National SCR's published between January and June 2017

CASE	THEMES
2017 – Anonymous - Child AB **Life threatening attempted strangulation and suffocation of child by mother, followed by mother's suicide attempt, in 2014 and 2015. Child AB became subject to child protection investigation and child in need plan.** **Background:** 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. **Key issues:** 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; professional decision-making impacted by affluence and status of family. **Recommendations:** include: strengthen professionals' understanding of the negative impact of professional biases and beliefs in safeguarding practice; review procedures to improve understanding of the child as a protective factor, risk of filicide and harm to others in cases of parent mental illness. **Keywords:** parents with mental health problems, filicide Read the overview report	Non Accidental Injuries Paternal MH issues Domestic abuse
2017 - Anonymous - Child F and Family **Harmful sexual behaviour and death of 17-year-old boy in 2015 as the result of stab wounds.** **Background:** Child F was assessed as a Child in Need in 2011. Behaviour and attendance at school erratic, and several incidences of involvement with others in minor and serious offences, including rape of a 12-year-old and 14-year old. Decision made that prosecution relating to first rape was not in public interest. **Key issues:** include: when cases are not pursued in the public interest it is still necessary for the young person to be given a full understanding of the implications of their actions; lack of support for mental health needs due to referrals to	Sexual Abuse Sexually harmful behaviour

and from between agencies; good chronologies of key events would help spot risks; agencies should take great care when describing sex as consensual when in law it cannot be; young teenagers are often unclear about consent. **Recommendations:** include: review safeguarding approach to young people with harmful sexual behaviour; encourage education providers to ensure law around consent is explained clearly; ensure that a young person's concern about violent risks to them is taken seriously by agencies. **Keywords:** harmful sexual behaviour, adolescents, consent Read the overview report	
2017 – Anonymous - Considering child sexual exploitation **Child sexual exploitation of 3 girls by a young adult female who was involved in sexual activity with them and recruited them in abusive sexual behaviours by a number of older adult males between January 2013 and August 2015.** **Key issues:** all girls had complex needs and missing from home episodes. The alleged perpetrator was part of a wider network of predominantly male operatives. **Learning:** difficulty in identifying the alleged perpetrator as a risk to children; the need for services to work with parents to strengthen parental confidence as perpetrators set out to deliberately drive a wedge between child and family; importance of early intervention in responding to sexual exploitation; the need to understand children as victims without choice or informed consent. **Recommendations:** introduce a process for responding to vulnerable children/young people which incorporates child sexual exploitation and: identifies and minimises the risk from a non-familial source; builds on factors that increase resilience; facilitates a multi-agency team around the child; and facilitates partnership with key people in the life of the young person. **Keywords:** alcohol misuse; child sexual exploitation; grooming; harmful sexual behaviour; runaway adolescents Read the overview report	Child Sexual Exploitation Missing children Sexually harmful behaviour
2017 - Bedford - Baby Sama **Death of a baby girl under 2 months old of white British/Pakistan origin, in October 2015 as a result of fatal injuries received after falling from her car seat. The Coroner's Inquiry found her death was a tragic accident that could not have been predicted.** **Key issues:** mother was 20 and father 28 when Sama was born. Mother spent time in foster care and had had witnessed	Domestic abuse Care leaver vulnerabilities Child Sexual Exploitation

domestic abuse against her mother when she was a child. Mother was looked after for 4 months when she was 15 when concerns were raised that she was involved with a 23 year old male (Sama's father) who was known to be violent. Father had convictions for domestic violence, assault, drug dealing and breeding dogs for fighting. Concerns identified about father being involved in the sexual exploitation of two looked after children. In July 2015 Salma was made subject to a Child Protection Plan under the category of neglect. **Learning:** issues identified include: recognising and addressing the impact of child sexual exploitation (CSE) in assessments and plans to safeguard children; understanding the dynamics of domestic abuse including perpetrator behaviour; recognising the links between animal abuse and child abuse/domestic abuse. **Recommendations:** makes recommendations relating to the safeguarding of babies from domestic abuse. **Keywords:** child sexual exploitation, grooming, infant deaths, children in violent families, official inquiries, partner violence, drug misuse Read the overview report	
2017 – Blackpool - Child BW **Death of 3-month old child in 2015 due to medical causes.** **Background:** Child BW lived with mother and two siblings. A child protection plan had been in place for all children 1 year before the death due to concerns of neglect. **Key issues:** include: views on a good enough home environment can be subjective and complicated by working in a deprived area; mother's disguised compliance may have added to the optimistic view of her intentions and capacity to change. Good practice identified: robust information sharing processes and good local professional relationships. **Recommendations:** include: wider promotion and clarification for staff of neglect assessment tool; audit on how expected outcomes are recorded on Children's Services' documentation; audit of pre-birth child protection processes to ensure that when siblings are on a child protection plan the needs of an unborn baby in the family are considered separately; review progress of earlier recommendations of safe sleep assessment. **Keywords:** infant death, neglect, disguised compliance, sleeping behaviour. Read the overview report	Neglect Disguised compliance Infant death
2017 – Birmingham – Shi-Anne Downer [birth name]: AKA Keegan Downer **Death of an 18 month-old-girl from a white British and black African background in September 2015. The post mortem revealed over 150 internal and external injuries that had been caused over a number of months. Shi-Anne's guardian was subsequently convicted of murder.** **Background:** mother had a history of drug abuse, mental health issues, reluctance to engage with services and time in	Non Accidental Injuries Maternal substance abuse Maternal Mental health issues Poor assessments

prison; father was in prison at the time of her birth; 5 older siblings had previously been taken into care. Shi-Anne was made the subject of a child protection plan before her birth and was placed in foster care after birth. In January 2015, Shi-Anne became the subject of a special guardianship order (SGO). **Key issues:** the pre-birth decisions made about Shi-Anne's care followed the same approach as decisions made for her older sibling, without considering whether this was also appropriate for Shi-Anne 5 years later; the assessments for the special guardianship order (SGO) were flawed and incomplete; professionals had little or no contact with Shi-Anne after the SGO; risk factors for the guardian's reduced parental capacity, such as becoming pregnant and the breakdown of her relationship, were not recognised and acted upon. **Learning:** all relevant checks should be carried out and the need for a period of monitoring should be considered before a special guardianship order is finalised. Model: blended methodology. **Keywords:** infant deaths; physical abuse; selection procedures; special guardianship orders Read the overview report	
2017 - Croydon - Claire **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.** **Background:** Claire was known to multi-agency services from the age of 5 months and had previously been the subject of a child protection plan. At 6-years-old she was sexually abused by a member of the household and became a looked after child in the care of her paternal grandmother. This placement broke down and Claire was placed in foster care. Claire was removed from the placement after 15 months when she was diagnosed with chlamydia and gonorrhoea. **Key issues:** 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 looked after child service; the importance placed on performance indicators compromised the role of the Independent Reviewing Officer. **Recommendations:** strengthen the contribution of family members in looked after child 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. **Model:** uses the Social Care Institute for Excellence (SCIE) methodology. **Keywords:** child sexual abuse, children in care, foster parents, placement breakdown, professional collaboration, sexually transmitted infections. Read the overview report	Sexual abuse Vulnerabilities of Children In care Lack of professional curiosity Kinship care

2017 – Halton – Young Person **Life-threatening asthma attack experienced by a teenaged boy in December 2014; at the time he was visiting relatives who did not seek medical help for around 18 hours. After being treated in hospital he was taken into care due to concerns about his health and the cumulative effects of neglect.** **Key issues:** Young Person lived with his mother and her partner, and did not know his father. He suffered from long-term asthma and severe eczema which was being treated at a satellite dermatology clinic. He and his mother had Common Assessment Framework (CAF) support between 2009-2012. **Learning:** from early age, professionals held information about Young Person which was not shared; professionals had limited understanding of the young person's lived experiences; treatment for the young person's eczema was provided by a medical team that primarily worked with adults, and had limited knowledge of how chronic conditions can affect a child's life and age appropriate pathways for support. **Recommendations**: identifies findings for the local safeguarding children board (LSCB), which can be used as a basis to make the local safeguarding system safer. These include: professionals need to be confident to raise questions about family or household members who could pose a risk of harm to a child. **Model:** Social Care Institute for Excellence (SCIE) Learning Together model. **Keywords:** child neglect, children with a chronic illness, disguised compliance, health services. Read the overview report	Ongoing neglect Long term illness Disguised compliance
2017 Merton - Child B **Serious physical assault in September 2015 of a 16-year-old girl whilst she slept. B's mother pleaded guilty to grievous bodily harm and was sentenced to a Hospital Treatment Order under the Mental Health Act, 1983. Child B became a looked after child.** **Background:** long history of mother's poor mental health, reports of excessive alcohol consumption and tensions in the parental relationship resulting in disputes which sometimes escalated to possible domestic abuse. B was subject to a child protection plan for emotional abuse, later becoming a child in need and finally a vulnerable child, supported by universal services. She was also a young carer for her mother. **Learning:** a holistic 'Think family' approach had not been embedded across multi-agency children's and adults' services; young carers were not always recognised as such and their needs were not always understood or attended to by the whole multi-agency system; recognition of trends or patterns of risk, or changes in risk and when to 'step up' or 'step down' a case were not robust with a lack of confidence in escalating concern. **Model:** Multi-Agency Child Practice Review methodology	Non Accidental Injuries Maternal Mental Health Issues Alcohol misuse Domestic abuse Emotional abuse

Recommendations: review how the principles of the holistic 'Think Child, Think Parents, Think Family' approach are operating and how they are embedded in commissioning and leadership of frontline practice and its management, with joint working and understanding of mental ill-health and parenting. **Keywords:** mental health problems; alcohol abuse; domestic abuse; physical abuse; emotional abuse; risk assessment; interagency cooperation; holistic approach Read the overview report	
2017 – Swindon - Child S **Death of an 8 week old girl in October 2015 whilst sleeping with her mother on the sofa. Child S was taken to hospital following a cardiac arrest and life support was withdrawn after three days.** **Background:** Child S was subject to an interim supervision order and a child protection plan at the time of her death. The family was known to Swindon Borough Council Children, Families and Health; Great Western Hospitals NHS Foundation Trust; CAFCASS. **Key issues:** neglect, the impact of time spent in hospital on ability to care for children, communication gaps between organisations, health visit delays. **Learning:** The impact of time spent in hospital on ability to care for children. **Recommendations:** include: make training available to Children and Families staff regarding the effects of long term drug use on the brain and to consider the impacts on patient's ability to care for their family after a discharge from intensive care. **Keywords:** sleeping behaviour, child neglect, depression Read the overview report	Co-sleeping Neglect Maternal Mental Health issues
2017 – Surrey – Child BB **Death of a 23-month old child in May 2014 due to non-accidental injuries.** **Key issues:** Child BB was taken to hospital in a state of extreme physical collapse, with bruises and burn marks, and died the following day. Criminal charges were brought against the mother and her partner in March 2015, but the partner committed suicide before the trial. Mother was found not guilty. **Learning:** better interagency work and closer communication between police, probation services and children's services could have resulted in a better understanding of the behaviour of the mother's partner; safety messages on dating websites focus on the users' personal safety but not on potential risks after a relationship is established. **Recommendations:** include: police, probation service and children's services to review processes for liaison about	Non Accidental Injuries Poor interagency working Domestic abuse

incidents and call-outs in relation to domestic violence; national consideration be given to how mothers can be alerted to the need for caution when engaging in new relationships with previously unknown men, potentially with an emphasis on relationships made through internet dating sites and social media. **Keywords:** child deaths, physical abuse, online safety, domestic abuse Read the overview report	