National SCR's published in 2015

CASE	THEMES
March 2015 - Coventry – Child T **Death of a 3-week-old girl in June 2013; coroner classified cause of death as 'unascertained'.** **Background:** Following Child T's death, a home visit found that the family were living in dirty and unhygienic conditions. There had been no previous concerns about the mother's care of her children and they were not known to children's social care. **Key issues:** issues identified include confusion across partner agencies about when the Common Assessment Framework was open and when it had been closed and a failure to check the room in which the child was to sleep during the community midwife's home visit. **Recommendations:** simplify the Common Assessment Frameworks' management system and always check the room in which the child sleeps in the day and night. **Keywords:** infant death, neglect, home environment Read the overview report January 2015 - Leeds – Child Y **Death of a 14-week-old girl in March 2012. Post-mortem examination jointly conducted by two pathologists resulted in the recording of two different probable causes of death: Sudden Infant Death Syndrome and unascertainable.** **Background:** Child Y lived with mother, father and five older siblings in a three bedroom property at the time of the incident. Family had been known to children's services since 2003 and children were subject to Child in Need and Child Protection plans at different times before and after Child Y's death. Professionals' concerns primarily related to home conditions, children's personal hygiene and school attendance. **Key issues:** poor assessments, not carried out in a timely manner contributing to 'drift'; and lack of appreciation of the long-term impact of neglect and belief that better outcomes would be achieved by maintaining parents' cooperation **Recommendations:** various, focusing on conflict resolution, multi-agency working and training. **Model:** systems model. **Keywords:** child neglect, drift, co sleeping	Neglect, Early help (lack of), parental substance misuse

Read the overview report January 2015 – Liverpool - Mary **Death of a 6-month-old girl in July 2013, cause of death unascertained. Post-mortem recorded that Mary was a well-nourished child and found no past or current injuries; a number of risk factors for sudden infant death syndrome were identified, including prematurity and parental smoking.** **Background:** History of family violence; parental substance misuse; and professional concerns about school attendance levels and the health of Mary's two older siblings who were significantly overweight. **Findings:** lack of a common language and understanding between agencies; insufficient professional recognition of parental failure to meet a child's education or health needs, as significant indicators of neglect; and ineffective follow-up from health services for a baby with on-going health needs in the care of parents with a poor history of engagement. **Recommendations:** raises issues of consideration for Liverpool Safeguarding Children Board based on the review findings. **Model:** uses a systems approach. **Keywords:** Sudden Infant Death Syndrome (SIDS), child neglect, professional challenge Read the overview report 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. **Recommendations:** all agencies should fully engage with the Multi-Agency Safeguarding Hub (MASH); family assessments should involve the whole family, including the father; and parental non-compliance with drug services should result in immediate action to bring multi-agency professionals together. **Model:** systems methodology **Keywords:** addicted parents; poisons and poisoning; neglect Read the overview report	

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". **Recommendations:** develop a multi-agency pathway for identifying and responding to children who may have weight faltering and develop a multi-agency case review and planning process for individual highly complex cases. **Model:** uses a hybrid methodology, drawing on a variety of theoretical approaches and techniques. **Keywords:** child neglect, emotional abuse, kinship care Read the overview report 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. **Recommendations:** makes various recommendations, including the provision of training on neglect and disability. **Keywords:** children with a chronic illness, child neglect Read the overview report	

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.

Keywords: alcohol misuse, risk assessment

Read the overview report

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.

Recommendations: makes various recommendations and includes a multi-agency action plan. **Keywords:** child neglect, children with a chronic illness, start-again syndrome Read the overview report 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. **Recommendations:** makes various recommendations covering: NHS, community health services and probation services. **Keywords:** alcohol misuse, adults neglected as children, co-sleeping. Read the overview report	
March 2015 – Nottingham City – Child G **Death by drowning of a 10-month-old baby girl in May 2012.** **Background:** Mother stated she briefly left her infant unsupervised in the bath and pleaded guilty to involuntary manslaughter. Family were known to a number of services, including: police, health visitors, social care, probation services and Cafcass. **Key issues:** professionals didn't consider the impact of parents' mental health, domestic abuse and substance misuse on children and some decisions were based on self-reported information from the parents as opposed to thorough assessments. **Recommendations:** incidents of children being left home alone must be treated as a child protection issue and all appropriate family members should be included within risk assessments. **Model:** systems methodology. **Keywords:** infant deaths, family violence, optimistic behaviour. Read the overview report 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.	Toxic Trio, physical injuries, complex family dynamic

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. **Model:** uses some elements of the Social Care Institute for Excellence (SCIE) Learning Together model. **Keywords:** parents with a mental health problem, substance misuse Read the overview report March 2015 – Blackpool – Baby Q **Serious unexplained head injury of an infant, under 4-weeks-old.** **Background:** Mother found guilty of causing or allowing her baby to suffer serious physical harm. Baby Q was removed to permanent care of an approved family member. **Key issues:** family's transient living arrangements, lack of engagement with antenatal care, substance misuse, domestic abuse, maternal depression and high levels of parental anxiety. **Learning:** importance of midwives and health visitors co-planning and coordinating responses and need to routinely and confidentially ask parents about domestic abuse, mental health and substance misuse. **Recommendations:** put in place a mechanism to reduce the risk of confusion caused by recording the same case under multiple surnames and ensure there is full consultation with other agencies before a diagnosis is changed from non-accidental injury to medical cause. **Keywords:** head injuries, infants, non attendance. Read the overview report March 2015 - Haringey – Child D **Serious injury of an 11-week-old baby.** **Background:** Mother took Child D to hospital with a fractured arm. X-rays identified a number of old fractures sustained when Child D was about 1-month-old. Child D was taken into foster care; mother and father were arrested and charged with neglect and causing or allowing Grievous Bodily Harm (GBH). The case was later dismissed due to the non-availability of a key witness. **Key issues:** mother was physically abused and neglected as a child and had spent time in care. Family history of violence and criminal activity. **Learning:** focus on targets led to lack of critical assessment and professional desensitisation of the environment of violence and criminal activity the baby was growing up in. **Model:** Social Care Institute for Excellence (SCIE) Learning Together model **Keywords:** infant; injuries; adults abused as children.	

Read the overview report March 2015 – Isle of Wight – Q Family **Long term physical, emotional and sexual abuse and neglect of several children within a family.** **Background:** Family had complex needs, requiring the involvement of multiple agencies over a period of nearly 20 years. Children were exposed to a highly sexualised environment and had unsupervised contact with an individual believed to be a risk to children. For 2 brief periods some or all of the children were placed on the child protection register. Care proceedings were initiated in 2013. **Key issues:** domestic abuse; inter-sibling violence; parental alcohol misuse; and an aggressive, manipulative and litigious paternal response to professional interventions. **Learning:** need for supervision and use of discretion in excluding hostile parents from child protection conferences. **Recommendations:** multi-agency meetings should be convened if any agency has major concerns; records should be easily accessible and processes should allow multi-agency discussion of chronic cases without a single trigger event. **Keywords:** repeated abuse, disclosure, hostile behaviour. Read the overview report February 2015 – Southampton – Child K **Death of a 7-year-old boy in December 2011, as the result of a serious head injury.** **Background:** Mother's partner, Mr X, and Mr X's brother, Mr Y, were arrested following Child K's death however no prosecutions were made. This decision was reviewed in April 2014 and mother, Mr X and Mr Y were arrested; in December 2014, the Crown Prosecution Service decided that no further action would be taken in relation to Child K's death. Family were well known to agencies and Child K and his siblings had been the subjects of Child Protection plans for a period in 2011. History of: significant and sustained domestic abuse; repeated witnessing of injuries to Child K; concerns from school over Child K's sexualised behaviour, poor attendance, attention-seeking behaviour and temper outbursts; and inadequate response to repeated referrals from maternal grandmother to children's social care. **Key issues:** possible low expectations of professionals in relation to the quality of life Child K and his siblings could expect; and failure of practitioners to make connections between being intimidated by Mr X and the probability that Child K would feel similarly threatened. **Recommendations:** raising public awareness locally of the links between domestic abuse and safeguarding of children. **Keywords:** domestic abuse, physical abuse, scapegoating Read the overview report January 2015 – Liverpool - Maisie **Death of a female infant in December 2013 as a result of Sudden Infant Death Syndrome** **Background:** Family were known to children's services in a neighbouring local authority where one of Maisie's siblings, Sibling 4, had been subject to a Child Protection plan.	

Key issues: maternal alcohol misuse; domestic abuse; volatile relationship between mother and older sibling, Sibling 1; and deaths of two of mother's previous children from natural causes, the second of these deaths having been the subject of a serious case review (SCR). **Learning:** need for clarity in relation to specialist roles such as the Enhanced Midwife, including clear expectations in relation to safeguarding; and changes in legislation, whereby previous contacts with children's services will be a contributory factor in granting Legal Aid, acting as a possible incentive towards making anonymous referrals. **Model:** Uses a systems approach to present findings and questions for Liverpool Safeguarding Children Board. **Keywords:** Sudden Infant Death Syndrome (SIDS), alcohol misuse, Common Assessment Framework (CAF) Read the overview report January 2015 - Oldham – Child D **Death of a 7-week-old English/Polish child in January 2014, as the result of a severe head injury and multiple other injuries.** **Background**: Mother, mother's boyfriend and another adult male were arrested on suspicion of murder. All adults were sentenced for Perverting the Cause of Justice; sentencing Judge commented that at least one of the adults must have been responsible for the injuries. **Key issues:** mother emigrated to the UK from Poland in 2010. Mother reported not knowing she was pregnant until 2-weeks before Child D's birth and did not engage with community-based ante-natal services. Mother was known to police following a number of allegations of assault and domestic harassment. **Learning:** insufficient professional curiosity given the concealment or denial of mother's pregnancy; and the use of two different formats for inputting dates of birth onto electronic systems contributing to an error that prevented sufficient sharing of information **Recommendations:** the use of genograms by community-based practitioners as a tool to gather information and to prompt practitioners to be inquisitive; and simplification and consistency in data inputting formats and processes. **Keywords:** professional curiosity, concealed pregnancy, domestic abuse Read the overview report January 2015 - Tameside – Child F **Death of a child as the result of non-accidental head injury.** **Background:** Mother was on holiday and the time of the incident and Child F had been left in the care of mother's partner, MP1. MP1 was arrested on suspicion of murder. **Key issues:** MP1 had a history of threatening and controlling behaviour. **Learning:** strengthen safeguarding in the private housing sector and consider the risks posed by mothers' intimate partner relationships. **Recommendations:** change police policy to ensure that any threats made indirectly or directly to children get a high risk rating and result in immediate action and ensure that child health checks and follow-ups are conducted in an effective	

and timely manner. **Keywords:** child deaths, non-accidental head injuries, family violence. Read the overview report 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. **Recommendations:** makes various recommendations including monitoring the use of escalation procedures. **Keywords:** physical abuse, fathers, assessment Read the overview report	
January 2015 - Walsall – W4 **Death of an adolescent girl in December 2012, caused by inhalation of the products of combustion.** **Background:** The Young Person had barricaded herself into her bedroom and set fire to a mattress following a dispute with her carers. At the time of her death, the Young Person was living in a care home where she was the only resident with two adult carers. When the Young Person was 3-years-old, she and her three siblings were removed from the care of their parents due to neglect and placed with their paternal uncle and aunt. The Young Person became a Looked After Child in the care of Walsall Children's Social Care when 15-years-old, during which time she experienced five placements, some of which were out of borough. Significant history of: aggressive and violent behaviour; offending; frequent absconding from placements to return to family; risk-taking; and fire-setting **Recommendations:** the option of secure accommodation must be regularly and robustly considered when the frequency and intensity of violent behaviour and absconding increases. **Keywords:** adolescents, risk assessment, allegations of abuse Read the overview report March 2015 - Kirklees – A young person **Attempted suicide of an adolescent boy in September 2013.**	Self Harm, LAC, suicide

Background: The young person's attempt on his life has been linked to a drug influenced psychotic episode. Family were well known to agencies and there had been professional concerns around neglect of the young person and his siblings since 2005. Between 2009 and 2011 the young person was the subject of a child in need plan, a child protection plan, care proceedings and a supervision order. **Key issues:** poor school attendance; offending; substance misuse; mother and young person's lack of engagement with professionals; mother's non-compliance with parenting orders and school attendance; and challenges associated with the significant number of professionals and agencies involved with the family. **Learning:** need for professional awareness about the link between substance misuse and mental health problems and the link between long term neglect and suicide ideation; and need to maintain focus on older children when there are younger children in the family. **Recommendations:** the development and implementation of a toolkit to help professionals engage with 'hard to engage' young people. **Keywords:** suicide, adolescent boys, substance misuse. Read the overview report March 2015 - Leeds – Child V **Death of a 17-year-old boy, as a result of hanging. Ryan was found with a ligature around his neck in a cell in a Young Offender Institute (YOI); Coroner's inquest concluded accidental death.** **Background:** Ryan had been in the care of Leeds City Council since he was 16-months-old; when he was 13-years-old his long-term foster placement broke down and he did not have another stable placement. **Key issues:** history of extensive record of offending; chaotic lifestyle and risk-taking; aggressive behaviour; and frequent movement between accommodation. **Recommendations:** corporate parenting responsibilities for promoting education, training and employment; and provision of suitable, specialised accommodation for young people with high support needs **Keywords:** adolescent boys, young offenders, suicide Read the overview report February 2015 - Hertfordshire – Young Person B **Suicide of a 17-year-old girl in April 2013. Child B was an inpatient in a specialist adolescent mental health clinic under Section 3 of the Mental Health Act 1983 at the time of her death.** **Background:** B was admitted to the clinic due to concerns that she had an eating disorder and because she had been self-harming. B lived with mother and step-father until January 2012 when she moved in with her boyfriend and then later her father. Although B's living arrangements were initially agreed by mother, she soon afterwards wanted B to return home. Family were known to services including Targeted Youth Support Service (TYSS) who worked with B, her mother and step-father to try to rebuild their relationship. **Learning:** contact with children's services should be considered when a young person presents with significant mental ill-	

health and where there are concerns about the impact of family dynamics on protective factors; and formal consideration should be given to sharing the details of Community Treatment Orders (CTOs) with agencies providing services to young people placed on CTOs, including schools. **Model:** Partnership Learning Review model **Keywords:** suicide, self-harm, anorexia, Mental Health Act 1983 Read the overview report 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. **Recommendations:** the police and the council should confirm what arrangements are in place to ensure relevant protocols, including the use of appropriate adults, are known and used by both services. **Model:** systems based approach **Keywords:** suicide, self-harm, risk assessment Read the overview report 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. **Methodology:** systems approach. **Keywords:** suicide, adolescent boys, physical abuse Read the overview report Read the executive summary 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. **Methodology:** systems methodology. **Keywords:** suicide, harmful sexual behaviour, child and adolescent mental health services (CAMHS) Read the overview report	
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. **Model:** review was undertaken using the Significant Incident Learning Process (SILP). **Keywords:** adult mental health services, suicide, referral procedures Read the overview report April 2015 - Lancashire – Child N	Parental mental health (suicide/filicide)

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. **Recommendations:** LSCBs to explore options to help frontline practitioners understand and assess behaviour of a parent who causes concern but does not have a recognised mental illness. **Keywords:** filicide, suicide, parents with a mental health problem, contact Read the overview report 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. **Methodology:** joint serious case review and domestic homicide review. Uses a systems framework to present the key learning. **Recommendations:** questions for consideration cover: overcoming cognitive influence and human bias in information sharing; ensuring sufficient enquiry and recording of any presentations for medical treatment; use and availability of	

tools and frameworks for assessing risk. **Keywords:** parents with a mental health problem, family annihilation/familicide Read the overview report Read the executive summary	
March 2015 – Oxfordshire - Children A, B, C, D, E and F **Sexual exploitation of 6 girls aged 12-16 who were the victims of offences between May 2004 and June 2012.** **Background:** 9 men were charged with offences, of which 7 were convicted on 14 May 2013. Girls targeted had complex needs, and many were known to children's services or in care. They were groomed by older men who supplied them with drugs and alcohol. **Key issues:** lack of understanding of child sexual exploitation, insufficient use of child protection processes, lack of organisational overview, difficulty managing missing children and a focus on young people's behaviour rather than their risk of being harmed. **Recommendations:** review escalation procedures, clarify agencies' child protection roles and review national guidance on the use of disruption techniques in safeguarding children. **Keywords:** child sexual exploitation, grooming, professional attitudes. Read the overview report	CSE
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. **Model:** Social Care Institute for Excellence (SCIE) Learning Together model **Keywords:** adults with learning difficulties, neglect and interagency cooperation Read the overview report	Parental Learning Difficulties, neglect
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	Missing, older children

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. **Recommendations:** makes various recommendations covering: professional challenge and escalation; communication between schools and colleges and other agencies during school/college holidays; and whether child protection services received by older children are robust and the extent to which gender and ethnicity effect them. **Keywords:** adolescents, runaway children, escalation Read the overview report 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. **Recommendations:** information coordinators should be appointed within teams working with families with complex needs, to compile a family history and facilitate information sharing; the Safeguarding Board should create a simple chronology tool that could be completed across agencies; and the Safeguarding Board should explore custodial and residential approaches to working with young people with severe behavioural problems. Read the overview report 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. **Recommendations:** makes recommendations covering: looked after children reviews and exploration of options for keeping children safe in emergency situations by police and children's services. **Model:** uses the Welsh Model for case reviews.	

Keywords: organised abuse, foster care, placement breakdown Read the overview report	