NSPCC Repository – March 2023

In March 2023 eight case reviews were published to the NSPCC Repository featuring a number of issues including sudden unexpected death in infancy, filicide, and asthma management

1. Local child safeguarding practice review Baby T

Death of a 7-week-old boy in December 2020 while co-sleeping with his mother.

Learning is embedded in the recommendations.

Recommendations include: propose a practice model recognising a continuum of risk of sudden unexpected death in infancy (SUDI), with support reflecting the differing needs of all families, including those with identified, additional vulnerabilities; promote safer sleeping within a local strategy for improving child health outcomes; multi-agency action to address pre-disposing risks of SUDI for all families, and with targeted support for families with identified additional risks; review existing 'reducing the risks to babies' NICE guidance with a view to developing a local policy; produce a briefing paper for multi-agency circulation that highlights the predisposing and situational risks of SUDI and appropriate guidance and referral pathways; audit current understanding and use of motivational interviewing across partner agencies and explore what training is already being offered; and incorporate safer sleep arrangements into threshold guidance.

Other resources Read practice review (PDF)

2. Thematic local child safeguarding practice review of Infants Under 1 Year: executive summary

Thematic review on infants under 1-year-old, covering seven rapid reviews from August 2019 to March 2020. Cases involve infants who suffered abusive head trauma, fractures consistent with non-accidental injury and concerns in relation to neglect, substance misuse and domestic abuse.

Learning includes: children aged 0-2-years-old are not always visible to services; the totality of commissioned services for infants needs to be mapped and a gap analysis completed in order to strengthen earlier identification of need and risk; the single point of access for children's services needs to be embedded and thresholds well understood and applied consistently; improving the knowledge and skills of practitioners to observe and assess the lived experience of pre-verbal and non-verbal children; information sharing continues to create challenges for professionals, including misunderstandings of data protection legislation; the need to understand and assess the emotional and physical risk to babies and children of being present in a household where there is known domestic abuse; professionals need to robustly consider the likelihood of future risk to children, considering how parental mental health concerns, substance misuse and domestic abuse can fluctuate over time; professionals should challenge colleagues if new information is not sufficiently considered which may lead to a safeguarding risk; fathers or co-parents need to be an equal part of assessments, support and plans in order to ensure that the needs and risks to a child

are known and met; professionals need to know when a formal pre-birth assessment needs to be undertaken, and provide challenge if this does not happen.

Other resources Read executive summary (PDF)

3. Serious case review Louise: executive summary

Serious, life changing injuries, sustained by 18-month-old girl in June 2019 while in the care of her mother's partner.

Recommendations include: ensure that there is a joint understanding and agreement in the application of thresholds of all levels of need and that referral pathways are clear and understood; ensure that both Child in Need and Child Protection Plans and processes are robust, outcome focused and clearly understood and owned by all agencies; to develop a one multiagency safeguarding access point, that there is robust and consistent management oversight; to ensure that information is effectively shared to make effective and safe decisions including in domestic abuse cases; ensure multi-agency responsibility to identify and respond to all aspects of neglect, including educational and emotional neglect and the effects of non-dependent alcohol use by parents and the impact of these on children; to ensure the impact of domestic abuse on children is understood and prioritised.

Learning includes: training on the cycle of change and motivational interviewing; escalation and professional disagreement; and recognition and prevention of abusive head injury in infants.

Other resources Read executive summary

4. Local child safeguarding practice review: Child S: review report

Death of a 7-week-old infant boy in August 2020. The cause of death was ruled as sudden unexpected death in infancy (SUDI).

Learning themes include: risk assessment and decision making; child neglect; substance misuse; and safe sleeping.

Recommendations for Kent Safeguarding Children Multi-Agency Partnership include: undertake an audit of the processes of convening child protection conferences to review the attendance of key agencies and the quality of reports submitted by agencies; consider learning from the Child Safeguarding Practice Review Panel's report “The myth of invisible men” to ensure the overt engagement of men in risk assessments across the partnership; raise awareness and understanding of the Public Law Outline (PLO) process so that practitioners are clear of the processes and aware of opportunities to influence risk assessment and decision making; children's services review the arrangements for risk assessment and decision making in the PLO process and the interface between the legal advice received and the decisions taken to ensure this is a constructive process with sufficient challenge; review the neglect strategy to develop a clear shared understanding of “good enough” home conditions that provide practitioners with an agreed baseline; develop a substance misuse strategy, with a specific focus on cannabis use, to support a shared understanding of risks, appropriate interventions and decisions on the threshold

for escalation; and to promote and raise awareness of the need to deliver safe sleeping advice, particularly when there is substance misuse by parents.

Other resources Read practice review (PDF)

5. Serious case review: Andy and Arin: overview report

Joint serious case review following two cases of filicide and maternal suicides which occurred within a two-month period between March and April 2019.

Learning includes: professionals must consider the implications and risk for wider family members, especially children, when dealing with vulnerable people with mental ill-health; checks must be made by health professionals to establish if the patient, or child are known to other agencies or teams in order to share relevant information; the use of information systems and good practice in sharing information must be part of any procedure and practice guidance within any health settings; practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children; agencies must review their assessment processes to ensure they include mechanisms to support teenage fathers; health professionals need to be professionally curious as well as dealing with the clinical care of a patient; assessment process for health visitors and midwives must be reviewed to ensure they include professional curiosity around impact and cultural isolation; and health Visitors need to consider the support needs of transient families, particularly when from communities who may be culturally isolated. Recommendations include: review assessment processes to ensure they include consideration of the impact on individuals, the subject of the assessment, and to ensure they consider the support offered to young parents; and consider the effect of parental mental health or physical needs when planning service provision.

Other resources Read full overview (PDF)

6. Child Dominik: practice learning review

Non-accidental injury to an infant boy in 2019 including eye injury, cracked ribs, and a fractured leg.

Learning includes: a need to assess the impact of parental mental health on parenting capacity; a need to identify potential safeguarding concerns to a new-born baby following a family dispute; a need for information held on early help systems to be held on children's social care systems; a need for a pre-birth assessment by children's social care which could have informed part of the court proceedings; and a need to ensure GDPR guidelines are correctly applied by children's social care.

Recommendations include: information sharing policy, between the multi-agency safeguarding hub (MASH) and partners, should not allow GDPR to act as a barrier to sharing information when there are safeguarding concerns; the quality of recording and decision making based on effective triage in the MASH needs to continue to be improved and monitored for consistency so that information, risks and vulnerabilities can be connected; the sharing of information between early help and children social care systems needs to be strengthened so that there is a stronger

interface between them; there needs to be assurance, from children's services and midwifery, that the threshold for initiating the pre-birth protocol is being applied appropriately; and any agency that identifies that parental mental health needs are impacting on parenting capacity needs to share that with other partner agencies working with the family so that information can be triangulated and an appropriate response agreed.

Other resources Read learning review (PDF)

7. Local child safeguarding practice review: Craig

Allegations of rape and sexual abuse of a boy in care by another child living at the children's home in 2019.

Learning includes: the importance of having specially trained interviewers in police and social work services available to undertake forensic interviewing with a good enough understanding about helping children disclose information and being sufficiently well informed about current guidelines for interviewing; there was a belief that the risk assessment measures put in place in the care home were impenetrable which excluded the possibility of abuse taking place; a need for strategic leaders to create a context in which practitioners and front-line staff are better equipped and supported to make effective and timely responses to children in care with the most complex needs; a need to ensure that therapeutic reports and updated risk assessments are received and considered as part of on-going, overall risk assessment; and a need for professional curiosity about allegations being made and a need for a neutral and enquiring position to support further exploration of allegations.

Recommendations include: provider impact assessments should have clear mitigations in place for children who exhibit harmful behaviour and are a risk to other children; ensure reviews of looked after children include a full account of any therapeutic input and how it integrates with the care plan; and ensure information sharing protocols reflect the national information sharing protocol issued by the Government and take into account immediate risk and assessed risk either identified through reports or assessment processes.

Other resources Read practice review (PDF)

8. Serious case review: Young person Mary: overview report

Death of a 13-year-old girl in February 2018 following a severe asthma attack. Her brother had died seven years before, aged 9-years-old, also following an asthma attack.

Learning includes: the way in which agencies and organisations recognise, respond to and manage long term life-threatening but common conditions such as asthma needs to be improved; highly articulate, plausible, and manipulative parents require confident and assertive practice, and a focus on the core issues; professionals need to act in the child's best interests and consider what their life (in all aspects) is like; professionals must challenge parental assertions, views, and behaviours from a child centred viewpoint; parental views should not override evidence-based concerns; agencies need to coordinate or communicate sufficiently to fully understand what the

issues are; failures by parents to comply with advice in relation to health care issues should be treated as a safeguarding matter, which triggers child protection processes, as necessary.

Recommendations include: improve the way long term conditions are managed such as evidencing in health records that every missed appointment matters holistically; supervisors focus on and audit the degree of assertive practice evidenced by practitioners in a case, and ensure staff are trained and supported in terms of their practice with challenging or plausible parents and carers; introduce better approaches to utilise contextual and historical information in assessing cases when multiple agencies are involved; and that the focus on assessing the risk of harm is changed from an incident focussed approach to a context focussed one.

Other resources Read full overview (PDF)