NSPCC Repository – March 2022

In March 2022 eight case reviews were published to the NSPCC Repository featuring a number of issues including sleeping behaviour, disguised compliance, culture and trauma-informed practice

1. Emma Learning Review Report

Death of a 16-year-9 month-old girl. Emma was staying with a relative at the time of her death; the relative's partner was convicted of Emma's murder and sentenced to life imprisonment.

Findings include: Emma's positive presentation may have resulted in professional over optimism and disguised her ongoing vulnerability; when an adolescent is on a child in need plan the supporting professional network needs to consider the parent's ability to support the child; when children are linked to exploitation it should be established if the parent is able to understand the risk posed by contextual safeguarding issues; practitioners outside of children's social care do not always clearly record the voice of the child.

Recommendations include: encourage practitioners to operate a reflective mind-set with their case work, being aware of over optimism and ensuring continuing practice of professional curiosity; practitioners understand expectations regarding recording standards, including how the 'child's voice' is recorded; education settings should ensure that child protection records are transferred in a timely fashion at points of transition; practitioners question the language used to describe a child, their presentation and context in assessments and other recording; practitioners know how to respond when unreported domestic abuse is raised by a child service user; the local safeguarding partnership conduct a multi-agency audit of adolescents known to agencies due to risk of harm following neglect.

Other resources Read practice review (PDF)

2. Learning Review Report: Liam

Professional concerns regarding an 11-year-old boy admitted to hospital in April 2020. Liam's presentation at hospital was due to an accidental injury, but his appearance and history of previous medical presentations raised concerns about his care and resulted in the instigation of care proceedings.

Learning includes: practitioners should take into account the impact of parental anxiety on a child's overall welfare; practitioners learn strategies for working with parents who are highly anxious; children cannot always easily articulate their day-to-day life experience, particularly when they have no ongoing relationship with an adult outside of the home; the need for practitioners to be professionally curious about information provided by parents and how that impacts upon the care provided; the challenges of working with families where there is partial engagement and disguised compliance.

No recommendations, but notes that learning has been incorporated into the local safeguarding partnership's workstreams, including multi-agency training, planned audits and professional guides.

Other resources Read review (PDF)

3. Child Safeguarding Practice Review: Child YS

Assault on a 7-months-old child by their father resulting in life threatening injuries.

Learning includes: understand the impact of trauma and become more trauma-informed in practice; understand the way in which different faith communities perceive domestic abuse and the difficulty in speaking openly; the importance of professional curiosity and challenge; the importance of clear and factual record keeping and interagency cooperation; create a safe space for multi-agency reflection and supervision; the importance of cultural awareness and challenging assumptions recognising that different families from the same cultural or religious group may have different views and practices.

Recommendations include: ensure effective implementation of information sharing, 'Think family' approach, using evidence-based tools, trauma informed practice, resolution and escalation policy; work with community groups to combat domestic violence; host training on effective safeguarding of Black, Asian and minoritised ethnic, cultural and faith groups.

Other resources Read practice review (PDF)

4. Local Child Safeguarding Practice Review: babies with injuries

Reviews the assessment and safeguarding of infants prior to and following a non-accidental injury, focusing on three infants aged 7, 9 and 11-weeks-old.

Learning focuses on: the need to increase awareness of the unborn baby protocol; child protection processes and case management across perinatal mental health services; the response to anonymous referrals and the scope of the resulting health checks; the need to consider and involve fathers; improving the exercise of professional curiosity; the impact of COVID across agencies; use of targeted support in pregnancy in order to prevent escalation of concerns post-birth; improved awareness of the voice of the child; need for improved information sharing and recording; understanding that parents can be persuasive and that a parent may not be protecting their child; caring for a new baby can lead to increases in parental mental health issues and domestic abuse; professionals providing support to families with a new born baby need to be aware of fathers' mental health.

Recommendations include: ensure the attendance of the appropriate health professionals at strategy meetings, including when these take place out of hours; consider how to encourage and support all professionals to talk to each other and collaborate, so

that that all information is known and considered; review systems and practice to ensure that fathers or male partners are equally considered by services.

Other resources Read practice review (PDF)

5. Child Safeguarding Practice Review: Ruby: review report

Death of an infant girl in 2020 found to be an accident, linked to an unplanned unsafe sleeping environment. Ruby was on a child protection plan due to risk of neglect when she died.

Learning focuses on: awareness of a parent's history; considering and involving fathers; assessing wider family members who play a key role in supporting or safeguarding a child; sharing concerns about the impact on a child of changes of circumstances; the impact of alcohol and substance misuse on children and unborn babies; safer sleeping advice; using virtual technology for key meetings; strengths based models of assessment and planning; avoiding over-optimism and losing focus on the child; knowledge of multi-agency safeguarding procedures and professional confidence in challenging when they are not followed.

Recommendations include: promote the involvement of fathers; ensure that the implementation of sleep assessments includes bespoke explicit and detailed safer sleep advice, including an explanation of why vulnerable babies are more at risk of sudden unexpected death in infancy (SUDI); ensure that key meetings such as child protection conferences being held by video conference or telephone have the optimum involvement of parents; ensure that professionals have the knowledge and confidence to challenge other agencies, including the use of escalation policies; consider how to ensure that accurate information about medication being prescribed to a pregnant woman is available to all health professionals working with the family.

Other resources Read practice review (PDF)

6. Serious Case Review: overview report Child LO

Death of a 16-month-old child in December 2017. Child LO died due to an airway obstruction whilst sleeping unsupervised in an unsafe environment.

Learning includes: seeing where babies and young children sleep (day and night) can improve assessment of safe sleeping environments and provide an opportunity for professional advice; local authorities should be aware of local holiday parks and ensure that the winter rules are adhered to; professionals need to be curious about why a mother and child is living in a holiday caravan and provide relevant advice and support to address any accommodation issues; the courts should share safeguarding concerns with front line staff; the midwifery electronic record and health visitor child health record should include full details of previous children by a mother or father, and new family members; parents are more likely to disclose their vulnerabilities if they know and trust the professional involved; multi-agency safeguarding hubs should share concerns with health professionals; better links between health visiting and nursery provision would

promote better assessment and support through Early help; recognising and addressing domestic abuse early has a beneficial impact on children and family life.

Recommendations include improved arrangements for: multi-agency working and information sharing; standards of domestic abuse processes; ensuring safe sleeping arrangements for babies and young children are involved; reduce the risk of children and families living in holiday park accommodation during the cold winter months.

Other resources Read overview

7. Family E: serious case review: (full overview report)

Injuries and trauma suffered by a pre-school child after father dropped them into a river from a bridge.

Learning includes: there is a need for/to: Child and Adolescent Mental Health Services to allow direct referrals; robust single and multi-agency systems for bereavement notification; the whole family approach, especially for bereavement support; seek the views of other professionals to build-up a child centred picture; co-locate children's centres with nurseries and schools; build stronger links and support the sharing of information on services that can be offered from the voluntary and community sector; enquire about significant others even if they do not live with the child; the size and complexity of Early help assessment tool can be a disincentive.

Recommendations include: train all professionals in bereavement support; Early help tool should address needs using a holistic assessment, not just to access services; maximise opportunities to engage with the voluntary sector in service delivery; all schools have a robust electronic integrated recording system or ensure robust safeguarding information recording and transfer arrangements are in place; implement a locally-agreed pathway to services for children at risk of self-harm.

Other resources Read full overview (PDF)

8. Serious Case Review of Family S: Learning briefing

Significant neglect of two children aged 7-years-old and 22-months-old. Learning is embedded within the recommendations.

Recommendations include: NHS England considers the feasibility of a system for raising alerts on children not registered with a GP for longer than three months; the local NHS Trust provides guidance to midwifery staff requiring that all women receive a post-natal visit at their normal address; the county council provides assurances on the capacity and workload pressures experienced by the health visiting service, addressing whether the practice of only visiting by prior appointment is universal or specific to a particular team; the county council establishes a multiagency working group to develop guidance regarding responsibilities for school attendance; agencies provide assurance that their assessment processes enable the effective involvement of fathers, partners and other

men within the household; agencies obtain independent verification of information rather than relying on self-reporting from service users.

Other resources Read learning briefing (PDF)