NSPCC Repository – November 2021

In November 2021 nine case reviews were published to the NSPCC Repository featuring a number of issues including child sexual exploitation, shaking, and children in care

1. Child V; Child safeguarding practice review

Near-fatal knife injury to a 17-year-old boy in December 2020. Child V had been subject to a child protection plan until March 2020.

Learning includes: the need to view children who are not in school, especially those with Education, Health and Care Plans (EHCP), as high risk and requiring a safety network of agencies to work together; there is a need for professionals to improve their understanding of the impact of cumulative harm on an adolescent who is struggling to find a safe transition into adulthood; there is a need to ensure that the work already undertaken to develop a contextual safeguarding approach is strengthened to include a wider range of agencies; ensure that the child's voice is heard. Recommendations include: EHCP reviews must involve health and social care to ensure that there is a multi-agency approach to addressing the educational needs of the children; ensure that there is an effective multi-agency partnership approach to identify critical indicators of the risk of extrafamilial harm by applying contextual safeguarding principles; ensure that there is a process in place for regularly reviewing children being removed from a child protection plan without the outcomes being achieved; ensure that children who are out of school are given opportunities to voice their views of their situation.

Other resources Read practice review (PDF)

2. Child sexual exploitation thematic child safeguarding practice review

Review of five children, three now adults, two of whom were abused during the 2000s. Considers the impact of learning from two other case reviews carried out locally in 2015 and 2016. Most children in the review lived with domestic abuse, physical and emotional abuse and neglect for most of their lives. Three of the children had a combination of learning, physical disabilities and communication difficulties. In several of the cases children were raped, sexually assaulted, physically assaulted, afraid and anxious, forced to take drugs and alcohol, involved in criminal activity, homeless and lonely and isolated from family and friends. One child is of Asian heritage and four children are White British.

Learning includes: the two audits of recent cases recognised that the Ofsted improvement activity resulted in more regular formalised supervision by children's social care; it is clear that the complexity of the cases and the scale of the challenges involved in the work risks that the cases 'run the worker' rather than the other way around.

Recommendations include: recognise that drugs and alcohol are used as part of the grooming coercion and control of victims by perpetrators and that responses need to be developed to reflect this; that the additional vulnerability of disabled children is recognised and that services respond appropriately; that the outcome for children (and

their children) who become pregnant as a result of sexual exploitation or abuse is better understood and responded to.

Other resources Read practice review (PDF)

3. Baby D: Child safeguarding practice review

Injuries to a 4-month-old baby boy in 2019 inflicted by his mother who was mentally unwell.

Learning includes: there is some inconsistent understanding regarding statutory guidance in the child protection procedures about undertaking pre-birth assessments related to mental health risk factors; coordinated work, robust information sharing and effective strategic oversight will better ensure all children are safeguarded; children are best protected when the local system of management oversight in supervision and meetings is strong, resulting in well-coordinated risk assessments, interventions, and planning; professional curiosity is best supported when working with families and other professionals if there is a local culture of collaboration and professional challenge; confident and open practitioners work better with families if their professional views are challenged, and all practitioners at times struggle to communicate with some families; families do well when they have a good understanding of their rights and responsibilities, and can make informed choices.

Recommendations include: ensure that all local multi-agency pre-birth risk assessment tools and protocols and information sharing comply with child protection procedures and local guidance, and that staff are aware of, and trained, in using these; seek assurance of the quality of individual agency supervision and management oversight; consider how empowering staff and supervisors in exhibiting professional curiosity can be encouraged in training and supervision, so that staff feel confident to have challenging conversations.

Other resources Read practice review (PDF)

4. Child P1: Serious case review

Injuries to a 6-week-old child in July 2017, including a fractured skull and injuries characteristic of a shaking injury.

Learning includes: there were specific areas in which awareness of honour based violence may not have sufficiently informed practice; limited use of psychological assessments to inform subsequent assessments and decision making raises the possibility that practitioners may not pay sufficient attention to historic reports when carrying out assessments; the rule of optimism appeared to be influential; co-sleeping was a continuing concern; the role of GP practices in safeguarding children was weakened in this case by father being registered at different practice to mother and their children and father's practice being unaware of his children and the prior safeguarding measures.

Identifies good practice including: effective multi-agency working; psychological assessments of mother and father proved to be insightful.

Recommendations include: guidance on how the honour based violence apparent in the early years covered by this case review should be responded to; consider whether court ordered reports should be shared during and post court proceedings; request partner agencies to include the extent to which practitioners make appropriate use of historic reports and assessments in the quality assurance of case files; ensure that professional challenge becomes an integral element of safeguarding practice; ensure that pre-birth assessments are carried out in accordance with the agreed multi-agency policy; seek assurance from health providers regarding decision making on the level of service provided to families where there are safeguarding children concerns.

Other resources Read full overview (PDF)

5. Child X1: Serious case review (full overview report)

Sexual abuse and sexual exploitation of a girl whilst she was looked after by the local authority. Child X1 was one of several victims and the evidence from the disclosures resulted in the successful convictions of the perpetrators.

Learning includes: the completion of full family histories by professionals is not always given sufficient priority and that this has the potential to undermine the quality of risk assessments and associated planning for children who are looked after; a safe system in terms of placing children who cannot live with their parents will necessitate decision-making, which has a clear understanding of children's needs; although resources are a challenge for all local partnerships, if these are balanced by a strong focus on the needs of a child this has the best likelihood of allowing and supporting a child to grow up with consistent carers, and helping them to reach their potential; an approach that is based on contextual safeguarding and includes proactive investigation and evidence gathering as a means of tackling child sexual exploitation is core; when children request contraception, good principles of critical thinking need to be applied to ensure that indicators of risk are clearly articulated and responded to within the multi-agency safety plan; good practice indicates that information sharing and risk assessment are key, as is transparency, in planning for the young person within a multi-agency context.

Makes no recommendations but ask several questions to the safeguarding partnership.

Other resources Read full overview (PDF)

6. Lauren: Serious case review (full overview report)

Sexual abuse, sexual exploitation and rape of an adolescent girl over many years. Lauren was placed in foster care under an emergency protection order when she was 17-years-old.

Learning includes: the importance of an effective professional response to the sexual abuse and exploitation of children; the importance of recognising the specific needs of disabled children and young people and responding appropriately; recognising, assessing

and responding to adolescent neglect; understanding relational and developmental trauma; dealing with professional disputes and differences of opinion in ways that put the child and young person at the centre.

Recommendations include: sexual exploitation itself should be addressed directly instead of just focussing on addressing family difficulties or programmes designed to educate young people; ensure that there is a process in place whereby all children who are subject to a child in need or child protection plan because of sexual exploitation have a disruption plan in place which would be incorporated into these wider plans; professionals need to support young people and address their fears and reluctance, alongside recognising their capacity; consider how best to address victim blaming language; focus on restorative practice principles that foster and enhance partnership working and a culture where respectful professional challenge is productive and welcomed as the voice of a 'critical friend'.

Other resources Read full overview (PDF)

7. Baby Kate: Serious case review report (full overview report)

Death of a 10-month-old girl. Baby Kate died four days after admission to hospital with a serious head injury. Medical investigations also revealed a second injury. Father stated Baby Kate had an accidental fall whilst in his care. Father's explanations were not felt to be consistent with Baby Kate's injuries and her death was subject to a police investigation; no charges were made. Parents were known to agencies regarding substance misuse and domestic violence, and there had been regular contact with children's services over several years. Baby Kate and her siblings had been subject to child protection plans for emotional abuse, which became child in need plans once care proceedings commenced. Baby Kate's ethnicity or nationality are not stated.

Learning includes: practitioners finding limitations in available pathways; systems and practices struggling to deal with the nature of domestic abuse and coercive control; the need to equip practitioners with training and tools to assist in dealing with disguised compliance; the need to consider risks to children as part of a wider picture recognising the full impact of abusive situations.

Recommendations include: consider how domestic violence perpetrator work is incorporated as an action into child protection plans; ensure practitioners have an understanding of coercive control, and that tools and processes are in place that support in evidencing and acting upon concerns; consider how information on adult patients is shared within ongoing safeguarding children processes.

Other resources Read full overview (PDF)

8. Serious case review: Case 11: Alex (assigned pseudonym): overview report

Significant injuries to an 11-month-old boy. Alex was admitted to hospital with cardiac and respiratory failure from suspected non-accidental injuries. Medical investigations

found bleeding, including bleeding in the brain, an old rib fracture and extensive bruising. These diagnoses resulted in significant disabilities for Alex leading to care in a children's hospice. Alex had been placed into foster care following his birth, as his parents had significant previous involvement with children's social care. At the time of his hospitalisation Alex had been living with connected carers, who were an extended family member and her partner. His connected carer mother had five other children, and did not live with connected carer father. There were no previous concerns regarding the connected carer family. Alex's ethnicity or nationality are not stated.

Learning includes: expediting social work assessment timescales may impact the quality of assessments; children who are looked after may be at risk of harm, and that being in foster or connected care does not automatically mean safety; professionals should recognise the difference between various fostering arrangements and prioritise visits and reviews accordingly.

Recommendations include: assessments for connected carers include a thorough review of family dynamics and explore motivations to care for children; unannounced visits of connected carer placements are undertaken during the assessment phase and post placement; when children are placed in another local authority, social workers should seek support from where the child has been placed and reciprocate arrangements with other local authorities; that recommendations are raised with the Family Justice Board and the Department for Education.

Other resources Read full overview (PDF)

9. Serious case review: Liam (full overview report)

Ingestion of a potentially fatal amount of methadone by a 20-month-old boy in the autumn of 2018. Both parents were arrested on suspicion of child neglect. Liam is the youngest of three children to the same mother and father. Prior to Liam's birth parents had only been known to universal services and substance misuse services, as both parents were known to have misused heroin. Liam was in the care of the local authority, placed with his mother. Enquiries subsequently revealed that Liam's father had been staying at the family home, without the local authority's agreement, and that, despite suspecting that Liam had consumed methadone, parents had delayed seeking medical help for him. Ethnicity or nationality not stated.

Learning includes: ensure that assessments collect and synthesise information from a range of sources; improve the quality of analysis of known risks; the importance of being tenacious about engaging fathers and understanding their role in the family; the challenges of working with families where children are placed with parents as an outcome of care proceedings; improve safeguarding of children living with parents when care proceedings have ended.

Recommendations include: revise existing multi-agency safeguarding procedures, protocols and guidance in respect of parents who misuse substances; improve levels of basic awareness of substance misuse, specific safeguarding issues and how to obtain specialist advice; undertake a multi-agency audit of cases where children are living in

households where adults are known to misuse drugs or who are now being treated with opioid substitute therapy.

Other resources Read full overview (PDF)