities and what needed to change and professionals should consider the impact of historic experiences of domestic violence.

October 2015 - Somerset – Child Y - Significant injuries to a 3-week-old child in October 2013. MRI scan indicated that Child Y had survived a subdural haemorrhage. Parents were arrested on suspicion of causing Grievous Bodily Harm; both parents were on police bail at the time review was published.
Background: father had been in care as a child and had a history of depression and anxiety and domestic abuse in relation to a former partner with whom he fathered two children. Father had no contact with either child and one of the children had been adopted. Mother had a history of domestic abuse as a child and was assaulted by her father when 10-weeks pregnant with Child Y.
Key issues: prior to the incident, father was noted to have been handling Child Y roughly by GP but was later observed by midwife to be handling Child Y more gently.
Learning: issues with maternity guidelines relating to domestic abuse in pregnancy including the absence of timely review, inconsistencies in advice given and insufficiently robust safeguarding supervision; importance of early handling and safety advice for parents; impact of the rule of optimism and clinical focus of midwifery services impacting consideration of social risk factors; and importance of identifying the role and impact of fathers.

September 2015 - Solihull – Child S - Death of a 22-month-old boy on 20 February 2013. Child S was taken to hospital after his mother found him lifeless. A post mortem examination established that he had suffered severe abdominal injuries. Mother and father were both convicted of causing or allowing the death of a child in December 2014.
Background: Child S had been the subject of referrals prior to his birth and had been subject to a child protection plan for emotional abuse since August 2012.
Key issues: mother had a history of substance misuse and mental health issues and father had a history of domestic abuse and drug dealing.
Learning: points identified include difficulties in working with individuals who disguise their compliance resulted in an overly optimistic view of outcomes for the child; problems were caused by misunderstanding between agencies about what and how information about adults who may post a risk to children could be shared; poor attendance by some agencies at initial child protection conferences.

July 2015 – Peterborough – Child J - Significant, non-accidental injuries to a 5-month-old boy, identified in November 2013; injuries were diagnosed as suggestive of physical and sexual abuse. Father was charged with neglect, to which he admitted and received a community sentence; he denied and was not charged with sexually abusing child J.
Background: Child J's mother had two older children, both of whom were living in foster care at the time of child J's birth; Child J was discharged from hospital to foster care when 2-days-old before being placed in the full-time care of his father when 4-months-old.
Key issues: paternal history of: depression; committing domestic abuse; offending with minor convictions; drug and alcohol use; and allegations of inappropriate sexual behaviour. A number of injuries were identified by various professionals in the month prior to the incident.
Learning: identifies themes, including: optimistic thinking driving plans for Child J to be placed with his father to the exclusion of thorough exploration of risk; insufficient information sharing between agencies; and lack of holistic assessment of family leading to unacceptable evaluation of risk.

June 2015 - Kingston - Child B - Suicide of a 15-year-old South Korean boy in July 2014. Child B jumped from the top floor of an indoor shopping centre and died in hospital.
Background: Child B moved to the UK aged 6 to live with his father and older brother; contact with their mother was sporadic. Child B was made the subject of a child protection plan, when 10-years-old, for physical and emotional abuse and was briefly looked after. From 2012 the family were receiving support after the father had an accident at work and they became homeless. On the day he killed himself Child B spoke of wanting to take his own life.
Learning: Child B's voice and experience were not present in any reviews; limited exploration of the impact of mother's absence; and copy and pasting of old information into new reports.

May 2015 - Blackpool – Child BT

Death of a young child in 2014. Initial post mortem proved inconclusive; second post mortem concluded that cause of death was inhalation of stomach contents with the underlying cause being poisoning by Methadone.
Background: Mother pleaded guilty to manslaughter; father went to trial and was found guilty of manslaughter and child cruelty. Family was known to children's services and both BT's sibling and step-sibling had previously been subject to child protection plans.
Key issues: both parents were engaging in drug treatment but mother was known, and father suspected, to have periods of illicit drug use. Both had a history of offending and problems with financial management. Father was suspicious of social care involvement and was rarely seen during home visits.

Learning: professionals in the area were used to working with complex families, which may have led to the 'normalisation' of issues; information on risk factors was not shared by all professionals and professionals did not always refer the family to children's social care when appropriate.

May 2015 – Bury – Baby I (Case I13) - Serious injury of a 6-week-old boy in October 2013. Baby I was made the subject of an emergency protection order following an examination that revealed he had sustained two broken ribs and a knee fracture.
Background: Mother and Father had been in a relationship for 3-months before Mother became pregnant with Baby I. Paternal history of: drug misuse; suicide attempt in adolescence; and self-reported thoughts of harming baby I to stop him crying. Maternal history of: psychotic depression, previous suicide attempts and incidents of self harm. Father was recorded as mother's carer.
Key issues: issues identified include: insufficient exploration and understanding of the impact of high energy drink consumption on father's mood and anger responses; and practitioners' belief that father belonged to a particular sub-culture possibly inhibiting them from challenging father's behaviour as they wished to appear non-judgemental.

Neglect

August 2015 – Anonymous – Child F - Death of a 5-month-old baby in September 2014. Child F was found unresponsive by mother after mother and baby had fallen asleep on a sofa when staying overnight at mother's friend's home. Ambulance crew noticed the smell of alcohol on mother and called police. Mother was arrested on suspicion of neglect, having thought to have unintentionally rolled on top of her baby; criminal investigation concluded with no charges being preferred.
Background: little is known about child F's father, beyond his extensive criminal history. Mother entered local authority care when 10-years-old, where she remained until discharge at age 18. Maternal history of: chronic neglect; disrupted placements; significant alcohol and drug misuse; domestic abuse; and offending.
Learning: identifies emerging lessons and reflections, including: the consequences of adverse childhood experiences such as chronic neglect and the inclination of individuals to deny or diminish these experiences; workload, difficulty in collating information or anxiety about challenging service users inhibiting professional recognition or exploration of patterns of behaviour such as missed appointments; invisibility of men; and obstacles to information sharing.

August 2015 – Stockton-on-Tees – Child H - Serious harm caused to a 12-year-old, identified in July 2013 when serious concerns were raised over poor home environment and Child H's presentation, including impaired vision. Child H was taken into the care of the local authority and mother and mother's partner were charged and sentenced to 30-months imprisonment for child cruelty.
Background: Child H was diagnosed with Juvenile Idiopathic Arthritis (JIA) when 5-years-old. JIA can lead to eye problems, which, if not detected and treated early, can cause permanent visual damage, including blindness. Child H was found to have early indicators of uveitis at an ophthalmology appointment in 2011; Child H did not attend any further ophthalmology appointments until July 2013. Children's social care received three referrals between 2011 and 2013 and concerns had been raised regarding Child H's presentation, hygiene and attendance at school and medical appointments.
Key issues: the system for screening children with complex eye problems is not designed around the needs of the child: the appointment system implied Child H was making informed choices about not attending, rather than parents' non-attendance being seen as an indicator of neglect.
Learning: children with medical needs necessitating a range of specialists, require a lead professional to maintain coordination of services, in particular, the role of the school nurse should be developed to engage with children and parents and to assist schools in understanding the impact of specific conditions

June 2015 – Cambridgeshire – Child K - Death of a 2-year-old boy in January 2014. Primary cause of death was bacterial pneumonia infection with secondary causes of dehydration, failure to thrive, norovirus and cerebral palsy.
Background: following his death, mother received a police caution for cruelty against Child K contrary to Section 1 of the Children and Young Person's Act 1933. Child K and his sibling had been subject to a child protection plan for neglect for a month prior to the incident.
Key issues: maternal history of: childhood abuse, time spent in the care of the local authority, offending, self harm and homelessness. Father was nine years older than mother and also had a history of childhood abuse and time spent in the care of the local authority. Child K was born 24-weeks prematurely, which affected his lung development causing chronic lung disease. Child K had additional complex needs resulting from a hole in his heart, concerns about his hearing and vision and a bleed in his brain resulting in him developing cerebral palsy.
Learning: analyses key themes, including: the impact of Child K's disabilities on assessment of risk and inconsistency in the level of professional concern; inconsistent perceptions of mother's understanding of Child K's needs or of her ability and commitment to meeting them; and lack of professional understanding of the interaction between Early Help, Early Support and Children in Need systems.

June 2015 - Havering – Child Y, Child X and Child W - Chronic neglect and emotional abuse of 3 siblings aged 15-years-old, 11-years-old and 6-years-old, and the sexual abuse of 1 or more of the siblings.
Background: children were subject to child in need status and child protection plans at various points in their lives due to concerns around neglect. Concerns were first identified shortly after the birth of the first sibling in 1998, and eventually resulted in the local authority arranging for them to live with their grandparents in 2009. Concerns continued, and in September 2013 the siblings were taken into local authority care.
Key issues: the prioritisation of keeping the children in their family above child protection needs; a lack of communication between professionals and the family about concerns and the actions that needed to be taken; the lack of explicit reference to neglect in some assessments of the children's needs; the absence of a plan or appropriate monitoring of support once care of the children was transferred to their grandparents and delays in taking action due to the grandparents' "false compliance".

April 2015 - Lambeth – Child I - Death by drowning of a 20-month-old boy in July 2013.
Background: Child I and his two older siblings were subject to child protection plans under the category of neglect at the time of the incident. Parents both had learning difficulties and at times reacted with anger and hostility to professional interventions. Child I was found face down in the bath; mother reported she had left Child I in the bath, informing father she had done so, before leaving the house. Parents were subject to police investigation as alleged perpetrator and witness throughout the case review process.
Key issues: professional emphasis on investigating physical injuries at the expense of considering indicators of neglect; and overreliance on written agreements with parents to support child protection arrangements.

Sudden Unexpected Deaths in Infants and Children

November 2015 - Kingston – Family A - Death of a 4-year-old girl and two 3-year-old twin boys who were smothered by their birth mother on 22 April 2014. The mother was given a hospital order in November 2014 after admitting manslaughter by diminished responsibility.
Background**:** Children P, Q and R all had spinal muscular atrophy type 2 (SMA2), a life shortening condition which causes severe muscle weakness. Due to the children's complex health needs many different health agencies were involved with the family.
Key issues: include: the parents' opposition to some medical interventions due to concern about the pain it may cause their children; the mother's low mood; staff commitment and the complexity of the case resulting in working outside professional boundaries; a focus on the possibility of using legal interventions rather than considering the wider child protection process.

October 2015 - Luton – Child D - Death of an 11-week-old girl in January 2013, as the result of serious injuries consistent with violent shaking. Post mortem found subdural and retinal haemorrhages and signs of damage to the brain and spinal cord. Father was found guilty of Child D's manslaughter.
Background: mother experienced abuse in the family as a child and, as a result, was made the subject of a child protection plan in 2006. During the review process a number of professionals expressed concerns that mother might have a learning difficulty; none of the professionals who had been in contact with mother in the 5-years previously felt she had a learning difficulty. Findings from a detailed assessment following Child D's death identified mother as having an IQ score which placed her in the lowest 3% of the population and identified significant difficulties with memory recall. Father was seen by GP as a young adolescent, in relation to problems with his temper, depressed mood and verbal aggression. Following the incident father admitted assaulting mother on two occasions, neither of which was reported to professionals prior to Child D's death. Following Child D's death, mother reported that Child D has been bruised on three occasions when in the care of father. One of these bruises was seen by 4 health professionals prior to Child D's death.
Key issues: identifies themes including: how vulnerable young people who might need additional support when they become parents are identified and helped; the value of information, including social information, being held in GP records; engagement of the father and assessment of his role; professional responses to bruises in small babies; working arrangements between health visitors and GPs; and assessment of parental learning difficulties and their impact on parenting.

July 2015 – Anonymous – Subject Child - Death of a 6-7-week-old-girl in May 2012. Subject child was found by mother with her face pressed up against the back of the settee at home where she had earlier fallen asleep. Mother had just woken from sleep after having drunk alcohol earlier in the day.
Background: mother was arrested in 2011 for being drunk in charge of a child, leading to half-brother being placed in foster care. Half-brother was returned to mother's care following assessments that recommended that there was no role for a social worker. Mother has a chronic abdominal condition, requiring abstinence from alcohol use to avoid the condition worsening and leading to hospitalisation.
Key issues: history of domestic abuse, alcohol misuse and referrals to children's services concerning the care of half-brother.
Learning: assessment of the impact of chronic alcohol misuse usually takes place when the parent is no longer intoxicated, leading to insufficient understanding of potential risks to the child; lack of professional knowledge of parents' persistent or long term medical conditions compromising understanding of the impact on parenting capacity; and professional response to incidents without consideration of previous concerns, leading to missed patterns and possibility of continued ineffective responses.

April 2015 - Lincolnshire – Baby W - Death of a baby boy during the hours following his birth in September 2013. Mother was 16-years-old at the time of the incident; she had concealed or denied her pregnancy and given birth, unassisted in her bedroom at home. Post mortem revealed that Baby W died from a tissue blocking his airway; mother pleaded guilty to infanticide and was sentenced to a 2-year Youth Rehabilitation Order (YRO).
Background: mother was known to universal services only; she did not present with any physical symptoms of pregnancy prior to Baby W's birth. During her pregnancy mother presented to GP a number of times with concerns of low mood and depression and self-referred to an Improved Access to Psychological Therapies (IAPT) service for support with her anger as a result of depression. Mother was asked and denied her pregnancy on a number of occasions, by professionals and family members.
Learning: identifies one missed opportunity to provide mother with age appropriate advice around sexual activity, contraception, sexual health and healthy relationships. Identifies lessons to be learnt, including: need for awareness raising and development of procedures and guidance around concealed or denied pregnancy; importance of young people receiving sexual health and contraception advice; and increased GP knowledge of the support that school nursing services can provide young people.

Sexual Abuse

2015 - Southwark – Child R - Rape of a 15-year-old girl in early spring 2014
The girl, who was in foster care at the time of the assault, reported that she had met the man in a hotel after a friend gave him her telephone number. The man involved was arrested and found guilty of a lesser offence against another young person.
Background: family history of: housing instability, drug dealing, child neglect and physical abuse. Child R was made subject to a child protection plan in 2009 and taken into care in 2010 after reporting that her mother had beaten her.
Key issues: whilst in care Child R had periods of: going missing, highly disruptive behaviour, multiple placements and exclusions from school.

October 2015 - Hampshire – Child F (Stanbridge Earls School) - Reviews the response of agencies to allegations of sexual assaults against a 14-year-old disabled girl by other pupils at an independent residential school.
Background: the girl, who had delayed social and emotional development, engaged in sexual activity with other pupils at the school. Staff were made aware of the sexual activity by her GP, but judged it to be consensual and a confidential medical matter. The girl later told her parents and further information came to light that suggested the sexual activity had been non-consensual. The police investigated the incident, the boy involved was arrested and the girl was also required to leave the school "for her own protection". Following a series of further child protection allegations the school was made the subject of an inquiry and due to declining pupil numbers closed in September 2013.
Key issues: the complexity of the regulatory safeguarding frameworks that apply to independent schools and confusion over how they work with Local Safeguarding Children Boards (LSCBs); a lack of awareness of how disability and gender imbalance impacted on female pupils' vulnerability to potential exploitation or bullying and a lack of information sharing between national and local agencies involved in the case.

Behavioural/Mental Health concerns

July 2015 – St Helens – Child JSH

Death of a 17-year-10-month-old boy found hanged at home in January 2014. Inquest found that Child JSH had intentionally taken his own life.
Background: history of: domestic abuse; anti-social behaviour; violent behaviour leading to arrests; sexually intimidating behaviour toward members of school staff and female pupils; and stalking and threatening behaviour toward a fellow pupil with whom child JSH had a relationship. Child JSH was described as having had few close friends but a wide network of associates on social media and a high-profile locally in relation to fighting and anti-social behaviour. Police had intelligence that child JSH was receiving threats via social media 2-3-weeks prior to his death.
Learning: identifies four key findings, including: remaining child-centred in responses to older children who present with criminal and harmful sexual behaviours (HSB); and meeting the needs of children who experience severe behavioural difficulties through the system of mental health referral and triage. Identifies wider learning around: the risks presented by social media in relation to developing networks that promote and encourage HSB.

May 2015 - Enfield – CH - Life imprisonment of a 15-year-old boy convicted of killing a 21-year-old man. CH stabbed Mr Z, a stranger, following a confrontation on a residential street.
Background: CH was subject to a child protection plan at the time of the incident. His case was being coordinated by Haringey children and young people's services as a transfer case conference had not been arranged following family's move to Enfield one year earlier. Family history of: mental health problems; alcoholism; domestic abuse; criminal behaviour and anxiety around their immigration status (they were originally from Jamaica). CH had a history of offending, self-harming; and running away from home. He had previously been subject to a care order.
Key issues: mother's problems distracted from the needs of her children; support for the family ended abruptly following the cessation of a care order; and domestic abuse between mother and female partner was not treated as seriously as heterosexual partner violence.

April 2015 - Tameside – Child M - Death of a 17-year-old girl in December 2013. Child M's body was found in a garden with a ligature around her neck; there was no evidence of any third party being involved.
Background: Child M was never identified as a child in need or requiring protection, but did receive support from Child and Adolescent Mental Health Services (CAMHS), although she was never diagnosed with a mental health condition. She also received support from: young people's services (YPS); the Crisis Resolution Home Treatment Team (CRHTT) and a drug and alcohol treatment charity.
Key issues: Child M had a significant history of self-harm, alcohol and drug misuse, truancy, school exclusions and verbal and physical violence. Child M disclosed to professionals an experience of being inappropriately touched by an adult and her feelings of distress over her father's use of alcohol and violent behaviour during her early childhood.
Learning: Child M's school interpreted her age, intelligence and social background as evidence she had the capacity to change her behaviour, and so their response focussed on behaviour management rather than assessing her support needs; her parents were not always consulted or kept informed about professionals' concerns for Child M's welfare; and police were not aware that, due to her complex needs, a social worker rather than a volunteer appropriate adult should have been allocated to Child M whilst she was held in custody.

Homicide

April 2015 – Fife and Edinburgh Child Protection Committees – Child MK - Death of a male child in January 2014. MK was reported missing by his mother on 16th January; his body was found on 17th January following a police search. Mother pleaded guilty to culpable homicide and was sentenced to 11-years imprisonment.
Background: MK entered foster care in July 2012 following a notification received by social work services that mother had left her children unattended. MK returned to the care of his mother under a supervision order in August 2013. Family was receiving support from Fife Social Work Services on a voluntary basis at the time of the incident.
Learning: identifies areas for future learning and action including: Scottish government should consider the need for the development of national guidance for the transfer of non-child protection cases across local authority areas; and NHS Fife should review how information, which is below the child protection threshold but which impacts on child wellbeing, is shared between GPs and health visitors.

April 2015 – Croydon – Josh - Death of a 3-year-old boy in March 2013. Mother carried Josh into the path of an oncoming train, killing them both.
Background: Mother had a history of severe anxiety disorder and had been receiving treatment from her GP and various mental health services in the months preceding Josh's death.
Key issues: procedural failure responding to a children's social care referral made by Mother's psychiatrist; a culture of overreliance on children's social care for actions regarding a child; and perceived inconsistent and misleading advice from mental health services leading Mother and Family to continue accessing private mental health providers as they lost trust in NHS providers.

April 2015 – Lancashire – Child L and Adult L - Death of a 6-year-old boy and his mother and the attempted suicide of his father in April 2013. Father was diagnosed with a psychotic mental illness and detained under the Mental Health Act 1983.
Background: Child L and parents were not known to any specialist services. Previous contacts with health services for injuries to Child L and Adult L were judged to be accidental. The day before the father consulted his GP about feeling in low mood and hearing voices. There had been no previous mental health issues. GP requested an assessment by a mental health practitioner and a meeting was scheduled for the next day.
Learning: identifies good practice including the GP's referral to mental health services and school support to pupils and families after the deaths.
Key issues: missed opportunities for sceptical and curious enquiry by health professionals; no enquiry about Child L by GP; 'shortcoming of human inference' leading mental health specialists to think a GP would rate a case high risk to get a quick assessment; use of a telephone triage system for mental health assessment.

April 2015 - Lancashire – Child N - Death of a 4-year-old boy and his mother in May 2014 as the result of a house fire in Liverpool. Coroner's verdict was that Child N had been unlawfully killed and mother had taken her own life after deliberately starting the fire.
Background: parents separated acrimoniously prior to Child N's birth. Mother requested a termination, but was refused due to the late stage of her pregnancy. After the birth, the mother briefly went missing which resulted in Child N spending a short time in foster care. Due to concerns about his safety and on-going contact disputes, Child N's care was subject a number of court proceedings. The court's decision in the second case resulted in the father, who lived in Lancashire, being granted a residence order and the mother a contact order. During the fourth and final set of proceedings, whilst Child N was on a contact visit, the mother made allegations of child sexual abuse which resulted in Child N staying with her in Liverpool.

Key issues: family history of: maternal mental health problems, domestic violence and multiple parental allegations and counter allegations of poor care and abuse. Challenges identified include: language and translation issues when communicating with maternal grandparents; and the lack of means for professionals to enforce court imposed decisions regarding child contact.
Learning: parental mental health assessments should be shared with all professionals involved in the child's life; and when closing a case social workers should ensure they inform all professionals working with the child.

April 2015 – Croydon – Child M - Death of a 14-year-old black boy in September 2012, as the result of a fatal stab wound to the heart. Child M was stabbed by another teenager, following an altercation. Child S was found guilty of murder and sentenced to life imprisonment, to serve a minimum of 14-years; the Judge referred to the incident as a "revenge killing".
Background: At the time of the incident, Child M had been missing from home for nine weeks. Child M attended college a week after he was first reported missing. Police and children's social care were informed and told that Child M did not want to return home as he was scared he would be beaten by his stepfather; neither agency visited the college nor investigated this disclosure and Child M was allowed to leave college without confirmed arrangements for his care.
Learning: passive response from police and children's social care to a missing 14-year-old child; passive attitude of police to communicating with parents; and insufficient involvement of mother's partner in assessments.