NSPCC Repository – October 2021

In October 2021 ten case reviews were published to the NSPCC Repository featuring a number of issues including adolescent parents, child sexual abuse and Fabricated or induced illness (FII)

1. Serious case review: overview report: Holly

Death of an 8-month-old girl in 2016. Holly was found unconscious and not breathing in the family home and was pronounced dead at hospital.

Learning includes: professionals should encourage parents to elaborate when conversations reveal stress factors that could affect their capacity to care for their children; family members being registered with different GP surgeries could be a weakness from a safeguarding perspective; pathways for support staff in managing the risk of not being able to see children at home would enable staff to persist in their follow-up with families where increased risk factors are identified; professionals ensure that vulnerabilities identified at an early stage in work with families reduce rather than increase over time; the safeguarding risk factors associated with babies and very young children, particularly that children under 1-years-old are the most likely age group to die through abuse or neglect.

Recommends that the safeguarding partnership ask agencies to provide evidence they have completed proposed actions and to summarise their impact.

Other resources Read full overview report (PDF)

2. Child safeguarding practice review (CSPR): TS

Sudden unexplained death of a 5-month-old baby. An expert witness concluded that TS's death met the criteria for a sudden infant death syndrome, but no criminal charges were made.

Learning includes: routine questions and assessments need to consider the relationship with all significant family members who are involved in the care of the child; social workers need to consider information held by all involved health professionals; professional curiosity about the child's lived experience including considering the impact of living between homes on babies; the Bruises and injuries in non-mobile children policy should be followed in all cases where a non-mobile child has injuries.

Recommendations include: ask the Department of Education and Department of Health to consider adding to guidance about routine questioning and assessments in domestic abuse whether any household members are experiencing domestic abuse in the child's home; consider how partner agencies can influence a cultural change regarding the role of fathers and secondary carers in the family.

Other resources Read CSPR (PDF)

3. Child safeguarding practice review (CSPR): Child Charlie

Death of a 16-week-old infant in early 2020 whilst in the care of their father. Cause of death is the subject of ongoing criminal investigation.

Learning includes: future safeguarding practice will be strengthened by: reviewing the governance of multi-agency safeguarding arrangements for responding to the needs of children living with domestic abuse, including developing a practice toolkit and information sharing arrangements; a focus on safe outcomes for children living with domestic abuse as opposed to an incident focused response; developing the culture of partnership working and therefore individual and collective accountability for safeguarding children; a partnership agreement and approach to share information and analyse the needs of children living with domestic abuse.

Learning identified by individual agencies will support them to safeguard children by strengthening capacity to: recognise and consider the impact of domestic abuse on babies/children; identify the needs of a child/family; reflect on the needs of a child/family.

Recommendations are embedded in the learning.

Other resources Read practice review (PDF)

4. Child safeguarding practice review (CSPR): Child Alex

Serious injuries to a 10-week-old infant in early 2020. Medical examinations determined that the injuries were caused by inflicted trauma.

Single agency learning includes: consistency of social worker to co-ordinate holistic and purposeful assessment of parenting capacity; robust supervision and management oversight to support social workers to reflect on progress of assessment and consider likelihood and severity of risks as well as strengths and protective factors; police officers should escalate their concerns about the action or inaction of another agency where they consider that a child remains at risk of significant harm; contemporaneous and comprehensive recording of discussions, plans and agreed actions for safeguarding and promoting the welfare of children, including discharge from hospital.

Learning across the partnership includes: understanding and defining levels of need/statutory threshold; there is further work to do to improve the effectiveness of multiagency strategy discussions; embracing and resolving professional differences as an opportunity to share expertise, evaluate need/risk and promote a culture of shared accountability; need for a clear process for transferring child in need cases between local authority children's social care services; shared accountability needs to operate at an individual, organisational and system level; the need for professional knowledge of safeguarding legislation, guidance and procedures.

Recommendations are embedded in the learning.

Other resources Read practice review (PDF)

5. Child safeguarding practice review (CSPR): Fred

Accidental overdose by a teenage boy who subsequently recovered in June 2020.

Learning includes: always consider the impact of domestic abuse and/or adult substance misuse or overdoses on children of all ages, especially when a child is directly affected; consider multiple incidents cumulatively as well as in isolation, and any contradictions between the child's expressed wishes and their lived experience; when undertaking S47 enquiries, preparing for initial child protection conferences or conducting assessments, obtain relevant information from GP records about all adults involved in children's care; need for awareness of the legal implications of a child being subject to a Special Guardianship Order (SGO) in terms of parental responsibility and potential eligibility for support services; consider calling a strategy meeting if a child under an SGO returns to parental care; need for practitioners to discuss concerns with the young person.

Recommendations include: ensure that a child's perspective on what being safe physically and emotionally means to them is a starting point for any plan to safeguard them and that thought is given about how multiple plans in use for any individual child could be explicitly linked or streamlined; promote the use of evidenced based tools to better support practitioners in understanding family dynamics and support for children including who is best placed to do any direct work with a child or young person; raise awareness of the legal implications of a child being subject to a Special Guardianship Order in terms of parental responsibility and potential eligibility for support services; ensure relevant information about adults involved in caring for children is obtained from GP records at all stages of the child's journey; ensure that the response to neglect adequately focuses on the needs of adolescents.

Other resources Read practice review (PDF)

6. Child safeguarding practice review (CSPR): Daniel

Life-changing injuries to a 17-year-old boy who was the victim of a shooting in March 2020. Daniel was a child in care at the time of the incident.

Learning includes: where concerns about a child have been identified and statutory agencies are involved, any significant changes in education that could have an impact on a child's safety or long term outcomes should be formally scrutinised by safeguarding partners; unless professionals are skilled in building relationships, being directive, supportive and non-judgemental in their work with parents, they are more likely to face resistance, ambivalence and disengagement; early intervention to prevent or disrupt involvement in street gangs, offending behaviours and youth violence needs to involve skilled and trained facilitators to work with young people.

Recommendations include: safeguarding partnership should urge the Department of Education to to set out a strategy for how it intends to improve residential care for looked after children in England; explore how schools and academies can be supported and

challenged, but also held to account, by partner agencies when there is evidence that school exclusions or non-attendance is placing, or would place, a vulnerable child at greater risk.

Other resources Read practice review (PDF)

7. Child safeguarding practice review (CSPR): Charlie

Overdose of medication by an adolescent girl in 2019. Charlie's mother was found unconscious by ambulance services after taking a drug overdose and had reportedly given Charlie tablets. Family were known to health services and children's services. Mother had problematic drug issues, using prescription opioids and illicitly obtained drugs. Charlie had a history of poor school attendance and repeated hospital attendances and was suspected to have been the subject of fabricated or induced illness (FII). Ethnicity or nationality are not stated.

Learning is embedded within the review.

Recommendations include: review data to benchmark the number of families with children who could be affected by parental opioid prescribing; parental substance misuse guidance should include further guidance regarding safeguarding concerns arising from parental dependence on prescribed drugs; a designated doctor review Charlie's medical records to establish lessons on identifying and responding to indicators of FII, particularly in older children and adolescents; agencies identify how to improve practitioner engagement with fathers in safeguarding and child protection work; regular dip-sample audits of cases where child protection enquiries have concluded with substantiated concerns but where the decision was made not to proceed to a child protection conference.

Other resources Read practice review (PDF)

8. Learning from Amy

Disclosure of sexual abuse by a 12-year-old girl who gave birth as a result of rape. Amy was sexually abused by her mother's partner and disclosed her abuse following the arrest of the partner due to allegations of physical abuse against Amy's brother. Following these incidents Amy and her siblings were placed in care. Various agencies had previously been in contact with the family due to allegations and concerns around violence, lack of care, and lack of safety and security. Amy's ethnicity or nationality are not stated.

Learning includes: agencies not recognising and responding to issues of coercive and controlling behaviour; agencies not putting the child first; agencies not recognising anger in a child as an appropriate response to trauma; agencies failing to provide effective advocacy for the child.

Recommendations include: when a new adult joins a family, who are open to children's services and are deemed to be vulnerable, partner agencies should assess any risk of significant harm posed by this adult; children's services use information from all sources,

and use 'healthy scepticism and cautious optimism, when making decisions concerning families; front facing staff in health and social care receive training to identify indicators of coercive and controlling behaviour; children brought to an antenatal clinic should be seen on their own at some point on first appointment.

Other resources Read learning review (PDF)

9. Serious case review Child U (full overview report)

Death of a 3-month-old boy in 2017. Child U died after reportedly falling from his parent's bed onto the floor. A skull fracture was evident that had occurred around three to seven days prior to Child U's death. Following Child U's death, two of his siblings were made the subject of child protection plans and care proceedings. Child U lived with his mother, father and siblings. Prior to his death there were no safeguarding concerns about Child U or his siblings. Mother had a long-term dependency on a prescribed pain killer. Ethnicity or nationality are not stated. Uses the Significant Incident Learning Process (SILP) methodology.

Learning includes: the need for professionals to ask detailed questions about the use of prescribed or over the counter medication and consider the impact of any dependence on parenting, including the impact of withdrawal; the importance of information sharing about a parent's misuse of prescribed drugs; if there is a lack of certainty in a child protection case, considering a timely high-level meeting of professionals from the main agencies involved.

Recommendations include: local substance misuse training covers risks from prescription and over the counter drugs, and the need to share information; consider the government's review of prescription drugs to determine if findings can be used to strengthen local safeguarding practices.

Other resources Read full overview (PDF)

10. Serious case review C67 and C68: incident: 22nd January 2018 (full overview report)

Injuries to a 9-year-old girl in January 2018. C67 was taken to hospital after presenting at school with blood in her underwear. Medical examinations identified injuries to her bottom and vaginal area, with professionals judging the injuries non-accidental. Police investigation has been unable to ascertain how the injuries were caused and no one has been charged. C67 lived with her 12-year-old sibling C68 and their mother and father. There were concerns about parenting capacity and the home environment. C67 and C68 were made subject to child protection plans for neglect, which was later changed to risk of emotional harm. Both children displayed sexualised language and behaviour from an early age, but C68 changed his behaviour once in secondary school. Family is white British.

Learning includes: parents require effective education programmes that are delivered in a timely manner to assist them in effectively coping with family life and improve the lives of

children; there is a lack of confidence that decision making will be robust in similar cases where there has been a non-disclosure by a child but sexual abuse is suspected.

Recommendations include: review the current process of the allocation of parental education programmes (including Triple P) to ensure that they are delivered at the earliest opportunity; review and identify all available options to improve the current provision of services for adolescents with complex behavioural issues; review training and guidance in respect of non-disclosure issues in sexual abuse cases.

Other resources Read full overview (PDF)