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 March 2017:

A serious case review: 'Child AB': the overview report.

Published by NSCPP on behalf of unnamed safeguarding children board – 2017

Abstract

Life threatening assaults of child by mother, followed by **mother's suicide attempt**, in 2014 and 2015. On two occasions Child AB, a junior school-aged child, was subject to **life threatening assaults** by attempted suffocation and strangulation by the mother, who then attempted to commit suicide. Mother was charged with attempted murder and placed on bail, and Child AB became subject to **child protection investigation** and **child in need plan**, and was placed with father, with contact arrangements managed by **children's social care**. After a second assault mother was charged and convicted of child **neglect**. No indication of child abuse prior to the first event. Maternal history of: **mental illness**, **self-harm**, disclosed **attempts to harm husband** and **attempted suicide**; disclosure of **emotional abuse in marriage**. Key issues identified include: management of screening for maternal mental health and **domestic abuse** not fully embedded in practice; lack of direct questioning regarding thoughts to harm others and extended suicide in **primary care** and **mental health services**; ineffective use of child protection processes; lack of a joined-up process of **multi-agency assessment** and **management of risk** by adult and children's services; **professional decision-making** impacted by **affluence and status of family** ; management of contact arrangement unclear; ineffective staff **management and supervision** processes; limited practitioner awareness of increased **risk of filicide**, harm to others and the **risk of viewing the child as a protective factor**. Makes recommendations to strengthen professionals' understanding of the negative impact of **professional biases** and beliefs in safeguarding practice, and to review procedures to improve understanding of the child as a protective factor, risk of filicide and harm to others in cases of adult parent or carer mental illness. Please note that this report was written in May 2016 but was published in 2017.

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

The latest NSPCC thematic analysis is: Harmful sexual behaviour: 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 'Claire' [full overview report].

Bridget Griffin – Published by Croydon Safeguarding Children Board – 2017

Abstract

Review of the responses of agencies between 1 January 2012 and 31 January 2014 to a young girl who was found to have contracted two **sexually transmitted infections** whilst in **local authority foster care**. "Claire" was known to multi-agency services from the age of five months, and had previously been the subject of a **child protection plan**. At six-years-old she was **sexually abused** by a member of the household and became a **looked after child** (LAC) in the care of her paternal grandmother. This placement broke down and Claire was placed in foster care. The female foster carer raised concerns about her ability to care for Claire, after which the male foster carer became Claire's main carer. Claire was removed from the placement after 15 months, when she was diagnosed with chlamydia and gonorrhoea. Issues include: lack of **assessment, support and guidance** for **kinship foster carers**; absence of **scrutiny and challenge** when assessing and approving new foster carers; lack of **collaboration** between social workers representing different teams within the LAC service; the importance placed on **performance indicators** compromised the role of the **Independent Reviewing Officer**. Uses the Social Care Institute for Excellence (**SCIE**) methodology to identify findings, including: strengthen the contribution of family members in **LAC reviews** and **child protection conferences**; review how agencies are kept informed of planned changes for a child and consider adapting processes to facilitate the involvement of partner agencies; put processes in place to embed challenge as an accepted responsibility in safeguarding children.

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

James: serious case review: overview report.

David Byford – Published by Thurrock Local Safeguarding Children Board – 2016

Abstract

Death of a 17-year-old boy of Ghanaian heritage in July 2015 in North London. "James" was found collapsed with a sheet tied around his neck. The Coroner recorded an "Open Verdict" on his death. James was a **looked after child** in **semi-independent accommodation**, following a breakdown in relationships with his family. He was known to the **police** and **children's services** in a number of local authorities. James had a history of: **running away**; **violent and criminal behaviour**; sporadic **school attendance**; **non-engagement** with services; **drug misuse**; self-reported **mental health issues** and suspected involvement in **gangs**. Issues identified include: looked after child (LAC) placements situated too close to areas where gangs operate; incomplete mental health assessments; insufficient work by professionals on understanding family dynamics and rebuilding family relationships and the absence of a positive **action plans** in response to concerns raised in **LAC reviews**. Examples of good practice include: James was listened to, efforts were made to engage him and he was supported regarding his court appearances. Uses a mixed methodology to identify factors that influenced how agencies and professionals worked together. Recommendations include: review safeguarding arrangements for **children in custody** and young people presenting as **homeless**; widen the remit of looked after children inspections nationally to include semi-independent placements; embed a more robust **record keeping** and follow-up process for **health assessments**; assess the risk posed by any condition disclosed by a child or young person in custody to a forensic medical examiner and develop a matrix for identifying and **escalating concerns** about children in care.

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

Overview report on the serious case review relating to Child AA.

Ruby Parry – Published by Surrey Safeguarding Children Board – 2016

Abstract

Serious, **non-accidental head injuries** to a 10-week-old baby, Child AA, whilst in the care of parents. The parents were arrested and bailed pending further investigation and Child AA and an older sibling were taken into care. Sibling was subject to a **Child in Need** plan which continued following Child AA's birth. **Team around the child** and **professionals meetings** were also convened following Child AA's birth. Concerns about the family included: **young age and immaturity of parents**; lack of **support from family or friends**; **dependence on professionals** for money, food and equipment for the children; **poor living conditions**. Mother was a **young carer** for her mother, was subject to a Child in Need plan and received services from **CAMHS**. Issues identified include: the differences of opinion between **children's social care** and the **community health services**, which were compounded by a lack of clear and current **assessment and co-ordinated planning**. Recommendations include: guidance for social workers on assessment should include **joint visiting** with other professionals to share perceptions and views; **risks to new born babies** should be fully understood with the expertise of community health professionals in this area acknowledged; inclusion criteria for the **Family Nurse Partnership** should be revised to include young parents who have a **second or subsequent child**.

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

Serious case review: Family HJ: overview report.

Nicki Pettitt – Published by Herefordshire Safeguarding Children Board – 2016

Abstract

Concerns of **neglect** and possible **physical abuse** of a period of five years of a **minority community** sibling group, with **mobility, sight and learning difficulties** and **health challenges**. Children known to **children's social care** and the **police**. Concerns around **missed or cancelled appointments** for weight checks and immunisations, sight and delayed development checks and **lack of cooperation** by the parents. **Child Protection Plans** were in place for some of the children as a result of neglect and one was subject to a **Child in Need** plan. The youngest child was briefly taken into **foster care** following concerns of possible **sexual abuse**. **Care proceedings** started in October 2014 were delayed by legal processes and the children were removed by the court in February 2015. Themes identified include: identification of neglect and **children with disabilities**; lack of cooperation by family; clarity of purpose of **multi-agency meetings**; consideration of each child individually; **drift** and **changes of professionals**; internal and external **escalation and professional disagreements**; specialist **social work** provision and **legal processes**. Sets out key findings using the Significant Incident Learning Process (**SILP**) methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted in a certain way at the time. Recommendations include: to provide an effective multi-agency childhood **neglect strategy**; to request that NHS England reviews its commissioning arrangements for **child sexual abuse medicals** in the local area; provision of training in **culturally competent practice**.

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