**NSPCC Repository – February 2022**

***In February 2022 eight case reviews were published to the NSPCC Repository featuring a number of issues including child sexual abuse, contact, health services, sex offenders and professional curiosity***

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| 1. **Local Child Safeguarding Practice Review: overview report: Child RS**   Serious and potentially life changing non-accidental injuries to a 4-month-old baby in June 2019. A police investigation and care proceedings were instigated.  **Learning includes:** bruising on non-mobile babies should always be treated seriously and advice immediately sought from the safeguarding lead; practitioners should guard against 'second guessing' the response of MASH to a referral of concern about a child; importance of early identification of vulnerability, assessment of risk and consideration of appropriate services; importance of gaining an understanding of who lives in a household and their role, not focussing solely on mothers but proactively engaging with fathers; information sharing alone does not safeguard children; be aware of the impact of professional desensitisation and cultural normalisation; importance of professional curiosity and respectful challenge; be aware that moving between areas, away from support systems, can increase a family's vulnerability.  **Recommendations include:** ensure that the learning from this review is disseminated widely and incorporated into updates, and the development of policies and procedures; ensure that the safe sleeping policy is shared with all relevant staff; ensure that guidance on bruising to non-mobile babies is widely disseminated and embedded in practice across all agencies.  **Other resources**[Read full overview (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2022SandwellChildRSCSPR.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E1AAAFFECACF78EB3674FD2EBF3A8A52C714E57523D062F59E09D916ECD85B45BA9D5330A93CF99429CEC7A94FD73D957A2C98997459E7&DataSetName=LIVEDATA) |
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| 1. **Local Child Safeguarding Practice Review: Joshua**   Neglect and sexual abuse of an 8-year-old boy by two associates of his mother. The abuse took place prior to and during the time he was subject to a child protection plan.  **Learning includes:** the need to assess and understand parental ability to protect when making decisions around supervised contact; limitations of an evidence-based response to child sexual abuse (CSA); importance of requesting and sharing police intelligence at the earliest opportunity; the need for the development of a strong and robust response to CSA that is not a purely evidence-based approach and includes the provision of appropriate tools and training; recognising when the Graded Care Profile 2 (GCP2) should be used to help identify and address neglect; understanding the purpose and effectiveness of written agreements and assessing whether they should be used within current practice; the importance of perpetrator disruption.  **Recommendations include:** develop an overarching multi-agency strategy for responding to CSA; develop a CSA training programme for practitioners across the multi-agency partnership; review the way in which multi-agency meetings facilitate the discussions and recording of confidential information and how that information is shared with families to facilitate an increased understanding of the risks; explore and understand rationale for not sharing information with parents and carers, and ensure that the information not shared is kept to a minimum.  **Other resources**[Read practice review (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2022AnonymousJoshuaCSPR.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E1AAAFFECACF78EB247BFC24B132894BF736E36A2FF750F59E09D916ECD85B1821FE7030A93CF90305514A0E8C72FE363819301D8A5E9E&DataSetName=LIVEDATA) |
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| 1. **Baby ‘R’: Local Child Safeguarding Practice Review**   Death of a 4-week-old boy in July 2020 attributed to non-accidental head injuries.  **Learning includes:** the family should have continued to receive the right level of support when they were transferred to another local authority; disagreements between local authorities over the transfer and status of the family caused delays in the family receiving the appropriate level of service; housing services not being aware of the neurodiversity and safeguarding needs of the family; lack of communication between mental health services and children's services; bruises or marks observed on a non-mobile baby should have triggered a robust multi agency response.  **Recommendations include:** current approaches to risk assessment through child protection enquiries or child in need processes obtain and take sufficient account of family background and previous experiences such as trauma, neurodiversity, and parental mental health difficulties; strengthening education and training on the “think family” approach, as well as neurodevelopment disorders and what such difficulties mean for parents' understanding and interpretation of information and advice; raise the role of housing services in statutory child protection processes as an issue of concern with the Child Safeguarding Practice Review Panel, including how housing services share information with partners and how they assess vulnerable families who need accommodation; ensure practitioners understand the significance of bruising in infants and the need to act.  **Other resources**[Read practice review (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2021BexleySHIELDBabyRCSPR.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E2AAAFFECACF78E82770EB26AD26B576CD39C05D05E353CF9F1AD868CE924DAF678E07221C404CE0B2AEE8D075F4B17A901C82ABE3417E6AB3&DataSetName=LIVEDATA) |
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| 1. **Local Child Safeguarding Practice Review: Overview Report: Mia**   Death of an 8-month-old girl in July 2020 after becoming submerged in the bath whilst unsupervised by her parents. Mia was treated in hospital intensive care until her death three weeks later.  **Learning focuses on:** considering risks for a blended family of several households; identifying and responding to neglect; sex offenders spending time within a family home; whether COVID-19 restrictions affected the single or multi-agency response.  **Recommendations focus on:** emphasising the importance of documenting how a child is presenting and the interaction between the child and parent or carer to better understand the child's lived experience; the importance of understanding the lived experience of children in blended families, particularly when they are visiting or staying in different households within the blended family; situational risks such as house moves and temporary housing; the many forms coercive control can take in intimate and familial relationships; a robust process for information sharing between partner agencies when sex offenders are suspected of presenting a risk of sexual harm to children; work to support women who have been exploited by sex offenders should consider a range of scenarios in which women may become vulnerable to exploitation in the future.  **Other resources**[Read practice review (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2021BlackburnWithDBLMiaCSPR.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E2AAAFFECACF78E82779F229A33D934CEA2BE56D2FC673FA8030EA7BCFEC6FE5716835C08099C69C0757DF16B8A86D62BC1BD1F31FED614C067544&DataSetName=LIVEDATA) |
| 1. **Local Child Safeguarding Practice Review: Child R**   Extensive physical injuries to a 2-year-old boy in April 2020.  **Learning includes:** Issues around information sharing, particularly regarding arrangements for transferring community health records and the transfer of cases between local authority areas; issues around the ability and confidence of safeguarding practitioners to recognise risk and act with authority in cases involving both domestic violence and child abuse; the importance of safeguarding practitioners including relevant adult males in their assessments of risk.  **Recommendations include:** review policies covering the transfer and receipt of community health records to ensure the timeliness of record transfer, case closure and escalation; review procedures for the transfer of children in need cases, defining the requirement for formal handover meetings; promote training and awareness raising that reinforces the seriousness of domestic abuse in the context of children's safety; ensure that local threshold tools sufficiently describe the significance of risk associated with domestic abuse, particularly when such abuse forms a repeating pattern; improve how practitioners engage with adult males that are significant to the lives of children.  **Other resources**[Read practice review (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2021CityAndHackneyChildRCSPR.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E2AAAFFECACF78E8267CE73389318276E51FE77722FB72DEA435EF6ADFEF6D992F7C37DA915B494D7E526F9876319055A1F9585CDB4F5A60D2876CD4&DataSetName=LIVEDATA) |
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| 1. **Serious Case Review: Child P (full overview report)**   Injury and mental trauma suffered by a 5-year-old child in September 2018 during a knife attack including several other family members. Father pleaded guilty to attempted murder.  **Learning focuses on:** the potential impact of ethnic, religious and cultural influences on families; the need for a robust response to domestic abuse, including information sharing and a joined-up approach; the impact of bereavement on families; working with fathers; effective multi-agency working.  **Recommendations include:** use interpreters consistently when English is not the family or parents first language; the need for accurate family assessments, including the family's background, culture and beliefs; ensure that the views of the multi-agency network are considered within the body and analysis of single assessments; comprehensive training to be undertaken for frontline practitioners on domestic violence and vulnerability factors, including an understanding of what partner agencies can offer; multi-agency training on bereavement and how to support bereaved families; ensure that staff attending strategy meetings are appropriately trained in relation to Working Together to Safeguard Children 2018 and the actions that the police should take.  **Other resources**[Read full overview (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2021OldhamChildPOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E2AAAFFECACF78E82A79F722A932A556ED10E84908F454C4BB30EE4FB2CC59AD203FE7D8D03949501DB160AA31FBDFF103852A1E6EBF7637&DataSetName=LIVEDATA) |
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| 1. **Serious Case Review: Toby (full overview report)**   Death of a 5-week-old infant boy in January 2018. Cause of death initially assumed to be Sudden Infant Death Syndrome (SIDS), but post-mortem found rib fractures and evidence of non-accidental head injury.  **Learning includes:** lack of collaborative working between health professionals resulted in poor information sharing and parents' and children's vulnerabilities not being properly understood or responded to; information sharing within health agencies tend to be ineffectual due to a lack of clarity about why information is being shared, what to do with it and whether to follow it up.  **Recommendations include:** develop systems and tools to enable midwives to facilitate the reporting of low level concerns such as maternal presentation; observations about father's presence, interaction with baby and professionals and their role in parenting should be routine; improve the capacity for midwives to work in a continuity of care model, especially where additional needs are known or suspected.  **Other resources**[Read full overview (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020SouthGloucestershireTobyOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9367AE63EA0188A51F11FE96A33E743C5A530F95DC8D35FB24E7A36CE2AA5DC67DCD7FBBE8CBB0F08CA6B3FB013780B0CCB5F2B8551D4D254B08D82AD&DataSetName=LIVEDATA) |
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| 1. **Serious Case Review Child L: significant non-accidental injuries to a young baby (full overview report)**   Significant non-accidental injuries to a 3-years-6-months-old girl. Child L's father was convicted of grievous bodily harm and sentenced to 9 years in prison.  **Learning focuses on:** issues around communication and information sharing between agencies; reluctance to initiate early help assessments; the need for curious and holistic practice, and getting the whole picture by knowing the whole family; the need to engage with fathers and male carers, instead of the focus being primarily on the mother.  **Makes no recommendations but includes details of actions initiated as a result of learning, including:** revision of midwifery and health visitor pathways; revision of multi-agency protocol on bruising and injuries in non-mobile babies and children, including guidance for parents; a thematic review into significant physical injuries to children under 1-year-old; a pilot project focused on engaging fathers and developing models of good practice.  **Other resources**[Read full overview (PDF)](https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2020WiltshireChildLOverview.pdf?filename=AA58F75CEDE68892A73FB681FE246B8371684F102152F0AA780A14959D3BCE5767137B3B2A935011CBAEC3068664FF681AA6D2524E357BAB96C006752CCD756759AD77BD1E389823A55CFAAE74B2EE64F46C611AD1724BE1AC50776136E3AAAFFECACF78E9327CFF3EBB378F4CE13FE4702BE67DF9BB3CF94EF5D94AE57168357E071ECD9C0757DFBDBABE14A68AA0BB9BC9F918C5E16D60&DataSetName=LIVEDATA) |
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