NSPCC Repository – January 2022

In January 2022 eight case reviews were published to the NSPCC Repository featuring a number of issues including children with disabilities, child sexual abuse, shaking, and special guardianship orders

1. Serious Case Review: BSCB 2017-18/02 (full overview report)

Death of a 21-month-old girl in November 2017 as a result of brain injuries following physical abuse by the partner of the child's special guardian. The perpetrator was found guilty of murder and sentenced to a minimum term of 20 years in prison.

Learning includes: the importance of a close family relationship for the child with the special guardian; the importance of wider family support for the arrangement; management of contact; the importance of understanding a special guardianship order (SGO) as at the adoption end of permanence.

Makes no recommendations but identifies learning points with actions: enough time should be given to assess the integration of a child placed within a family, the care of that child and the impact on all members of the family before a final SGO is made; organisations need to reflect on how the impact of a change of social worker and team in the middle of proceedings and planning can be mitigated to keep the needs of the child at the centre; there is an absence of guidance on what action to take when a child is presented with concerning bruising for frontline professionals; an absence of appropriate challenge and professional curiosity, particularly around apparently open reporting.

Other resources Read full overview (PDF)

2. Child Safeguarding Practice Review: Child M

Death of a 12-year-old boy in 2020 due to multi-organ failure, sepsis and cerebral palsy. Concerns were identified regarding neglect. Child M had significant disabilities and complex chronic medical needs.

Learning includes: a need to better understand child M's lived experience and his family's coping mechanisms; insufficient case co-ordination and development of agreed ways to maintain health and minimise risk of harm; a need for a review of the respective roles of school nursing assistants and school nurses; a need for debate about the extent to which existing service user information systems support or constrain information exchange; a review of the extent to which education, health and care plans (EHCP) or non-school attendance policies are being applied to those in special education facilities.

Recommendations include: develop child-centred guidance on the meaning and application of 'mechanical' and 'physiological or medical' restraint to children in the community who are vulnerable by virtue of physical or learning disabilities; ask agencies to remind professionals of the existence and importance of compliance with the existing 'was not brought' policy; review special schools to provide confirmation that non-school

attendance responses are of comparable or superior standards than those applied to non-disabled pupils; children's social care disability service to discuss and agree the co-ordination role that it could play in complex cases.

Other resources Read practice review (PDF)

3. Report of the serious case review regarding Child L

Serious injuries to a 20-month-old boy in 2018. Child L and his half-brother were made subject to an interim care order.

Learning includes: there was no shared understanding of mother's learning needs or her emotional needs, and there were differing perceptions of her; when extended family are providing support it is important to balance the strengths alongside the risks and to understand the nature of the relationships between family members; all behaviours must be viewed as potential trauma and the impact of this trauma on the lived experience of the child.

Recommendations include: to build on the multi-agency understanding of risk for children under a child in need plan to include dynamic risk assessments and challenge from partner agencies; to explore how a list of children on a child in need plan can be shared with the multi-agency safeguarding network; ensure that private pre-schools and nurseries are meeting the required standards of safeguarding, and to consider raising the issue with Department for Education to bring private providers under the same guidance as statutory services.

Other resources Read full overview (PDF)

4. Child safeguarding practice review: Hatty and Jen: Family J

Sexual abuse of two sisters aged 14-years-old and 13-years-old by their father over a period of six years. Both children were placed with a foster family, and a police investigation was initiated.

Learning focuses on: home education of children; working effectively to identify and address sexual abuse and exploitation; understanding adult sexual offending behaviour and evaluating the risks of likely and future harm; supporting children to seek help from professionals; children communicating that something is wrong through their behaviour; interviews with children which do not follow guidance are likely to undermine effective safeguarding, decision-making in the family courts and criminal processes; recognising and addressing the impact of domestic abuse; safeguarding children from being physically harmed, characterised as "physical chastisement or physical punishment"; delivering culturally competent practice; the importance of a structured approach to children's experience of parental neglect over time.

Recommendations include: make a recommendation to the National Panel to complete a thematic review of serious case reviews, rapid reviews and child safeguarding practice reviews that relate to home educated children; scrutinise how partner agencies are

equipping their staff to understand and support children's help seeking behaviour; issue a child centred position statement about the appropriateness of physical chastisement and provide guidance about what safeguarding responses are required; understand and scrutinise how supervision arrangements promote professional curiosity, are child centred, and address fixed thinking across partner agencies.

Other resources Read practice review (PDF)

5. Independent overview report of the serious case review concerning Child V

Unexplained death of a 2-year-7month-old girl in December 2018.

Learning includes: when the siblings of an unborn baby are subject to a child in need plan (CiN) the multi-agency CiN meetings should discuss the likely effects and ensure there is multi-agency agreement prior to closure of the plan; conduct a parenting assessment so that practitioners have realistic expectations of parents and to minimise the vulnerability of children; need to use processes and tools to identify, assess and respond to neglect; the voices and lived experiences of children should inform all assessments and interventions; there needs to be a multi-agency assessment if there is a disclosure of sexually harmful behaviour; strained professional relationships can impact on multi-agency cooperation and safeguarding practice.

Recommendations include: improve the early identification of and response to neglect; remind partner agencies about the decision making process prior to closure of a CiN or child protection plan; consider the development of pathways with adult services to assist with the assessment of parents and carers when there are concerns about their cognitive ability; identify the barriers to the effective use of tools to support the early identification, assessment and analysis of neglect, specifically, Graded Care Profile 2; robustly monitor and evidence the impact of the voice of the child in practice; identify and address barriers to the effective use of the escalation policy.

Other resources Read full overview (PDF)

6. Child W serious case review

Non-accidental injury to a 4-month-old child in 2018, attributed to shaking. Mother received a custodial sentence.

Learning includes: provide child impact chronologies to understand the daily lived experience of children; the views, wishes and feelings of children are critical to effective interventions; a trauma informed approach to assessment, incorporating a strengths based methodology, can be invaluable when adverse experiences in childhood have been identified; cannabis use, particularly if prolonged, is a significant feature contributing to poor mental health and compromised parenting; family engagement is critical to keeping children safe; consider the possibility of abusive head trauma in cases where there are young babies and children and domestic abuse is present.

Recommendations include: planning and interventions should be informed by a conceptual model of change, particularly when working with families struggling with interrelated mental health issues, alcohol or substance misuse; ensure that a trauma informed approach to planning and interventions is embedded into practice, particularly where adverse childhood experiences have been identified.

Other resources Read full overview (PDF)

7. Report of the serious case review regarding Child AG

Neglect of a 2-year-old boy in 2018. Child AG presented at hospital severely malnourished and with fractures of varying ages.

Learning includes: issues around the assessment of risk and impact of domestic abuse on the mother and children; issues around how the parents' learning difficulties were understood in relation their parenting; issues concerning how child neglect is understood by practitioners and the ability of services to identify and recognise malnutrition; assessments by medical practitioners should not take precedence over concerns raised by other professionals within a safeguarding network; not all professionals being competent in working with and understanding the culture of a Traveller family.

Recommendations include: review the ability of partners to deliver the neglect strategy; equip practitioners with the confidence and skills to work with clients from diverse cultural backgrounds, including Gypsy, Traveller and Roma communities; local health agencies review the effectiveness of faltering child growth management.

Other resources Read full overview (PDF)

8. Child T: child safeguarding practice review

Death of a 17-year-old boy by suicide in November 2019.

Learning includes: there needs to be a personalised approach to identifying a child's needs, to ensure that children with autism spectrum disorders (ASD) and conduct disorders are effectively safeguarded within education settings; the 'reachable moment' can be lost for a young person who has attempted suicide and is admitted to hospital; it is crucial for services to listen to the child and to question the child's field of perception.

Recommendations include: promote a family-based practice model across the safeguarding partnership that is underpinned by trauma informed, contextual and restorative principles; ensure that the SEND partnership conducts a review to address the issues holistically before consideration of an exclusion; challenge agencies and partnerships in how they listen to young people for transition to adult services.

Other resources Read practice review (PDF)