Torbay Safeguarding Children Partnership

NSPCC Repository – September 2023

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

1. Child safeguarding practice review report: Children N and O

Death of 16-year-old boy who was stabbed in the street and fatally injured by a 17-year-old boy in November 2020.

Learning includes: young people who have disengaged from education can be motivated to obtain employment; referral orders can be effective in supporting young people and reducing their offending behaviour; prompt and effective liaison between police youth offending service (YOS) and children's social care in both local authorities when a child involved with gangs moves to live in another area; usefulness of better arrangements for criminal justice liaison and diversion (CJLD) to have timely access to background information about the children they see in custody; usefulness of CJLD staff sharing information with YOS about the children they see in custody as standard practice; awareness of the employer's responsibility to do a risk assessment for any employee working in construction who is under 18; when children subject to a care order are placed with parents at short notice a statutory review should be held to discuss this and ensure the meeting and care plan includes attendance or a contribution from all practitioners working with the child and parents; deterioration in behaviour and increase in risk can be very swift if young people involved with gangs in one area connect with gangs in a new area; children vulnerable to being involved in violent incidents due to their involvement in gangs need to be supported by detailed operational multi-agency; the importance of practitioner and agency records being clear; and where children have moved areas to keep them safe from gangs the importance of reciprocal information sharing between police forces if they are different in the host and home authorities.

Other resources Read practice review (PDF)

2. Serious case review overview report: serious case review in respect of Matt

Death of 2-and-a-half-month-old boy in June 2019. Cause of death has not been formally determined.

Learning includes: need for all agencies to ensure practitioners are aware of the lived experience of the child and understand the cumulative effects of continued neglect; where there is concern regarding safe sleeping, despite advice, there is a need for escalation and differentiated response; clear procedure required once disguised compliance is identified; suspected drug use by parents should be effectively considered in social work assessments, to allow this is be ruled in or ruled out; there should be a clearer pathway between children's social care and early help; exploration required of how well children leaving care are prepared for parenthood; pre-birth assessment should be considered when there are concerns around neglect or other vulnerabilities; where a

referral is made to the MASH and a strategy meeting takes place, the professional making the referral should attend, and any assessment by children's services should seek the views of other involved professionals.

Recommendations for the local safeguarding partnership include: review of the neglect strategy, including implementation and embedding of the Graded Care Profile 2 (GCP2); review the approach to safe sleeping, with particular focus on parents that are suspected or are known to use substances and/or alcohol; review the support, training and advice for professionals dealing with families demonstrating disguised compliance or who are avoidant and/or resistant.

Other resources Read overview report (PDF)

3. Serious case review: Children O and P

Death of two 23-month-old toddlers in December 2018.

Learning includes: a need for information sharing between the general practitioners (GP) and the health visitor; a need to draw on the wider healthcare team to obtain as full a picture as possible of a child's life in order to recognise those in need; a need for insight into the impact of the breakdown in the parents' marriage on the children; a need for information sharing with regards to updating the NHS spine when people move address; professionals need to recognise the relationship between adult mental health and safeguarding children; a need for further focus on the impact of a parent's deteriorating mental health on their capacity to care for their children; and recognition that there is less likelihood of determining a patient's true condition when contact with a service is over the telephone.

Recommendations include: review the effectiveness of the 'health visitor/GP link meetings' in relation to parental mental health issues; consider how to enable patient's addresses on local records and the NHS spine to reflect their current whereabouts; review the effectiveness of telephone and email contact and its impact on mental health assessments and practitioners' capacity to assess risk; and ensure all professionals are aware of the risks around parental mental health, including the potential for children being harmed, and that children should not be viewed solely as a protective factor.

Other resources Read overview report (PDF)

4. Sudden unexpected death in infancy (SUDI) review

Two cases of sudden unexpected death in infancy (SUDI). It was concluded that neither of the SUDI cases met the criteria for a serious incident notification, but a joint agency response (JAR) meeting identified that there could be learning for multi-agency partners.

Learning includes: the importance of children's services pursuing the need for housing support for families experiencing homelessness; the socioeconomic impact of poor housing on families, especially mothers and babies; agency checks should be completed and obtained in a timely manner to establish past concerns about a family and current intervention; more professional curiosity from health visitors and midwives regarding the home environment of a family.

Recommendations include: safeguarding partnership to commission training or briefings on the impact of poor housing and homelessness on safeguarding children and families; undertake a review of the effectiveness of early help in dealing with issues of homelessness; provide and promote information and training around the risk factors relating to SUDI identified nationally, including signposting partners to the national SUDI review and considering the availability of safe sleeping advice in a range of languages.

Other resources Read review (PDF)

5. Local child safeguarding practice review (LCSPR) Children O, P and Q

Three siblings aged between 6-15-years-old who experienced a significant domestic abuse incident in August 2021. The abuse was perpetrated by their father against their mother and lasted over 11 hours in the family home.

Learning includes: agencies should be cognisant of the assessment, chronology, and history of families, before making judgements about risk based upon the decisions of others; children's case closure should highlight ongoing support offered to the family and identify risk factors which would result in the case being escalated and re-assessed; agencies need to follow up and follow through when parents are tasked with self-referring for agency support or services; significant low attendance at school should at least prompt an early help assessment; supervision should consider gender bias and ensure that discussions focus on the risks presented by both parents; agencies working with children and young people would benefit from hearing from domestic abuse survivors and their experiences of statutory interventions.

Recommendations include: agencies should alert the multi-agency safeguarding hub (MASH) if it is known or becomes apparent that children have been the subject of care proceedings or child protection planning in another local authority; safeguarding partners should consider how learning from the Covid-19 pandemic is embedded into organisational forward plans; raise practitioner awareness of young carers and their routes for support, and the link between the young carer role and neglect; child protection plans, child in need plans and early help plans need to reflect the actions that safeguarding agencies take if parental relationships and contact is resumed without formal agreement.

Other resources Read practice review (PDF)

6. Local child safeguarding practice review:

Suspected non-accidental head injury to an 8-day-old infant. At the time of Child R 's birth all of the children in the household were the subject of child protection plans.

Learning themes include: knowing and considering the parent's history and vulnerabilities when working with a family; understanding a child's lived experience and what they may be communicating by their behaviour; the likelihood of child neglect coexisting with other forms of abuse; the impact of 'growing families and growing children' on the ability of parents' to cope; the cumulative impact of long-term neglect; awareness among professionals of control and coercion and non-violent domestic abuse; need for professionals involved with adults to be aware of plans

for the children in the household; the effect of COVID-19 on families and services received; considering making older siblings aware of safe handling and careful behaviour around a new born baby; child protection procedures regarding parental contact following an injury.

Recommendations to the safeguarding partnership include: ensuring improvement actions are taken, including seeking assurance that the learning from this review is considered by those responsible for ICON training, and that ICON recognises the need for bespoke plans about safe handling for parents with learning difficulties and where there are older children in the family; ensure that services are aware of the need to follow child protection procedures when a non-mobile child has injuries; and ensuring that when children are the subject of a plan, this is recorded on the GP record of any adults in the household.

Other resources Read practice review (PDF)