Torbay Safeguarding Children Partnership

NSPCC Repository – August 2021

In August 2021 eight case reviews were published to the NSPCC Repository featuring a number of issues including child sexual exploitation, young offenders and suicide. A summary of each of these cases can be found below:

1. Serious case review: Child I (full overview report)

Death of a 16-year-old child from natural causes whilst in custody at a Young Offender Institution. Review does not consider the circumstances of Child I's death. Child I lived with his mother, father and older sibling. For much of his childhood there were no known concerns but after transition to secondary school difficulties rapidly emerged. History of school exclusions, violence, theft, carrying weapons; arrested several times in possession of Class A drugs. Child I was placed in foster care and later entered Local Authority care under a voluntary section 20 agreement. At the time of his death, Child I was on remand for murder. Child I was a Black child.

Learning includes: practitioners need to recognise 'subtle moments' that might present clear opportunities to help and protect a child; where children are identified as needing early help, it is important that parents and carers fully understand what this involves in respect of a coordinated, multi-agency approach to help and protection.

Recommendations include: ensure that policy, procedure and practice relating to critical moments (both well established and those less obvious) is sufficiently robust to ensure effective safety planning; work with schools to ensure that they are able to identify children who show persistent behavioural difficulties; ensure that a multi-agency response to the persistent disruptive behaviour of children is sufficiently described in threshold tools; explore with primary and secondary schools how multi-agency involvement could be improved both prior to and at the point decisions are being made about permanent exclusions.

Other resources Read full overview (PDF)

2. Local child safeguarding practice review report: Children: Q and R: Date of significant incidents: December 2020

Serious injuries to two unrelated children, Child Q aged 4-years-old and Child R aged 7-weeks-old, whilst in their parents' care in December 2020. In both these cases there was some professional disagreement about whether the injuries sustained were non-accidental, with paediatricians believing that the injuries in both cases were likely to be non-accidental. The families involved in these cases were both known to children's social care prior to the children's injuries. Professionals made several referrals to children's social care but these often did not meet the threshold for statutory intervention. Both cases featured recent and historic domestic abuse and historic safeguarding concerns. Mothers had experienced adverse childhood experiences and mental health problems. Disguised compliance and a lack of professional curiosity were also features in these

cases, as well as issues around hidden men. Child Q was of a mixed background and Child R was mixed Black and White ethnicity.

Learning includes: there was a lack of clarity about the men involved in the children's lives; domestic abuse didn't appear to have been considered by professionals; and there was disagreement between medical and children's social care professionals about the cause of the injuries.

Recommendations include: decision making at strategy meetings should include all appropriate agencies; the children's workforce should feel confident recognising potential non-accidental injuries; and the development of a practitioner forum should be considered, where medical and social care staff can gain an understanding of each other's roles.

Other resources Read full overview (PDF)

3. Local child safeguarding practice review: Leo

Death of a 9-year-old boy in June 2019. Leo was found unresponsive in the family home, and taken to hospital where he was pronounced dead. Leo died from bacterial meningitis and orbital cellulitis and had been unwell for six days prior to his death. A police investigation for neglect concluded that the cause of death was due to natural causes. Leo and Sibling 1 were subject to a child in need plan, due to concerns regarding neglect and unsatisfactory home conditions. The family were receiving support from several services and the children's school. Leo and his father had a history of physical health issues and Mother had mental health issues. Leo was of White British and American heritage.

Learning includes: social workers should take the “think wider family approach”, considering all members of the family or household to assess their impact on the whole family; professionals should be involved in multi-agency meetings, including healthcare professionals, to ensure effective plans are in place; when families are living in poverty focus needs to remain on the cause and impact of poverty on the children, and professionals should escalate cases where families' access to funds and services is not sufficient; children's services and partners should use specialist assessment tools in cases of neglect to quantify need and measure perceived improvements or deteriorations; when an adult or child is recognised as a carer, the full extent of their role and its impact should be clearly articulated in assessments and shared with partners.

Makes no formal recommendations.

Other resources Read practice review (PDF)

4. Child Safeguarding Practice Review: Child C

Death of a 16-year-old girl in 2018, assumed to be suicide. Child C had experienced adverse childhood experiences, including sexual abuse, and was believed to be at risk of exploitation. History of self-harm and had spoken about ending her life from time-to-time since 8-years-old. Child C was known to the universal services, Police, Children's Social Care, Child and Adolescent Mental Health Service (CAMHS) and local voluntary agencies. In July 2016, she was made subject to a child protection plan under the category of sexual

abuse which includes sexual exploitation, until March 2017. In 2018, she stayed in a specialist facility for young people with mental health problems. Diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at 15-years-old. Ethnicity or nationality not stated.

Learning includes: it's essential that practitioners understand parental capacity, strengths and attitudes to increase the effectiveness of interventions and avoid placing additional stress on children and their families; child sexual exploitation (CSE) requires a different focus from other forms of child abuse; adolescents can be exposed to a wider range of risks than younger children and concentrating on a single issue may lead to an over optimistic assessment of risk; assessments should include listening and responding to children's views.

Recommendations include: develop a research-based risk management strategy designed to address the specific features of adolescent risk taking and suicidal ideation; promote the concept of “contextual safeguarding” and ensure that it is adopted by practitioners and managers working within the child protection process.

Other resources Read practice review (PDF)

5. Everybody’s business: keeping children safe in school: a serious case review into events at St Paul’s School (full overview report)

Review commissioned in April 2017 following five convictions for sexual offences of adults who had previously worked at St Paul's School London. Allegations had also been made against 32 ex-staff members and there had been recent involvement from the police, local authority, health professionals and Local Safeguarding Children Board (LSCB) with the school. Alleged offences had taken place from early 1960s onwards with many relating to the 1970s and 1980s. Sixteen of the alleged perpetrators were deceased. Fifty-nine ex-pupils were seen by the lead reviewers. Attendance at the school ranged from pupils who started in 1953 through to those who left in 2015. Six of the 59 ex-pupils seen were victims of perpetrators who stood trial. Ethnicity and nationality not stated.

Findings include: accepting responsibility for past abuse must be a foundation for moving forward and developing an effective safeguarding culture; schools face difficulties in balancing a response to allegations of abuse that takes account of employment law, education legislation and good safeguarding practice; there are gaps in the national safeguarding system in relation to the recruitment and regulation of teachers, the Disclosure and Barring Service and the way in which information is shared across national organisations.

Recommendations include: Charity Commission should make explicit their expectations regarding best practice at times of crisis and specifically that protecting the reputation of the charity includes openness and honesty about any poor practice; Home Office should establish a system of advocacy and support for complainants in child sexual abuse cases both pre- and post-trial to ensure consistency between areas.

Other resources View report online

6. Serious case review executive summary in relation to three children HH, II and JJ

Sexual assault of a child and possession of indecent images in August 2015. One of Child HH, II and JJ who were 6, 3 and 1-years-old respectively, were sexually assaulted by their father Mr A. In 2008 Mr A was sentenced to prison for the possession of indecent photographs and videos, and was ordered to register as a sex offender for ten years. At this time Mr and Mrs A did not have children. Six months later Child HH was born and made subject to a child protection plan. Mr A was considered a High Risk Offender and monitoring software was installed on his laptop. In August 2015, police received intelligence that Mr A was using an online chat room dedicated to child sexual abuse. He was convicted for this behaviour and a serious contact offence against one of his children. Ethnicity and nationality not stated.

Learning includes: the lack of certainty in the assessment of those who access indecent images of children; the danger of relying on earlier assessments without reviewing them with agencies involved; the importance of identifying what changes in an offender or their situation might lead to that offender being assessed as presenting a greater risk of carrying out harmful behaviour.

Recommendations include: work with other bodies to review the approach to families in which a member has committed offences in relation to online indecent images of children; ensure that professional staff have sufficient skills and knowledge to work with those who access indecent images of children online and their families.

Other resources Read executive summary (PDF)

7. Child safeguarding practice review - Khalsa

Unexpected death from bronchial asthma of Khalsa, a 14-year-old boy, in October 2019. Khalsa had received medical care for acute asthma since he was 3-4-years- old and was admitted to hospital three times in the two years prior to his death. Khalsa was raised by his father following the death of his mother when he was 7-years -old. He lived with his father and three older adult siblings. Concerns raised by Khalsa's general practitioner about the management of his asthma and his father's understanding of how to support his son led to Khalsa being made the subject of a Child in Need Plan. A pattern of cancelling and rescheduling appointments by Khalsa's father was noted, however he was otherwise well cared for. Khalsa was raised within the Sikh faith.

Key findings include: communication between multiple medical services and trusts did not allow practitioners to understand and contribute to the risk discussion; the need to create systems that enable young people to have a voice to participate in their health plans, specifically when this may be overridden by parental influence; the perception of asthma as not being potentially life threatening can impact on how some professionals engage in professional curiosity.

Recommendations include: ensure timely information sharing between multiple universal services and acute hospital trusts; and increase awareness of asthma and its management across agencies and communities.

Other resources Read practice review (PDF)

8. Child A: serious case review: report into the injury of Child A (full overview report)

Injury and acute illness of a 6-month-old boy, taken to hospital in March 2018. Hospital staff found that Child A had a fractured rib and was seriously underweight and malnourished with a throat abscess. Following hospital admission, Child A became the subject of a child protection enquiry and was put on a child protection plan for neglect. Child A was made the subject of an interim care order, and was placed in foster care once discharged from hospital. A police enquiry was started, but was concluded due to insufficient evidence for a conviction for Child A's injury. Mother and father had traumatic and abusive childhoods; both had an autistic spectrum disorder and mental health issues. Child A's ethnicity or nationality are not stated.

Learning includes: professionals should be able assess when to explore parental backgrounds, indicators of vulnerability, and adverse childhood experiences; training for practitioners in neurodiversity; how professionals should use feelings of unease or discomfort to inform assessment and decision making; the role of early help services in working with and supporting vulnerable families.

Recommendations include: strengthening professional training and screening on autistic spectrum disorder, ADHD and anxiety disorders, and what such difficulties mean for parents' understanding of information from health agencies; when children's services check if a child and their family are known to the service, the whole family and household should be included; reviewing the effectiveness of the mechanism for alerts to community health services of children attending accident and emergency and other urgent care NHS services.

Other resources Read full overview (PDF)