NSPCC Repository – November 2023

In November 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including violence, neglect, and suicide
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 into the death of Adult A

Fatal stabbing of an adult in October 2020. A 14-year-old girl pleaded guilty to manslaughter on the grounds of diminished responsibility.

Learning themes include: identifying, understanding, and responding to the needs of those at greatest risk from children exhibiting the most harmful behaviour; the effectiveness of systems to protect those most vulnerable, particularly within the context of intersectionality, structural racism, adultification and extra-familial harm; understanding family dynamics, needs and history in its broadest context is vital; the importance of recognising and understanding the impact of trauma and abuse on children and utilising a trauma-informed approach; the importance of the continuity of care, support and information exchange when a child moves area; recognising that children involved in offending behaviours are vulnerable too and resolving their unmet needs is critical to reducing the risk they present to others; the need of all agencies to constantly question and challenge themselves on how well they understand a family and how effectively they are working, both with the family, within their own agency and with each other; a child at risk of being permanently excluded should trigger a multi-agency safeguarding response; and housing authorities should consider risk and vulnerability when placing vulnerable individuals and families into accommodation. Details local action taken to embed learning.

Recommends that: "Working Together to Safeguard Children, 2023" strengthens the importance of housing being involved routinely in multi-agency arrangements to safeguard children.

Other resources Read practice review (PDF)

2. Local safeguarding practice review: Sara, Edvina and Danuka

Neglect of female siblings aged 11-months-old, 1-year-old and 6-years-old. A home visit found the two younger children living in significantly neglectful circumstances with unexplained injuries. The eldest child was not in the accommodation at the time and was found to be physically unharmed.

Findings include: the importance of professionals working in a culturally competent way; the importance of robust consideration of the need for pre-birth assessments and pre-birth early help and support plans; the need for a proactive, holistic, and robust response to domestic abuse to increase safety for survivors and their children; the need for professional recognition and response to the early signs of neglect of young children by their caregivers; and an analysis of responses to referrals, completion of assessments, child in need processes and multi-agency working. Recommendations include: produce guidance on working in a culturally competent way, including information about the culturagram framework; the Child Safeguarding Practice Review

Panel look into why neglect tools developed over the last ten years are not having an impact on practice; seek information from the Child Safeguarding Practice Review Panel on what work is underway to address the lack of guidance about the appropriate response to referrals and information from family, the public and anonymous sources; and seek clarity about when and in what circumstances child and family assessments are shared with agencies who will be supporting children subject to child in need plans.

Other resources Read practice review (PDF)

3. Local child safeguarding practice review: Child K

A 17-year-old girl exposed to significant and serious harm between June 2021 and January 2022. Child K made several serious and life-threatening attempts to self-harm during this period and experienced multiple placement moves.

Learning includes: multi–agency planning meetings should provide an opportunity for information sharing, development of safety plans, co-ordination of care planning and appropriate professional challenge; when children are the subject of numerous multi–agency planning meetings the most appropriate forum for this should be agreed; appropriate placement identification needs to be supported by a co-ordinated multi-agency approach and consideration of joint commissioning, particularly when children and young people have complex and multiple needs; and frontline workers who are working with children in the context of significant risk need working conditions and a culture that promotes well-being and creates a safe supportive environment.

Recommendations include: when children are cared for and there are significant safeguarding risks, the frequency of care planning meetings should reflect the needs of the child and professionals should hold each other to account; collaborative working to ensure the child is at the centre of all decision making; agreement of the multi–agency safeguarding plan before hospital discharge following a serious incident; gateway meetings and the use of the risk stratification tool to support co-ordination of multi–agency plans for high-risk children to be safely supported in community settings; and the corporate parenting board addresses multi–agency approaches to joint commissioning arrangements for complex and vulnerable children where there are significant safeguarding concerns and how agencies work together to identify placements and manage risk.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Safeguarding children when there are adults in the family who pose a sexual risk

Three siblings potentially at risk from two known sex offenders in their family.

Learning includes: professionals working with children should be aware of adults in a family who may pose a sexual risk; when assessing the ability of a parent to protect their children from a risky adult in the wider family, there needs to be an understanding of the relationship, contact and whether the adults, as well as the children, have been groomed; if there is no conviction for child

sex abuse, there can still be a risk to children from an individual of concern; child protection procedures need to be used when information is shared that a person of concern is having contact with children; professionals need to be curious about a child's behaviour and consider other indicators of sexual abuse even if they don't disclose abuse.

Recommendations for the Partnership include: seek assurance about the use of the complex and organised abuse procedures in cases where there is a risk of child sexual abuse in the wider family; ensure that the relevant professionals and carers of children are aware of the risk to children in care of technology being used to locate and contact them; request agencies consider how to improve professional awareness and practice in respect of how perpetrators may conceal their abuse, how a non-abusing parent/carer may be complicit or unaware of abuse and how to work with children when they do not disclose sexual abuse but are likely to have been exposed to it.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: Child C

Death of a 17-year-old girl in October 2020 by suicide.

Learning includes: the importance of understanding the interplay between physical and mental health needs and neurodiversity; the importance of agencies taking a whole family approach; autism diagnosis in adolescence can result in social, emotional and cognitive needs in childhood not being addressed in agency responses.

Recommendations for the safeguarding partnership include: child and family assessment and child in need plan should be the recognised and expected mechanism for coordinating a whole person approach where a child/young person has complex needs; disabled children should be recognised as children in need in their own right when living in a family environment where there are multiple stressors affecting their siblings; consideration should be given to how to achieve an environment which supports critical reflection and challenge in multi-agency work with complex families; social care practitioners should be aware of the protocol supporting implementation of s117 Mental Health Act 1883, this should be updated in relation to young people, including the mechanism for accessing necessary funding; parental responsibility and next of kin should be clearly recorded and guidance provided as to how this should inform decision making; all agencies should increase awareness of neurodiversity including recognising signs, indicators and impact on the young person, promoting positive self-identity, identifying when a formal assessment may be offered; guidance on the use of virtual meetings should ensure that the circumstances of each child and young person are assessed, to mitigate any risks associated with using this approach.

Other resources Read practice review (PDF)

6. A local child safeguarding practice review: 'W' Siblings: overview report

Neglect and abuse over several years of seven siblings aged between 16-years-old and 1-year-old. The siblings' circumstances were discussed at a rapid review meeting in early September 2021 after suspected sunburn injuries which were the subject of a police criminal investigation.

Learning includes: importance and workload implications of focussing on individual children within larger sibling groups; behavioural and emotional symptoms of persistent neglect and how they are reflected in risk statements such as the signs of safety scaling; the importance of considering children's lived experiences when the cumulative effect of neglect and the impact on children's development and well-being is a factor; the importance of chronology and holistic assessments; need for GP practices to be involved in enquiries and assessments; procedures for escalating concerns about children through internal systems and how they can be linked with local partnership escalation pathways; importance of a clear strategy for responding to neglect that is owned by all respective organisations; the importance of providing trauma-informed early intensive help for parents who have experienced trauma in their own childhood; and aligning legal and child-based risk discussions.

Recommendations include: the Director of Children's Services (DCS) should satisfy themselves with the effectiveness of signs of safety in supporting effective assessment and management of risk for children; DCS should ensure that advocates for children can be appointed and are routinely considered in complex and/or longstanding cases involving neglect; DCS and Director of Legal Services should ensure appropriate arrangements are in place for social workers to seek emergency protection for children when necessary.

Other resources Read practice review (PDF)