NSPCC Repository – July 2023

In July 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including child sexual abuse, serious injuries, and harmful sexual behaviour

1. Serious case review: John: learning summary

Examines the involvement of agencies and services with a young adult. There were concerns around John exhibiting harmful sexual behaviours, which reached a criminal threshold.

Learning includes: early identification, plus early and targeted intervention are important in helping children through childhood, transition positively into adolescence and onto adulthood; assessment of risk and safety planning, in cases of potential harmful sexual behaviours (HSB), needs to be viewed as a multi-agency activity but with a clear lead role coordinating the combined efforts of all professionals involved; supporting young people that have experienced adversity in their lives, and who go on to follow negative pathways through adolescence, is achievable by developing meaningful and trusting professional relationships.

Recommendations includes: information sharing guidance for practitioners providing services to children, young people, parents and carers should be reviewed by explicitly naming all the signatories of the guidance so that it carries greater authority and weight, it should also be strengthened with practice examples to aid professional understanding about when information can legitimately be shared; online procedures should be reviewed and, where necessary, strengthened to reflect practice relating to HSB and specifically the practice challenges for professionals when responding to those children & young people who are victims of abuse but also pose a risk to others; use of professional challenge and escalation guidance should be further promoted to all professionals; and oversee the implementation of the action plan arising from the NSPCC audit, and should work together to identify, and where possible remove, any barriers to implementation.

Other resources Read learning review (PDF)

2. Child safeguarding practice review: Child A: review report

Serious injuries to a 2-year-old boy in November 2020. Child A was subject to a child protection plan at the time, having previously been subjected to other injuries.

Learning includes: professionals working with a family should fully understand the parental history held across agencies, including a full understanding of any learning difficulties; living with domestic abuse as a child can have an impact when a person becomes a parent; domestic abuse in the wider family may be a risk to a child; all professionals working with children need to be aware of and use the practice guidance for responding to bruises in non-mobile babies; if a child has an injury, information should be shared widely with all professionals to ensure awareness of the whole picture and any patterns of cumulative harm; when babies and children are reported to have sustained accidents, professionals should not only consider neglect through lack of supervision, but also the possibility of physical harm; professionals need to be empowered to

challenge each other; and for a child's plan to be effective, a chronology of each agency's involvement is essential.

Recommendations for the partnership include: review and update the practice guidance for assessment, management and referral on bruising in non-mobile babies; review and update the professional disagreement and escalation policy; partner agencies consider introducing a requirement that individual agencies produce impact chronologies for all child protection conferences; and request that agencies work together to develop systems that allow identification (possibly via a trigger or alert) when there are repeated injuries to a child or young person.

Other resources Read practice review (PDF)

3. Child safeguarding practice review: Kubus

Death of a 15-week-old baby boy in July 2021. Kubus died while sleeping on an inflatable mattress along with his mother and was sleeping on his stomach.

Learning themes include: pregnancy care through antenatal, perinatal and postnatal stages; housing; disclosure of domestic abuse; cultural competence; inaccuracies in documentation and record keeping; communication and escalation pathways; and risk assessment processes embedded during Covid-19, which may have contributed to reduced visibility and support.

Recommendations include: explore the barriers and operational challenges to having contemporaneous accessible electronic records, with a view to identifying solutions to prevent gaps in information sharing which can lead to risk and result in harm; gain assurance that operational systems are robust in ensuring they hold the most recent contact information for service users; commission and sustain Identification and Referral to Improve Safety (IRIS) provisions in primary care; ensure that staff understand the cultures of the demographic that they work with; if English is a second language ensure that information delivered and received is checked to avoid miscommunication and consider an offer of an interpreter if necessary; recognise the importance of including fathers in assessments, whether absent or living in the household; and ensure that accurate quality documentation is maintained, irrespective of the challenges posed to staff.

Other resources Read practice review (PDF)

4. Child safeguarding practice review: Lloyd and Mark

Death of a 16-month-old boy due to non-accidental injuries in August 2019. Mother's partner was charged with murder and Mother was charged with causing or allowing the death of a child.

Learning themes include: the effectiveness of local multi-agency safeguarding children thresholds and pathways; the child's lived experience; the formulation and management of child protection plans and core groups; working with parents who are reluctant to engage; the impact and management of house moves on safeguarding systems; responses to domestic abuse; parenting education; parental drug and alcohol misuse; and the use of written agreements.

Recommendations include: local children's agencies, midwifery services and adult services review their assessment guidance and procedures to ensure curiosity about and consideration of the welfare of other household or family members, especially children under 5-years-old; a review of the protocol for re-housing families where children are subject of child protection plans to minimise moves away from the borough and key safeguarding networks, except where a move is essential to safeguarding a child or parent; relevant staff in partner agencies to have sufficient training in domestic abuse awareness, including the use of risk assessment tools and when to refer a case to a Multi-Agency Risk Assessment Conference (MARAC); a review of the use of written agreements with families when they are not part of agreed Child Protection Plans or Public Law Outline work, with guidance needed on when to share information about these agreements with key partner agencies.

Other resources Read practice review (PDF)

5. Child Angela: safeguarding practice review report

Sexual abuse of a girl by her mother's partner. Angela disclosed multiple counts of rape and sexual assault to hospital staff in June 2020.

Learning includes: protection of children should not rely solely on disclosures from children; lack of grasp by professionals on the lived experience of the child; lack of awareness of the impact of domestic abuse in the safeguarding system; the need to support professional curiosity regarding recognition and response to sexual abuse; differing levels of confidence in the recognition of child sexual abuse, leading to professionals deferring to unspoken hierarchies; even for parents whose first language is not English who appear to have a good grasp of the English language, language used by professionals is more complex than conversational language.

Recommendations for the safeguarding partnership include: consider development of a multi-agency neglect strategy; any individuals or families living in property deemed unfit for human habitation are offered temporary accommodation without delay; consider a pan-London protocol about children missing education that move between boroughs; remind partner agencies of the function and purpose of a multi-agency risk assessment conference (MARAC) and the specialist domestic abuse services available; children services to consider a practice standard requiring a strategy meeting or management overview where there have been three or more referrals of children involved in domestic abuse incidents; ensure that practitioners and managers are aware of child sexual abuse expertise available in the borough; emphasise the importance of professional difference by developing the escalation process to create space for a multi-agency professionals meeting to explore perplexing cases; ensure availability and quality of interpreters used for children and parents whose first language is not English.

Other resources Read practice review (PDF)

6. Serious case review: Jacob 22 (full overview report)

Injuries indicative of physical and possible sexual abuse of a 7-year-old boy in May 2019.

Learning includes: practitioner knowledge and beliefs about children and families from different ethnic groups or migrant backgrounds can influence their ability to address children's needs; when a school records safeguarding concerns in the CPOMS electronic system, used by many schools, to report, record and track safeguarding concerns, they should notify key professionals and record any discussions and plans made between agencies; the need for clear terms of reference for safeguarding teams in schools; seek out information about significant people in a child's life in order to recognise risks posed by some men; information about commissioned services proposed by schools should be provided to parents; designated safeguarding leads should have access to opportunities to develop their practice; well-kept records in schools are vital to keep children safe; professionals need to be supported to remain curious about children's lives.

Recommendations for the safeguarding partnership include: assurance sought through the local workforce safeguarding strategy, that agencies provide briefings and access to training supporting culturally competent practice; seek assurance that all professionals, including safeguarding leads in schools, are well equipped to work with diversity, culture and ethnicity in safeguarding work; explore how supervision, team learning, training and programmes can help professionals improve their skills as professionally curious practitioners in relation to relation to 'significant males'; ensure a robust system for quality assuring safeguarding audits and action plans in schools and partner agencies.

Other resources Read overview report (PDF)