# Safeguarding Information and Research Digest
# Issue 14, July 2014
# Special Edition Serious Case Reviews

This special edition of the LSCB Safeguarding Information and Research Digest has been produced to share messages from recent published Serious Case Reviews (SCRs). The cases identify lessons to be learnt and should help with our learning to improve and develop practice and multi-agency working to safeguard children and young people who are vulnerable. Please share this edition with your staff and/or colleagues to prompt discussion and develop practice and multi-agency working.

The information in this edition has been obtained from Safeguarding Matters, April 2014 (Leicestershire and Rutland Safeguarding Children Board) and is not a conclusive list of all the SCRs that have been published. A full list of published SCRs is available from the NSPCC at: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/case-reviews-2014_wda101121.html

## Substance Misuse and Mental Health

***December 2013 - Derbyshire - BDS12***

Death of a 2-year-old boy in March 2013 from cardiac arrest. BDS swallowed his mother's methadone, which was in a child's beaker. Mother and father were convicted of manslaughter and received custodial sentences. Issues identified include: overreliance by universal health services on specialist health professionals to inform them of child protection concerns; and lack of recognition of thresholds for referral to children's services.

For more information see **Derbyshire - BDS12**

***December 2013 – Wolverhampton – Daniel Jones***

Death of a 23-month-old boy in May 2012, as a result of ingesting heroin. Father was convicted of manslaughter and mother was convicted of causing or allowing the death of a child. Maternal history of drug and alcohol misuse and offending; she had one older child who did not live with the family. Paternal history of prolific offending and drug misuse. Family was well known to children's services. Issues identified include: lack of focus on the child; professional optimism; insufficient management and supervision; insufficient information sharing; and working with resistance and avoidance.

For more information see **Wolverhampton – Daniel Jones**

***July 2013 - Lancashire - Baby E***

Death of a 4-month-old baby boy from a serious head injury in December 2011. Both parents had been looked after children, had experienced childhood abuse and were chronic substance users. Identifies themes for learning including: establishing a professional lead in multi-agency processes; acquiring comprehensive social histories from parents; recognising unemployment and poverty as risk factors; recognising disguised compliance and maintaining a sufficient level of professional scepticism; impact of coercive relationships on vulnerable women; and engaging with men and fathers. Sets out key findings using systems based typology developed by SCIE.

For more information see **Lancashire - Baby E**

***February 2013 – Manchester – Child U***

Death of a 4 year old girl in September 2011 who was subject to a child protection plan. Mother pleaded guilty to manslaughter on the grounds of diminished responsibility and was detained in a secure mental health facility. History of inappropriate sexual behaviour by mother towards her daughter and parental mental health issues. Identifies themes including mentally ill parents, substance misuse, child sexual abuse and hostile behaviour.

For more information see **Manchester – Child U**

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## Child Sexual Exploitation

***December 2013 - East Sussex - Child G***

Abduction of a 15-year-old girl in 2012, by her teacher, Mr K. Child G was involved in a sexual relationship with Mr K, which began around her 15th birthday. Mr K was found guilty of abduction and admitted a number of charges of sexual activity with a child under 16 years; he received a custodial sentence of 5 years. Identifies serious concerns relating to school's actions, including: failure to identify the abuse and exploitation of Child G; fixed thinking; failure to hear concerns raised by students; failure to involve Child G's mother; concerns about LADO response; insufficient recognition of Mr K's inappropriate use of Twitter to communicate with Child G; and serious concerns with the ways in which information was recorded, stored, retrieved and provided for the review.

For more information see **East Sussex - Child G**

***December 2013 - Rochdale Young People 1, 2, 3, 4, 5 and 6***

Serious and prolonged sexual exploitation of 6 adolescent girls at the hands of a number of men, who subsequently received criminal convictions. Issues identified include: frequent incidences of young people missing from home; recurrent attendances at A&E; optimistic thinking; unqualified staff and inadequate supervision. Contains multi-agency and single agency recommendations covering: placing young people at risk of sexual exploitation with specialist foster carers rather than semi-independent living accommodation; and having a twin safeguarding focus when working with teenage parents and their children.

For more information see
http://www.rochdaleonline.co.uk/uploads/f1/news/document/20131220_93449.pdf

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## Sexual Abuse

***August 2013 - Birmingham - Case No.2010-11/3***

Serious sexual assault of a toddler by an early years student and staff member at a nursery in Birmingham in 2010. Knowledge of the incident came to light following an accusation by a 13-year-old girl of online grooming in January 2011. Issues identified include: recruitment and screening procedures; management and team culture; inspection and complaints procedures; and early identification of online sex offenders by police. Recommendations include: effective recruitment processes; balancing physical environments in nursery settings between a respect for privacy and reducing opportunities to abuse; rigorous inspections of early years settings that examine the implementation of safeguarding policies and procedures.

For more information see **Birmingham - Case No.2010-11/3**

## Neglect

***November 2013 - Bradford - Hamzah Khan***

Death of a 4-year-old boy in December 2009, as a result of chronic neglect. Hamzah's body was discovered by police during a search of the family home in September 2011. Mother was convicted of manslaughter and child cruelty in October 2013. Maternal history of: chronic alcohol dependency; depression; social isolation; domestic abuse; and reluctance to engage with services, including registering children for health and education services. Issues identified include: invisibility of children to education and health services; failure to take into account the impact on children of living with domestic abuse; absence of enquiry into the cultural and religious complexity of the family; insufficient significance given to disclosure by adolescents; lack of professional curiosity.
For more information see **Bradford - Hamzah Khan**

## Physical and Emotional Abuse

***September 2013 - Coventry - Daniel Pelka***

Death of 4 year Daniel on 3 March 2012 as the result of an acute subdural haematoma. Daniel's mother and step father were convicted of murder in August 2013 and sentenced to 30 years' imprisonment. For a period of at least six months prior to his death, Daniel had been starved, assaulted, neglected and abused. History of incidents of serious domestic abuse and violence, chaotic lifestyle with multiple house moves and alcohol misuse by mother and various partners. Issues identified include: deception of agencies and services by mother; impact of witnessing violence on children; impact of culture, race and language; and Daniel's isolation and 'invisibility'.
For more information see **Coventry - Daniel Pelka**

***October 2013 - Birmingham - Keanu Williams***

Death of a 2-year-old boy in January 2011 from multiple injuries. The mother was convicted of Keanu's murder and of 'cruelty to a child' in respect of one of his older half siblings; she was sentenced to 18 years imprisonment. Mother spent periods of time in foster care subject to care orders throughout her own childhood. History of: frequent house moves and periods of homelessness and frequent changes in maternal relationships. Issues identified include: focus on the child; professional curiosity in relation to injuries. Recommendations include: multi-agency audits to track records across agencies; critical review of the interagency protocol for child protection medical assessments.
For more information see **Birmingham - Keanu Williams**

***February 2014 - Leicester - Baby Z***

Serious head injury of a baby girl in October 2012. Medical examination revealed multiple injuries, thought to have occurred up to 3 weeks before the incident. Mother pleaded guilty to Section 20 Grievous Bodily Harm and received a 2 ½ year custodial sentence in September 2013. In December 2013, mother was removed from prison and sent to India as part of the UK Visa and Immigration Service's Facilitated Return Scheme. Family were known only to universal services prior to the incident. Mother presented injuries to health visitor and GP in August 2012, which were not identified as non-accidental and not referred to children's services. Identifies missed opportunities on the part of professionals, including: professional optimism; lack of professional challenge; and lack of professional curiosity. Makes recommendations covering: GPs, health visitors and Leicestershire Partnership NHS Trust. Review was undertaken using a systems-based methodology.
For more information see **Leicester - Baby Z**

## Domestic Homicides and Child Deaths

***May 2013 - Surrey - Children U and V***

Death of a 7-year-old boy (Child U) and his 6-year-old sister (Child V) on 30 September 2012. Children were found on a bridleway with their father who was also deceased. Police evidence later revealed that father stabbed both children before taking his own life. Mother had disclosed domestic abuse (verbal/emotional) to GP in October 2011. Lessons learned include: domestic abuse is a child protection issue; children should be actively spoken to, engaged with and observed by professionals; and violent acts that lead to the death of children can occur without any prior indication.
For more information see **Surrey - Children U and V**

***February 2013 - Stoke-on-Trent - Case No.SOT12(1)***

Death of a pre-school aged child in January 2012. Mother's partner was charged with murder and received a life sentence. Child lived with mother, father and three elder half siblings. Father was physically abusive and controlling towards mother, misused alcohol and was verbally abusive toward one of the subject child's siblings. Children witnessed significant domestic violence and experienced multiple moves before father was convicted of assault against mother. Issues identified include: lack of professional curiosity; lack of focus on the children during domestic abuse risk assessments; lack of assessment of mother's ability to protect and care for her children.
For more information see **Stoke-on-Trent - Case No.SOT12(1)**

***January 2013 – Wirral – Child G***

Death of a 17-year-old girl in May 2012, by strangulation. Her boyfriend at the time of her death was charged with her murder. Child G had learning difficulties, ADHD and behavioural problems and had been the subject of a child protection plan for neglect when she was younger. She was living independently in specialist accommodation at the time of her death. Makes recommendations for developing professional understanding of the effects on child development and social presentation of moderate learning difficulties; working with young people who are sexually active from a young age; and safeguarding young people who are 16 and 17 years old.
For more information see **Wirral – Child G**