NSPCC Repository – October 2023

In October 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including infant deaths, co-sleeping and youth violence
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Serious case review: Child T

Death of a 9-week-old-boy in November 2018 from non-accidental injuries, including a very serious injury to his brain and fractured bones. The investigation into his death is ongoing at the time of this report being written. It would appear from the post mortem that Child 'T' had fractures in his left leg at the time of a GP visit just before his death. The mother and maternal grandmother voluntarily took him to a GP as they were worried about his feeding and posseting. The symptoms as described are consistent with reflux, so a full body examination was not given and the doctor had no cause for concern in the mother's or grandmother's interactions with the baby.

Concludes that: there were no obvious issues that would have suggested to staff working with the family that Child 'T' was at risk of abuse or neglect; with the exception of a missed pre-birth visit by health visitors, agencies did accord with their own policies and procedures and managers within public health and the midwifery service are taking action to resolve the communication issue; there is evidence of good practice in the record keeping by both midwives and health visitors; and staff in both agencies kept comprehensive records that clearly evidenced assessments they completed and conversations they had with parents to discuss known risk factors to babies.

Other resources Read practice review (PDF)

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

Death of a 15-month-old child who was found by Father caught in a high chair, became asphyxiated and subsequently died. Learning is embedded in the recommendations.

Recommendations include: consider developing criteria for professionals meetings to be formally integrated into local Child Protection procedures to provide a multi-agency reflective space to consider risk and support for families; develop a multi-agency substance misuse strategy to provide clarity on the impact of different substance misuse, particularly cannabis on parenting capacity and guidance for practitioners in relation to escalation and effective interventions; consider how to support practitioners to manage the interface with one plan arrangements for children with special/additional needs within Early Help arrangements; consider the learning and undertake a multiagency self-assessment and any resulting actions from the national panel's thematic review "the myth of invisible men" 2021 to support practitioners in improving the engagement, involvement and assessment of male carers; and consider the learning from this

review and the national panel's review "Child Protection in England" 2022 to ensure that the views of family members are always considered in assessments of risk.

Other resources Read practice review (PDF)

3. Child safeguarding practice review: Child AK

Death of a 4-week-old girl while co-sleeping with her mother. The services provided to Child AK's siblings are included in the scope.

Learning themes include: the risks posed by neglect; the impact of neglect on the children's lived experience; family dynamics and the role of the fathers in the lives of children; the impact of domestic abuse on children; understanding the risk of physical harm within a family, especially with regards to 'physical chastisement'; the risks of substance misuse within the family; the impact of Covid-19 restrictions; use of language by services, practitioners and managers.

Recommendations for the partnership include: the revised Norfolk graded care profile (GCP) must be used when there are concerns about child neglect and an audit of neglect cases from across the child's journey used to assess how it impacts on planning and interventions within 12 months; babies born into large sibling groups receiving interventions should be recognised as increasingly at risk; to produce and promote sector specific good practice guides on working with fathers and father figures; to write a position statement about 'physical chastisement' and substance misuse and be clear about how to promote and endorse these; professionals should be mindful of the extent of current and historic substance misuse and the impact on the unborn child as well as any existing sibling groups, including financial impact, parental ability to regulate mood and neglectful and/or emotionally abusive parenting.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Baby JS

Death of 4-month-old-baby after being found unresponsive in bed with its mother.

Learning includes: reinforcing messages about potential risks to a child's safety of alcohol use by parents, even where there is no dependency; adequately managing every stage of the social care response from screening to the allocation of support; allowing for disclosure of domestic abuse by female perpetrators at routine domestic abuse screenings of pregnant women and new mothers; ensuring multi-agency co-ordination takes place as soon as the need for early help is identified and before a threshold for social care involvement is met; and keeping the lived experience of the child central to practitioners' work.

Recommendations to the safeguarding partners include: learning from the National Review into SUDI in families where children are considered at risk of significant harm should be fully implemented in their area; changes introduced to the referral process should be monitored to ensure all cases are being appropriately screened; relevant partner agencies should review their internal systems and guidance around making and following up referrals including providing feedback to all referrers in a timely way; screening questions used for domestic abuse should be

reviewed and if necessary reframed to avoid any unconscious bias; action should be taken to ensure that all practitioners are confident to explore situations involving domestic abuse, including establishing who is using abusive behaviours and who is the victim; and communication around the potential risks to a child's safety of alcohol use by parents should be reviewed and strengthened.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: death of Child E

Death of a 15-year-old-boy in July 2021. Child E was fatally stabbed by another 15-year-old-boy.

Learning considers: the involvement of young people in exploitation and knife crime and the potential for rapid escalation of violence; the heightened risk that children who have special educational needs, or who experience a disrupted education, may become involved in serious youth violence or may be exploited; helping children involved in criminal activity or at risk of exploitation who have suffered severe adverse experiences in early childhood; responding to the needs and circumstances of Black children and their families; and the role of social media in exploitation and the response of professionals.

Recommendations include: local safeguarding children partnerships (LSCPs) test whether there is effective response to the rapid escalation in violence that can occur when there is child exploitation or serious youth violence; LSCPs test the effectiveness of arrangements to promote better school attendance, and reduce rates of exclusion, among young people at risk of exploitation; LSCPs review the effectiveness of responses to families from Black and minority ethnic communities to consider how best to understand and discuss their experiences, values and perspectives; the Child Safeguarding Practice Review Panel should promote learning from the review of services provided to suspected perpetrators of serious youth violence and criminal exploitation, both through guidance issued by the panel and by seeking changes to the statutory guidance 'Working Together to Safeguard Children 2018'; consideration should be given to wording in the draft 'Police, Crime, Sentencing and Courts Act 2022' guidance on the review of offensive weapons homicides.

Other resources Read practice review (PDF)

6. Child Safeguarding practice review: 'Jake'

Suicide of a 17-year-old boy. Jake was subject to a care order, living in supported accommodation and awaiting an alcohol rehabilitation placement at the time.

Learning themes include: early help; the help seeking nature of challenging behaviour; drug awareness; responding to risk in adolescence, especially for high-risk children who are not engaging in services; identity and belonging and youth culture; engaging family members; and models of care for children with a complex and high-risk presentation.

Recommendations for the local children's safeguarding partnership include: consider how multi-agency reflective forums will be built into multi-agency meetings or panels and other current established processes; develop and promote the directory of statutory and voluntary services so

that services and referral pathways are visible and known to all agencies; promote substance misuse training; raise awareness of intersectionality and the use of an appropriate framework or tools to consider a child's presenting needs; assess the number of services involved with a child, their engagement and impact; consider how current training and awareness raising forums can be used to facilitate an understanding of youth culture; review, with services, support offered to families; oversee the development of multi-agency plans for children where contextual risks exist and when risks do not fit into the usual categories of gang affiliation and sexual exploitation; and agree across agencies the main principles for in-patient admission, welfare secure or other response including clarification about who is the lead agency in the child's care to ensure multi-agency ownership of care for children who are known to be at high risk.

Other resources Read practice review (PDF)