



LEARNING LESSONS FROM NATIONAL SERIOUS  
CASE REVIEWS ON CHILDREN

A PRECIS OF 9 SERIOUS CASE REVIEW EXECUTIVE  
SUMMARIES

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## **Introduction**

This review has looked at 9 executive summaries of serious case reviews (SCR) involving the death or serious injury to a child where abuse or neglect was the main or contributing factor.

A brief summary of the case has been provided with some of the key learning points for all practitioners. The full Executive summaries are available on the Ofsted website [www.ofsted.gov.uk](http://www.ofsted.gov.uk)

<b>1. Child B Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Tameside</b>	<b>2010</b>

Summary:

This 13 year old was known to the Police and Children and Young People Social Care (CYPSC) for a number of years due to concerns about his learning and behaviour. Alongside universal service provision (Health and Education) work was also undertaken by the Youth Offending Team (YOT) and Children and Adolescent Mental Health Service (CAMHS).

The review does not provide details of the incident/s leading to the SCR but comments on a number of serious incidents and a number of children being hurt. The incidents appear to relate to sexual assault.

Key Findings:

- Assessments did not lead to service provision.
- No one assessment set out the child's needs in full.
- CAMHS lacked persistence.
- Outcomes reflected poor decision making.
- Inter-agency working was poor.

Lessons Learnt:

- Assessments should take into account information held by all agencies, including past and unproven information.
- Where a young person poses a risk to others, a detailed risk management plan should be in place, overseen by a suitable multi-agency group (Risk Management Group) and the level of risk reviewed.
- Young people who pose a risk to others should be identified as such.
- Services should be considered even if charges are outstanding (aim to reduce the risk to others whilst awaiting trial).
- Ensure safe environment for young people.
- CYPSC and YOT – management of all work, integrated with any concurrent assessment plans or reviews.

Key Recommendations:

- Improve quality of Core Assessments.
- To agree safe multi-agency processes for assessing and managing the risk posed by children known or suspected to sexually abuse other children and young people.

- Day/Residential facilities to provide evidence that risk assessment protocols address the potential risk that some children and young people may pose to one another.
- YOT, specialist services and safeguarding to identify all known children who pose a risk of sexual harm.

Executive Summary Useful For:

CAMHS  
 CYPSC  
 YOT  
 Education  
 All council services where children and young people meet.

<b>2. Child Q and Child R Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Manchester</b>	<b>Not stated</b>

Summary:

Two siblings (Child Q, a girl aged 4, Child R, a boy aged 2) died in October 2009. The cause of death was strangulation. Their father was convicted of their murder.

Key Findings:

- No outward signs of concern for either of these children.
- Two reported incidents of domestic abuse (the first on Q's day of birth and the second 7 days before the incident).
- 5 key themes around domestic abuse are raised within the report.

Key Themes:

- Need to improve knowledge and skills development for frontline staff in relation to domestic violence and child safeguarding.
- Better assessment tools needed for staff in relation to above.
- Better multi-agency communication and recording processes around domestic violence.
- The barriers to women in recognising their experience of domestic violence and accessing appropriate services.

Executive Summary Useful For:

Universal Health Services - Midwifery and Health Visiting  
Education  
Early Years  
Housing  
Safer Leeds

<b>3. Baby A Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Cambridge</b>	<b>2009</b>

Summary:

A 7 week old who died from a wide range of Non-Accidental Injuries (NAI). Father was found guilty of murder and the mother guilty of allowing the murder.

Key Findings:

- Domestic violence emerged during the court case after the death of this child.
- No indication of any risk to warrant referral to CYPSC.
- Parents known to the Police (this was not known to Midwifery/Health Visiting).
- Information sharing between Hospital Trust and Primary Care (there were no obvious concerns identified but there was a potential for some risk).
- There was a delay in the identification of the NAIs during the child's 12 days in hospital.
- There was a delay following identification of concerns in CYPSC obtaining a medical on the older sibling.
- Record keeping was identified as poor in many parts of the system, notably records of discussions with staff in other organisations.
  - lack of minutes from strategy meetings.
  - lack of handover paperwork, clarity around source of information and whether it was evidence.

Executive Summary Useful For:

Universal Health Services - Midwifery  
Health Visiting

Paediatricians  
Ward Nursing Staff  
CYPSC  
Police

<b>4. Child K Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Manchester</b>	<b>Not stated</b>

Summary:

Child K was 3 months old when he was taken to the Emergency Department with life threatening head injuries. Child K had an older sibling aged 16 months (child Z). Their mother received a conviction for causing a young person under 16 to be ill treated. At the trial the Judge directed that a review of multi-agency working and procedures should be undertaken. Manchester LSCB re-considered the case at their Child Death and Critical Incident Panel and decided to carry out a SCR.

Both children lived with their mother, moving between their father and maternal grandparents. Child K's father arrived in the UK in 2005 aged 16 seeking asylum. His mother was a young girl, who with her first pregnancy had informed her Connexions Advisor about difficulties within her family and between Child Z's father and her family.

During her first pregnancy mum was a poor ante-natal clinic attender. Following the birth of Child Z the family were linked with Sure Start and a Family Support Worker. In 2006 Child Z was taken to the Emergency Department with minor injuries on two occasions.

- Mum fell whilst drunk late at night in the street. The Doctor accepted the history of this incident but referred to CYPSC due to the circumstances.
- On the second occasion the Doctor did not accept the history given around bruising to the child.

Following the second incident Child Z was sent to stay with a relative. The Police and CYPSC investigated but closed the case without following through the child protection procedures.

During her second pregnancy (Child K) mum told the Family Social Worker (FSW) and the Health Visitor that she was anxious she may not bond with the

new baby. The FSW closed the case just after Child K was born. Mum continued to need individual support for herself and her children.

Child K was seen by his GP in May and diagnosed with conjunctival haemorrhages due to coughing and a few days later he was taken to the Emergency Department presenting as 'limp'. This was diagnosed as an 'apnoeic' episode. Neither of these injuries were considered in the light of Child Z's earlier injuries.

In July Child K was taken to the Emergency Department with critical injuries and as a consequence has life long disabilities.

#### Key Findings:

- Young parental ages.
- Misuse of alcohol.
- Children moving between two sets of procedures (child protection/children in need).
- Misuse of child protection procedures (no Initial Child Protection Conference (ICPC) for Child Z and no explanation why.
- Poor quality of assessments at every level.
- Case planning needs to focus on the child and expected outcomes which demonstrate that the child is thriving.

#### A Key Comment in this Review:

'A poor environment and low expectations of a family should not be dismissed as the norm for the area.' The assessment must be undertaken from the child's prospective.

#### Executive Summary Useful For:

Universal Health Services – GP  
Maternity  
Health Visiting  
  
Early Years  
CYPSC  
Police  
Connexions  
Housing

<b>5. Child H and Child I Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Manchester</b>	<b>2009</b>

Summary:

In November 2008 Miss A (aged 21) was described as displaying bizarre behaviour. Her GP was informed of concerns and he contacted the Police. When the GP realised that the Police would not respond immediately and due to the level of concern the GP undertook a home visit. Miss A was not at home. On the same day both children were found in the family home (aged 2 years and 4 months). They had been stabbed to death.

Miss A was detained under Section 2 of the Mental Health Act. She later pleaded guilty of manslaughter on the grounds of diminished responsibility.

Key Findings:

- The need to use and understand support networks within the family.
- Health workers were unaware of self harm and attempted suicide in her first pregnancy.
- Miss A had previously been a Looked After Child (LAC).
- Her grandmother died a few days before the birth of her first child. She was seen by a psychiatrist.
- Appeared to cope well with her first child.
- Combined motherhood with University and received support with this.
- Miss A made a significant cry for help when she found she was pregnant for the second time.
- There were a number of referrals to CYPSC. A Core Assessment was undertaken, the case proceeded as a child in need (of support).
- Domestic abuse does not come out in the Executive Summary but is evident through the multiple recommendations.

Executive Summary Useful For:

Education (University)  
Housing  
Universal Health Services – GP  
  Maternity  
  Health Visiting  
  Psychiatry  
  Walk In Centres  
  
Connexions

Early Years  
Police  
CYPSC  
Third Sector Services

<b>6. Child S Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Lancashire</b>	<b>Not stated</b>

Summary:

The mother of Child S had been a LAC for most of her 17 years of life, described as being in a stable placement. The review indicates that, although the foster placement was stable, there were significant events in this young mother's life which impacted on her emotional development and behaviour.

The leaving care plan was initially on track for her to remain with her long term foster cares. During this time she became pregnant and decided on a termination. At some point her foster parents requested that she leave the family home due to her abusive behaviour.

Over the next 3 to 4 years what is described is a very chaotic lifestyle and destructive downward spiral. The After Care Team (ACT) were aware of a number of key risk factors which identified this individual as a very vulnerable young women. Contact with the Police and alcohol related incidents are a key feature.

Key Issues:

- Once aged 21 the review suggests that she was 'swiftly removed from the ACT caseload. When she became pregnant there was a failure to undertake a comprehensive assessment of needs.
- The Health Visiting records stated that this mother was not receptive to the information highlighted to her around the prevention of cot death.
- The importance of information sharing and the need to consider historical information alongside current information.
- This mother was known by some agencies to drink regularly, perhaps heavily. This information was not considered as a risk to the child.
- This child died as a result of 'overlay' by mother.
- Concerns were known about this mother but were not acted upon.

Executive Summary Useful For:

Universal Health Services – Health Visiting  
 Maternity  
 GP  
 LAC Health Team

CYPSC – Pathway Planning  
 LAC Team  
 Independent Reviewing Officers

<b>7. Baby M Case Summary</b>	
<b>LSCB</b>	<b>DATE REVIEW COMPLETED</b>
<b>Lancashire</b>	<b>Not stated</b>

Summary:

This baby who died aged 7 weeks was admitted to hospital aged 6 weeks with a urinary tract infection. The child was declared fit for discharge. On the day of discharge the child collapsed in hospital whilst in the care of his father. Baby M was resuscitated but died a few days later.

The post mortem revealed multiple fractures of varying ages.

Key Findings:

- Young parents in a continuing relationship (under 18 years).
- Significant issues in Baby M's mother's life (left home at 13 years, problems with step-father).
- Agencies held considerable historical information on the extended family.
- Baby M and her mother should have been identified as children in need with a multi-agency assessment in place.
- Father of Baby M did not feature in any assessments.

Executive Summary Useful For:

Education  
 Universal Health Services – Maternity  
 Health Visiting  
 CAMHS

Note: This Executive Summary was difficult to précis as a full picture is not provided.

<b>8. Baby HA Case Summary</b>	
<b>LSCB</b>	<b>DATE OF REVIEW COMPLETED</b>
<b>Herefordshire</b>	<b>Not stated</b>

Summary:

Baby HA died aged 6 weeks, the cause of death was not conclusive; a fracture of the skull was identified with overlay and asphyxiation. The fractured skull may have occurred up to 3 days prior to death.

This review looked at information dating back to 1998, it included all HA's siblings and the 3 key adults. All 3 adults were long standing chronic drug users. HA's mother was described as an articulate, anxious young women able to ask for support. Past domestic violence issues from a previous partner were known and one child had been subject to a child protection plan in 2004 with issues around substance misuse and domestic violence.

Key Issues:

- Lack of child focus
- Lack of consideration of substance misuse on children
- Chronic poor school attendance
- Lack of knowledge and focus on the children's father.
- Poor information sharing by substance misuse services.
- The children were 'invisible' to the adult services.
- Lack of consideration to review/use the child protection/child in need procedures.
- Adult services must see 'the adult' as a parent and consider the impact on the child and family.
- A general lack of understanding of children in the environment of longstanding drug misuse.

Executive Summary Useful For:

Universal Health Services – Health Visiting  
 Maternity  
 Substance Misuse Services, all  
 Education  
 All Substance Misuse Services  
 CYPSC

<b>9. Child AB Case Summary</b>	
<b>LSCB</b>	<b>DATE OF REVIEW COMPLETED</b>
<b>Lancashire</b>	<b>2010</b>

Summary:

Child AB was a 15 month old male, pronounced dead in hospital. The post mortem identified two intracranial bleeds (possibly from impact injuries), a fractured skull and two minor bruises to his face and toe. Mother's partner was charged with murder and 26 counts of child cruelty. There was no suggestion that AB's mother was aware of the abuse to her son.

There were previous concerns about mum and two older children in a different geographical area. Professionals held little information about mother's partner but no previous concerns were found. The two older children were not with mum and were subject to residence orders.

When AB was born the midwife made a referral to CYPSC due to previous concerns about mum's older children and post natal depression. Parenting skills and support services were put in place. The case was closed March 2009 as mum was described as coping well and her previous partner had left the family home. The review identified that the perpetrator of the abuse on AB was a significant figure in the family home in February 2009. None of the involved professionals had identified this.

In September 2009 AB was admitted to hospital with vomiting and bruising to AB's hand was noted. He was discharged following medical assessment. AB was admitted in November following a possible 'fit' and was pronounced dead.

Key Issues:

- AB's mother had a pattern of relationships with inappropriate men and repeated victimisation.
- Professional assessments were viewed as static rather than dynamic tools.
- Gaps in inter-agency working increased by the need to consider information held in another county.
- Medical staff not considering AB's presentation in September being possibly related to abuse.
- Lack of child focus.
- Workers being 'over optimistic' about circumstances needing to be more balanced/evidence based.
- No preventative work with mother around domestic violence.

- Missed opportunities to re-assess AB's circumstances.
- Lack of a collaborative approach between two CYPSC authorities.
- GP missed an opportunity to consider AB's presentation in September (the review felt that the GP should have spoken to the Health Visitor and CYPSC at that point).
- The hospital also missed the possibility of exploring the child's background and family in September.

Executive Summary Useful For:

CYPSC

Universal Health Services – Maternity  
Health Visiting  
GP  
Acute Trust Staff

Domestic Abuse Services

Police

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