ISCP *In Brief -* Serious Case Reviews

National case review repository

The NSPCC launched the nationals case review repository in November 2013, in collaboration with the Association of Independent LSCB Chairs. It provides a single place for published case reviews to make it easier to access and share learning.

The repository is accessible via the NSPCC Library Online.

These case reviews have been added during February 2017:

Serious case review: Child N [full overview report].

Published by NSPCC on behalf of unnamed safeguarding children board – 2016

Abstract

The **harmful sexual behaviour** of a 16-year-old child. Child N was briefly made subject to a **children in need** plan following two allegations of **child sexual abuse**. The second allegation led to Child N's conviction and imprisonment for the sexual assault of an under 13-year-old. Child N had a history of: **disrupted education** due to difficulties in concentration and attainment; diagnosis of **Attention Deficit Disorder** (ADHD); Statement of **Special Educational Needs**; concerns about inappropriate sexual behaviour and going **missing** from home. Identifies significant learning about responding to children at risk of sexually harmful behaviour, including: a **lack of supervision** for vulnerable children using **shared school transport**; interviewing **child witnesses** was not a shared agency activity; lack of shared **assessment of risk** and response; **health care** staff involved with Child N were not informed of the sexual assault allegations; outcome of assessment overly influenced by **view of positive parenting** by the mother and not focused on the key risk issues; lack of **policy and procedures** to guide children's social care professionals; limited professional understanding of sexually harmful behaviour. Recommendations include: ensure that multi-agency practitioners are better equipped to work as part of a **multi-agency approach** in cases of harmful sexual behaviour; make sure early indicators of sexually harmful behaviour are **recorded and shared** across **education** settings; review the risk and safety for children who use local authority school transport.

The full report is available in the national case review repository.

The NSPCC also provide regular thematic analyses on the learning from case reviews.

There is more information on case reviews and related research on the NSPCC website – Case reviews at a glance.

For more information on the ISCP please contact David Foote, Business Manager – david.foote@gov.gg.

Or visit the ISCP website for relevant local information and procedures – http://iscp.gg.

Serious case review in relation to Baby Rose: overview report.

Ann Duncan – Published by Hammersmith and Fulham Local Safeguarding Children Board – 2016

Abstract

Death of "Rose", a 9-week-old baby girl, in January 2015. Rose's mother pleaded guilty to **manslaughter by diminished responsibility**. The plea was accepted following psychiatric reports and she was sentenced to remain in a **mental health** facility with an unlimited restriction order. Rose's body has never been found. Mother received **antenatal services** from her **GP** and Chelsea and Westminster Hospital (C&WH) **maternity services** until the 29th week of her pregnancy. GP also referred mother to the **perinatal psychiatry service** but she returned to her home country to give birth before they could see her. Mother came back to the UK with Rose shortly before her death. Risks identified include: mother's **anxiety and low mood** related to her pregnancy; previous **request to terminate the pregnancy**; **isolation** from her family; **low income**; and **separation** from Rose's father. Findings include: **communication** across and between **health services** and professionals was fragmented. Professionals did not fully understand **procedures for making referrals** and the geographical areas covered by the C&WH midwifery service. Recommendations include: the perinatal and maternity services must audit referrals to ensure the new system is robust and vulnerable women are identified and followed up; health services should work together to develop a communication pathway locally to improve outcomes for service users.

The full report is available in the national case review repository and on the Hammersmith and Fulham Local Safeguarding Children Board website.

'Borough 2' Safeguarding Children Board serious case review: Child G [full overview report].

Fergus Smith – Published by NSPCC on behalf of an unnamed safeguarding children board – 2016

Abstract

Death of a 3½-year-old African boy in November 2015. There were indications that there might have been some degree of force feeding, causing ingestion of food into the lungs. The father was found guilty of **manslaughter** and **child cruelty**. Family was known to **children's services** and children had previously been subject to **child protection plans** for **neglect**, **physical and emotional abuse** and **children in need** plans. Family history of: **missed health, optician and speech therapy appointments** and repeated attendance at **accident and emergency** departments due to children's injuries. Maternal history of: low level neglect; **domestic violence**; **disguised compliance**; **health problems** due to AIDS and missed medication. Paternal history of: physical abuse; domestic violence; refusal to attend parenting education; irregular attendance at the home as he rented another property where he stayed four nights a week. Child G's teenage step-sister had joined the family from Africa and was providing care for her step-mother and step-siblings. Identifies findings including: lack of recognition of the impact of the **mother's ill health** on her parenting capacity; insufficient awareness of **father's lifestyle** and the reliance placed on Child G's step-sister to provide family care; parental inhibition of their **children's voices**; problems in **information sharing** following the family **relocation**; and professionals overlooking the **needs of the children**. Sets out key findings and opportunities for learning. Recommendations include: amending the **Neglect Toolkit** to include **feeding i**ssues and **dental health**; practice tool to be used by the **Health Visiting Service** to ensure systematic and robust information capture for new families.

The full report is available in the national case review repository.