Briefings from Serious Case Reviews (SCRs) in child protection

**Health Policy team**

NSPCC

Serious Case Reviews (SCR) in child protection have been identified and compiled by NSPCC and Knowledge and Information for the RCPCH. They are relevant to all paediatricians and key points have been outlined in bold.

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Executive summary of a review into the death of an eight-week-old baby boy in March 2012 from a significant head injury. Post mortem examination revealed blunt trauma injuries to head, abdomen, back and limbs and rib fractures of differing ages. Both parents were arrested on suspicion of murder. Both parents had troubled childhoods, characterised by: offending, aggressive and violent behaviour, school absence, and contact with adolescent mental health services. Mother was sexually abused as a child and father spent time on the child protection register for emotional and physical abuse.

Issues identified include: midwives' practice of not accessing fathers’ medical records due to a misunderstanding of data protection laws; midwives' over reliance on information volunteered by parents; insufficient consideration of the impact of parents' traumatic childhoods on their parenting capacity; Responsible Paediatrician's failure to identify significant child abuse injuries; and inability of the police Lead Investigator to challenge the Responsible Paediatrician. Makes recommendations covering health and police services.


Death of a five-month-old baby boy in June 2012 as the result of florid rickets caused by severe vitamin D deficiency. Following Baby F's death parents reported that he had been unwell for three days and not feeding; both pleaded guilty to manslaughter. Following his birth, parents initially refused consent to medical treatment for Baby F, leading to children's services involvement. It is assumed that the parents' spiritual beliefs informed their refusal to treatment however this was denied by both parents at the time.

Issues identified include: mother's late booking and declining of screening during pregnancy; failure to address the impact on the health of Baby F of mother's vegan diet and increased risk of vitamin D deficiency as a black African woman; and lack of professional curiosity in relation to parents' extreme spiritual beliefs. Identifies learning from the case, including: the need for all agencies to consider the tension between remaining sensitive to equality and diversity issues and safeguarding children. Makes various single agency and multi-agency recommendations:

- Good practice to involve paediatrician in post-natal care when there is a lack of pre-birth history;
- Good practice for paediatrician to be closely involved with parents in the days after birth when the baby’s condition was worsening;
- The paediatrician was omitted from the strategy discussion and valuable information could have been missed from the discussion;
- Need for all people involved in the care of vulnerable and/or sick children to follow-up DNA.

Summary of a review into the death of 1-year-old girl in July 2012, as the result of non-accidental injury. C2 sustained injuries whilst in the care of mother's partner, A2. A2 was convicted of murder and sentenced to life imprisonment. Family were known to a significant number of agencies including a number of health services in different hospital settings. In the month prior to her death, C2 attended hospital with a head injury and what was identified as a possible bite mark, considered to be non-accidental. A Section 47 investigation was progressed but assessments did not involve all agencies with knowledge of the family and the case was closed. A2 had a previous conviction for criminal damage and possession of an offensive weapon, relating to an incident of domestic abuse with an ex-partner.

Identifies lessons including: insufficient professional curiosity; lack of professional challenge; and need for robust and clear escalation procedures where there is disagreement between agencies. Makes recommendations including the review of the arrangements for taking photographs of possible injuries to ensure medical staff have access to this service at all reasonable times.

Specific learning points for paediatricians:

- Clinical photographs need to be taken as near the time of injury as possible to record the greatest detail.
- There needs to be a shared understanding between health, police and social care about arrangements for discharge and after-care. These need to be communicated clearly to the parents.
- Need to consider the impact of a discharge made late in the evening on a very young child.
- Lessons were identified for reporting, amending and communicating radiology reports to ensure prompt and accurate diagnoses.
- Need to bear in mind previous hospital admissions and consider the likelihood of NAI when treating seriously ill children.


Executive summary of a review into the physical, emotional and developmental neglect of a 3-year-old-girl and her siblings. Abigail presented to hospital with serious concerns about her health and development in November 2012. Parents were charged with criminal neglect and Abigail and her siblings were placed in foster care. Family were well known to a number of agencies and there was a history of professional concerns relating to abuse and neglect. Both parents had significant physical and mental health problems requiring a high level of contact with health professionals.

Identifies learning in relation to five key themes, including: limitations of an incident led approach to child neglect; need for professionals to feel valued and listened to and need
for professional challenge; and the impact of professionals feeling overwhelmed or desensitised and the challenge of disguised compliance. Makes recommendations including Gloucestershire Safeguarding Children Board to undertake an audit of assessments and child in need and child protection plans to ensure that the child's voice is heard and taken into account. Review was undertaken using the Significant Incident Learning Process (SILP).

Specific learning points for paediatricians:

- Good practice with regard to professional challenge identified from doctors in secondary care.


Death of an 8-year-old boy in April 2013, as the result of an asthma attack. Child H and his siblings were the subjects of a child protection plan under the category of emotional abuse at the time of the incident. Child H was diagnosed with moderate/severe asthma at 2-years-old and experienced problems with his eyesight, tooth decay, nosebleeds and enuresis. Issues identified include: paternal alcohol misuse; maternal depression; prolific domestic abuse; family debt and housing problems; missed medical appointments; and impact of mother's smoking, home environment and stress associated with witnessing domestic abuse on Child H's asthma. Uses some elements of the Social Care Institute for Excellence (SCIE) systems model to present key learning.

Makes various recommendations, including: **children subject to a child protection plan should have an individual Health Plan; the impact of stress on asthma should be considered during risk assessments, particularly for children living with domestic abuse and parental alcohol misuse;** and early consideration of the use of legal processes to clarify and restrict contact should be employed where appropriate.

Specific learning points for paediatricians:

- Need to ensure there is follow-up for children who are subject to child protection plans who miss medical appointments.

Serious injury of a 4-month-old baby boy in February 2012. EN12 was admitted to hospital with significant and chronic bleeds to the head and fractures to his ribs, shoulder blade and legs. Father was sentenced to three years, three months in prison; mother accepted a caution. EN12 is the subject of ongoing care proceedings; he has been placed with foster carers and plans for adoption are being sought. Father was well known to children's social care whilst he was in relationships with two previous partners. In 2003 father was suspected of causing bruising to his eldest daughter who was subsequently made the subject of a child protection plan. In 2009, he was suspected of harming his second child, who was subsequently made subject to a child in need plan. Paternal history of drug and alcohol misuse and offending. Maternal history of physically abusive relationships.

Identifies learning, including: the challenge for health organisations in identifying and tracking men who have dangerous histories as information is held on the files of their female victims and not easily accessible; and the need for recognition of the impact that parents can have on professionals and how this can affect their practice and ability to challenge and confront parents. Makes various recommendations for children’s social care, police and health services.

Specific learning points for paediatricians:

- Need to understand the significance of bruising on non-mobile babies and the importance of referring such cases to children’s social care with full and accurate information.
- Need to assess and interpret parental avoidance and missed appointments.
- Review record keeping and consider a mandatory template which ensures a ‘problem’ remains active until positively ‘resolved’.
- Be aware of correct procedures in the event of a GP (or other) referral of suspected non-life threatening NAI.


Death of a five-month-old boy in May 2012, as a result of serious, non-accidental injuries. Father was charged with murder and subsequently pleaded guilty to manslaughter. DD12 was born with a heart defect requiring continuing medical support. Application for an emergency protection order was made several months before DD12’s death following identification of significant bruising to his penis during a hospital visit. The injury was subsequently ruled accidental and the application dismissed.

Identifies themes, missed opportunities and lessons learned, including: the emotional needs of families with children with complex medical needs should be assessed and responded to; and professionals should not treat court decisions as undisputable statements of the truth. Makes various interagency and single agency recommendations, including: clear advice should be given to magistrates to help them assess emergency applications; and families of children with complex needs should, with their agreement, be subject to a Common Assessment Framework (CAF).

Specific learning points for paediatricians:
• More training in medical examinations in cases of suspected child abuse, specifically injuries in non-mobile babies and the process for escalating concerns.
• Include clinical photographs in all formal child protection reports.
• Develop procedures to address continuity of consultant care and senior medical input for the duration of child protection cases.
• It is not always good practice to separate out paediatric and child protection examinations – it can be distressing for an older child to be examined more than is necessary.


Summary of a review into the serious injury of a 9-year-old British boy of Bangladeshi ethnic origin, in March 2013. Child W3 presented to accident and emergency on two separate occasions with multiple injuries believed to be caused by a knife. Mother was arrested and charged with wounding her son; Crown Prosecution Service later decided there was insufficient evidence to prosecute. Family were well known to children's social care and were in receipt of services from over 20 different agencies. W3 and his 5 siblings, two of whom had additional needs, were subject to Child Protection Plans for a period prior to the incident. Significant history of domestic abuse allegedly perpetrated by mother and father.

Issues identified include: mother's domineering and demanding behaviour eclipsing children's wishes and needs; father's level of spoken English impeding his ability to communicate with agencies; and response of agencies made more challenging by the number of children in the household and the substantial number of agencies involved with the family. Identifies lessons learnt, including: the views of children and fathers are of critical importance in providing an holistic picture of a family; and parental insistence about a child's special needs should not supplant evidence-based, multi-agency assessments. Makes various recommendations covering children's social care, health services, school and police services.

Specific learning points for paediatricians:

• Establish with A&E an effective system for flagging children who are subject to child protection plans.
• Make sure there is joint planning with other agencies prior to discharge.


Serious injury of a 4-year-old girl of mixed heritage, in March 2013. Zara was admitted to hospital suffering from stomach pains. Ruptures to her duodenum, thought to be non-accidental, were identified following surgery. Criminal charges have been brought against suspected perpetrators (not mother). Maternal history of challenging behaviour, drug misuse, social isolation, financial problems and homelessness. Paternal history of drug misuse, prolific offending and imprisonment. Family were known to a number of agencies, including children's social care, housing services, police and probation services. Approximately a year
prior to the incident, mother was the victim of what the Police described as a racially aggravated common assault, which included a threat to burn mother's flat down with Zara inside.

Issues identified include: mother's intelligence, unusually good level of education and articulacy diverting the attention of professionals; insufficient exploration of the impact of ethnic, cultural and religious factors; assessments being treated in isolation leading to a limited understanding of cumulative risk; and insufficient exploration of the significance and impact of father. Uses some elements of the Learning Together methodology. Makes recommendations, covering early years services, schools, children's social care, health visiting, housing and rent collection services, probation, hospitals and GPs.

Specific learning points for paediatricians:

- Make sure that GP lists are available in all paediatric clinical areas.


Serious head injury of a four-month-old boy in June 2013. Baby T had attended hospital 6-weeks prior to the incident with bruising, strongly suspected to be non-accidental. Mother and father did not live together and mother claimed to be the sole carer for Baby T leading up to this incident. A subsequent Working Agreement named father as the parent with supervisory responsibility for all contact with Baby T and his three siblings. All four children were the subjects of a child protection plan at the time of the incident. Mother and father were arrested and later admitted causing or allowing physical harm; they received a Community Order and suspended sentence respectively. Family were known only to universal services prior to the first incident. Father had a long history of mental health problems including chronic and severe anxiety and depression. The depth of father's mental health problems, as told to his GP, were not known by mother or children's social care.

Identifies systemic learning and uses the Significant Incident Learning Process (SILP) model to pose questions relating to thematic learning, covering: low GP attendance at child protection conferences and the implications of a series of strategy discussions or conversations replacing formal, face-to-face strategy meetings. Makes various interagency and single agency recommendations.

Specific learning points for paediatricians:

- Consider formally recording discussions which take place during a medical supervision meeting where safeguarding concerns are identified.
- All paediatric medical staff need to document that they have read and understood the nature of safeguarding concerns affecting the child they are treating.
- Make sure that body-map used to document injuries is included in reports for dissemination at child protection conferences.

Death of a three-month-old baby boy, presented to hospital unconscious and not breathing, in January 2013. Baby F’s father was arrested on suspicion of murder and bailed without charge. Baby F’s parents were both Polish and had been living in the United Kingdom for six years; both had two older children from previous relationships who were all residing in Poland at the time of the incident.

Issues identified include: access to interpreter services and the impact on communication between parents and services; difference in cultural approaches to possible non-accidental injuries between hospital and police staff; the inability of professionals to identify when a strategy meeting is required; and where opinion of cause of injury is unknown or conflicting, professionals should proceed as if injuries are inflicted. Makes various interagency and single agency recommendations, covering children's services and health services.


Death of a 22-month-old baby boy from a serious head injury in November 2010. Mother and father were arrested; father later pleaded guilty to child neglect and received a 15-month custodial sentence. Maternal history of: troubled upbringing; behavioural issues at school; alcohol and drug misuse; depression; housing and debt problems; and one known suicide attempt. Children’s services received several referrals in relation to Child Y, including one in 2009, when a nurse practitioner noticed bruising to his cheek and forehead during a routine vaccination visit. The paediatrician who examined Child Y accepted the parents' explanations for his injuries and no further action was taken.

Issues identified include: missed opportunities for assessment and insufficient communication and coordination between agencies; impact of emotional and mental ill health on parenting capacity; impact of persistent housing concerns and debt on mother's wellbeing; lack of professional curiosity and challenge; and allegations from mother deflecting agencies' attention away from children. Makes various interagency and single agency recommendations covering health services, children's services and police.


Three month old child admitted to hospital with severe injuries caused by shaking.

- Lack of professional inquisitiveness, including by paediatrician.

Serious injury of a two-year-old boy admitted to hospital with non-accidental injuries. Child E was diagnosed with a serious medical condition at 12 months and hospitalised for 9 months, after which he received continued intervention from community and hospital health professionals. Child E was living at home with his parents and 2 older half siblings at the time of the incident, all of whom were subject to child protection plans. History of domestic violence in mothers' previous relationships. Mother became pregnant during Child E's time in hospital and subsequently agreed to place the baby for adoption.

Issues identified include: taking an holistic approach to assessment, considering changes in family circumstances; the complex nature of a serious illness deflecting from child protection concerns; and cross-boundary safeguarding procedures. Makes recommendations for multi-disciplinary training in working with complexity and uncertainty, use of effective challenge and maintaining professional scepticism.

This case highlighted that when a paediatrician is unable to state definitively that the injuries were caused deliberately, it can cause confusion and lack of clarity for other professionals about how to respond. In the context of the injuries being "likely to be non accidental or acquired because of lack of supervision?, the Police may not have been able to pursue a prosecution, but this statement should have prompted a more protective response from Social Care.

Child J. Ceredigion: Ceredigion Local Safeguarding Children Board (2012)

Summary of review into the non-accidental injuries sustained to a baby (age unspecified) in 2007. Child was made subject to care proceedings along with two older siblings. Children made around 60 visits to GPs, Accident and Emergency and paediatrics over a four year period - on 13 occasions bruising or suspicious marks were noted and on two occasions abuse was suspected.

Review emphasises the need to regard bruising to non-mobile babies with suspicion and recommends that photographs are taken as part of initial clinical assessments in cases where marks/injuries are potentially non-accidental. As a result of the review, changes have been made to better support hospital staff through weekly meetings with social services.


Death of a 3-year-old boy in January 2011. Child B, who had a severely disabling medical condition, was taken to hospital with multiple injuries and pronounced dead on arrival. A post-mortem examination found 36 separate injuries including a fracture to the right tibia, bruising to the liver and a significant bleed to the brain. Mother’s partner was subsequently convicted
of manslaughter; mother accepted a caution for perverting the course of justice.

Issues identified include: child B's severely disabling medical condition; and mother's social isolation, separation from child's father and new relationship with a man unknown to professionals. Recommendations include: health visitors should have a working knowledge of services available to families with a disabled child; health agencies should adopt the application of the Common Assessment Framework in cases involving children with disabilities; schools should follow up unexplained absences; and awareness should be raised of the vulnerability to abuse of children with disabilities.

Overall, there was a lack of “respectful uncertainty” (Lord Laming’s phrase) reminding those dealing with children of the importance of keeping an open mind about possible child protection issues. There does not seem to have been any consideration here of the possibility of deliberate injury.

**Child A. Kingston Upon Thames: Surrey Safeguarding Children Board (2010)**

Review into the death of a 17.5 year old in March 2008 who took her own life (by hanging) while an inpatient at a private psychiatric unit. Child A had a history of psychiatric problems, including 3 periods as an inpatient. Family had been receiving support from a range of agencies including adult mental health, child and adolescent mental health services (CAMHS), social care, special educational needs and specialist paediatric services. Finds that adult mental health services were slow to recognise the impact of mother's mental health difficulties on her daughter.

Recommends that staff in CAMHS work more closely with mentally ill adults and contact adult mental health services for further details if they are concerned about a child. Risk assessment was not well coordinated. Recommends that in complex cases involving multiple agencies a lead professional should be appointed. Also recommends: GPs must fully record child protection concerns and anything that may affect parenting capacity; and a thorough risk assessment must be undertaken when a parent(s) discharges a child from psychiatric care (or similar) against medical advice. Need for clear pathways for specialist assistance, including paediatric help, in cases where a child or young person presents at hospital with signs of self-harm.

External links
Full reports of each on NSPCC website