NSPCC Repository – August 2023

In August 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including serious youth violence, suicide, and child sexual abuse.
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Thematic child safeguarding practice review: services provided to young people and their families in relation to serious youth violence

Serious incidents in early 2021, including the fatal stabbing of a teenage boy and an adult. One adult and six young people were convicted of offences including murder and manslaughter.

Learning themes include: difficulties identified in school attendance and behaviour, and the professional response; the involvement of boys in criminal behaviour in early adolescence and the response of services; patterns of social care and early help service involvement, team allocation, assessment, and thresholds; child and adolescent mental health (CAMHS) and other specialist health services; and incidents of violence against girls and women.

Recommendations include: services should jointly develop a 'problem profile' of serious youth violence and child exploitation; services should evaluate the profile of children at risk of exploitation to provide a better understanding of any disparities in service provision and outcomes associated with race, ethnicity, and disability; there should be improved information sharing with schools about pupils who may be at risk of exploitation; the time taken for cases involving young people to be investigated and resolved should be reduced; the role that the Pupil Referral Unit can play in combatting child exploitation should be reviewed; the number of professionals who are involved with children and young people should be reduced; there should be earlier referral and engagement with CAMHS for children who are at risk of school exclusion; and the role of speech and language services in relation to young people at risk of entering the youth justice system should be reviewed.

Other resources Read practice review (PDF)

2. Executive summary of a significant case review carried out by the Child Protection Committee (Anne)

Death of a girl from an acute medical condition in 2018. Concerns were expressed that neglect of Anne's medical needs had been a factor in her death. Findings include: issues around mechanisms for bringing the right people together to share information and make joint decisions, resulting in some children not receiving the right service at the right time; issues across children's services in relation to the use of assessment tools and frameworks, running the risk of failing to identify the point at which older children are in need of protection; and the need for opportunities for formal critical reflection within and across agencies at all levels, as not having these opportunities makes it more difficult to develop and revise shared understanding of the needs of children in complex circumstances, and exacerbates the risk that assessments may rest on untested assumptions.

Other resources Read review online: www.northlanarkshire.gov.uk/social-care-and-health/public-protection/north-lanarkshire-child-protection-committee/significant-cases-and-learning-reviews

3. Local learning review of serious youth violence and gang related activity

Local learning review conducted following a serious incident of youth violence.

Learning points include: agencies would like clearly defined thresholds in relation to contextual safeguarding; agencies do not always feel confident on what information they should be sharing, with who, and how to escalate concerns of poor information sharing; it is difficult to evidence change where there appears to be positive engagement and possible disguised compliance; the benefits of extensive mapping, including the collection of data on gang related violence, hotspots, presentations at local hospitals, and local police intelligence data; the value of child criminal exploitation leads in agencies including children's social care.

Recommendations include: the completion of a review into information sharing between local police, children's social care and youth offending services; ensure information relating to the transfer of care of vulnerable children and their families from 'out of area' is shared with relevant local health agencies; information about hospital attendances by young people related to serious youth violence, especially in hospitals outside the young person's local area, is shared with relevant agencies; ensure the inclusion of health representatives in multi-agency forums related to children who are at high risk of youth violence; develop a clear threshold and pathways document on contextual safeguarding; consider the development of a transitional safeguarding approach with the Safeguarding Adult Board.

Other resources Read learning review (PDF)

4. Extended LCSPR: Teddy, Wilbur and Peter

Suicide of a 17-year-old and attempted suicides of a 16-year-old and 17-year-old, all cases occurred separately, in England.

Learning includes: a need for local authorities to find suitable alternative placements and health and social care to commission appropriate placements for 16 and 17-year-olds; the impact of chronic underfunding of mental health services nationally on young people's timely access to appropriate mental health services; the need to consider each individual in the context of their age, maturity and mental capacity at each contact; a need for professionals to maintain high levels of engagement and support throughout a young person's admission into hospital; a need for resources to support 16-17-year-olds who do not meet the threshold to be detained under the Mental Health Act, but are deemed to require a level of care that cannot be fully met within the home or by community services; and a need for triggers for harmful behaviours to be sufficiently considered when formulating plans of care.

Recommendations include: ensure appropriate services are being commissioned that can meet the needs of young people aged 16-17-years-old within the community; ensure that there is a clear record of parental responsibility that is amended if a child is placed on an interim/full care

order or adopted; review discharge planning processes and ensure a multi-agency response to discharge planning that commences on admission; and strengthen trauma informed practice and safety plan intervention.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: the long-term sexual abuse of children in care

Long-term sexual abuse of three siblings in foster care. The abuse was perpetrated by the male foster parent.

Learning includes: professionals should not assume that when a child has had therapeutic interventions this will be protective in the longer term; as children with disabilities are more vulnerable to sexual abuse, professionals need to ensure that this is considered when their behaviour is being assessed; professionals need knowledge and confidence about adult behaviours that might indicate a sexual risk to children; professionals need to be able to consider the 'unthinkable' about carers they may know well and be alert to the possibility of sexual abuse; when professionals predominantly work with one carer, they need to ensure that equal professional scrutiny applies to the second carer; opportunities should always be taken by trusted professionals to have age and ability appropriate discussions about sexual abuse with children in care; schools are key in providing an environment where children know who they can talk to about sexual abuse and what will happen if they tell someone; children in care in long term placements need significant relationships with professionals and/or their carers if they are to disclose sexual abuse.

Recommendations include: ensure professionals are thinking and talking about the risk of sexual abuse of children in care; learning from the review is shared with the local corporate parenting panel; training foster carers about intra-familial sexual abuse; and assurance of the local plan to include direct information from respite carers in child in care reviews.

Other resources Read practice review (PDF)

6. Local Child Safeguarding Practice Review: Child T

Death of an 11-month-old girl in April 2020, due to asphyxiation. Child T was found by her birth mother, between the bed guard and the mattress.

Learning includes: need for effective and appropriate transfer of children's cases between safeguarding agencies; children's cultural and ethnic backgrounds should be considered in assessments and care planning; the voluntary sector, including specialist domestic abuse services should be part of safeguarding partnership arrangements; impact of trauma experienced by parents can affect their ability to care for their own children; need for professionals to fully understand the role of absent or non-resident birth fathers; the temporary safety of a refuge should not influence decision making in relation to the significant harm experienced by the children; professionals should have an understanding about safer sleeping and be able to question arrangements.

Recommendations include: families moving to refuge accommodation and making homelessness applications to a local authorities should be referred to the local children's social care arrangements in the authority to which they are moving; survivors of domestic abuse moving from refuge, to new accommodation should be afforded a risk assessment as to its suitability; the Child Death Overview Panel, Public Health and Trading Standards should consider additional warnings regarding the safety of bed guards and their appropriate use in safer sleeping messages.

Other resources Read practice review (PDF)