Torbay Safeguarding Children Partnership

NSPCC Repository – June 2023

In June 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including criminal exploitation, harmful sexual behaviour, and suicide.

1. Local child safeguarding practice review (LCSPR): David

Arrest of a 16-year-old boy arrested on suspicion of murder in November 2021. David was a looked after child who had been the victim of criminal exploitation.

Learning includes: developing positive, strengths-based relationships with parents and carers supports safety planning; robust, child centred, and focused support plans must be in place for Special Guardians and these need to be regularly reviewed and adapted; children and young people at risk of criminal exploitation need consistent professional involvement and relationships; safeguarding agencies need to regularly review their approach to child criminal exploitation by listening to the experiences of young people and applying this learning to practice; contextual safeguarding meetings should have the same 'status' in safeguarding partnerships as child protection case conferences; practitioners need to develop their understanding of culturally sensitive practice and consider how a young person might experience oppression, discrimination, and risk.

Recommendations include: test and evaluate the use of contextual safeguarding meetings; pilot a 'child safeguarding pathway' for exploited children and use the evidence to inform future practice; consider learning from other safeguarding partners and agencies who have developed effective contextual safeguarding practice, particularly implementing 'Signs of Safety' as a practice model; develop a safety planning toolkit which supports practitioners in their child criminal exploitation work; children's social care to test out having a single social work practitioner to support children experiencing exploitation; consider how to implement a trauma informed approach to practice, including how to support staff with vicarious and secondary trauma and develop arrangements for critical debriefing.

Other resources Read practice review (PDF)

2. Local child safeguarding practice review (LCSPR) commissioned under The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018: David and Daniel 'UN21' the overview report

Harmful sexual behaviour between 11-year-old and 14-year-old male siblings who were in a long-term foster care placement.

Learning includes: professionals in looked-after and fostering teams need to feel confident about how to respond to child sexual behaviour; relevant professionals need to be aware of and confident to use recommended professional frameworks and toolkits; euphemistic or imprecise language can be unhelpful in understanding whether behaviour is normative or concerning; understanding that early neglect, trauma, exposure to abuse, poor attachment, and the development of inappropriate sibling relationships seeking support are some factors that create

latent conditions for harmful sexual behaviour; not all siblings are best served by living in their family group; and social work professionals should maintain professional curiosity with foster carers and not assume that experienced and well-regarded carers are managing the situation and responding appropriately all of the time.

Recommendations for the Director of Children's Services include: ensure that the policy and practice guidance about the use of any measures of control, monitoring or restraint of children living in family-based settings and residential care is being effectively implemented; ensure that social workers in looked after children's services receive the appropriate training in harmful sexual behaviour (HSB) and that they access support from HSB specialist practitioners when appropriate; ensure that the learning and improvement board give sufficient priority to the role of the Independent Review Officer, to be assured that it is performing in line with policy expectations and making an impact on children's outcomes including effective and timely escalation responses.

Other resources Read practice review (PDF)

3. Local child safeguarding practice review: Alan

Accident and emergency presentation of a 16-year-old boy in March 2021 following a social work visit. The home visit revealed significant neglect and malnourishment.

Learning themes include: multi-agency barriers and enablers to safeguarding adolescents from neglect including the application of mental capacity assessments; strengthening child protection processes for older teenagers who are experiencing neglect; the use of threshold criteria; the escalation procedure; and the impact of the Covid-19 pandemic on the child's well-being, parenting capacity and the multi-agency response to the child.

Recommendations include: agencies providing intervention at the early help level of need should feel like their voice is heard with authority and respect across the system; decisions about step-up and downs should be informed by multi-agency perspectives of those professionals involved with the child, and not taken solely on the grounds of threshold definition; decisions should be flexible with a willingness to use the skills and expertise in both early help and social care together; existing practice guidance on neglect should be reviewed, adding guidance for practitioners about working with adolescents who are difficult to engage with; the escalation process and its implementation should be reviewed to ensure it encourages both the airing of concerns about children and an expectation that those concerns will be received positively and responded to proactively; and procedures should focus more on expected behaviours and responses, on promoting the importance of escalating concerns within the system and include an approach to managing 'stuck' cases.

Other resources Read practice review (PDF)

4. Child A: Child safeguarding practice review

Death of a 16-year-old girl. Child A may have died by suicide.

Learning themes include: interagency working when there are disclosures of historical sexual abuse; the impact of sibling-to-sibling sexual abuse; partial disclosure of sexual abuse or assaults; responsibilities of private therapists to safeguard children; peer support and influence; and school transition from secondary to sixth form.

Recommendations to the safeguarding children partnership include: a multi-agency reflective learning event to explore the application of research to improve responses to child sexual abuse; undertake a multi-agency audit of cases of sibling sexual abuse to inform the learning event; contact the British Association for Counselling and Psychotherapy (BACP) asking that members are reminded that their counselling ethical framework sets out directives to refer safeguarding concerns; encourage schools to regularly audit their child safeguarding records to ensure compliance with school transfer protocols; and consider how peer mentoring could be developed and used to support children and young people who decide not to proceed with allegations of historical abuse.

Other resources Read practice review (PDF)

5. Serious case review independent overview report: Family T

Significant non-accidental physical injuries sustained by female twin siblings aged 14-weeks-old.

Learning includes: a need for risks and vulnerabilities to be effectively identified; the importance of stronger decision making procedures for unborn babies when parents have known vulnerabilities; a need to understand the impact of pregnancy on a looked after child and provide the necessary support; a need for improved information sharing; better understanding around the different roles and responsibilities of various professionals; where relationship coercion concerns are present, clarity is needed around the nature of the concerns and any support or intervention required; a clear understanding of escalation policies to ensure concerns are acted upon; the importance of following the correct policy and procedure when non-mobile infants require a child protection medical for suspected non-accidental injuries; and a robust multi-agency plan to safeguard vulnerable infants should be established during meetings prior to them being discharged from hospital.

Recommendations include: timely communication with the parents if there are concerns for the infant; identification of parental support needs; clear communication between social workers for the parent and social workers for the infant; opportunity for parents to contribute to care plans for the infants; improved process and procedures for multi-agency assessments, particularly regarding the involvement of fathers and the use of historical information to inform analysis; and early identification of actions required to safeguard infants when a looked after child becomes pregnant.

Other resources Read full overview (PDF)

6. Child safeguarding practice review concerning Marie

Death of a 16-year-old girl in January 2020 by suicide.

Learning includes: the need for a clear model for managing high risk self-harming young people; ensure clarity between professionals about responsibilities to coordinate, and ensure timely information gathering and effective intervention; the importance of a family assessment to provide background context and allow opportunities to assess parenting capacity; ensure concerns and worries raised by a child are considered and investigated; ensure professionals exercise professional curiosity to ask more questions and understand what a child has experienced, and to learn what other agencies know; and ensure initial early interventions are appropriate for meeting the child's needs.

Recommendations include: update the local documentation on self-harm and suicidal thoughts to develop an interagency "team around the child model and procedure" to assess and intervene with young people where moderate and high risks have been identified, ensuring that there is clarity about coordinated multi-agency care with clear plans and timely reviews; for young people where moderate and high risk of suicide has been identified, there should be a dedicated range of preventive and treatment resources available without long waits; and consider whether a new local response should be developed to prevent further deaths when a young person has died by suicide, considering new models for enhanced joint working and integrated provision emerging nationally.

Other resources Read practice review (PDF)