NSPCC Repository – January 2024

In January 2024 six case reviews were published to the NSPCC Repository featuring a number of issues including non-accidental injuries, criminal exploitation, child neglect, 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. Local child safeguarding practice review: commissioned by The Bradford Partnership – concerning Child A

Death of a 7-year-old boy in the summer of 2020. Child A was struck by a car and killed at a time when there was no one at his home address caring for him. Also addresses the neglect of Child A and his two siblings by their mother.

Learning themes include: identifying and assessing neglect; thresholds for intervention for child protection enquiries; impact of parental mental ill health on parenting capacity; barriers to hearing the children's voices; the inclusion of extended family assessments and interventions; use of formal routes by agencies to escalate concerns; issues arising from diversity and intersectionality and how these may have influenced service delivery; and impact of Covid-19 on service delivery.

Recommendations for the partnership include: update and re-launch the existing neglect strategy, associated tool kit, and training strategy; audit the effectiveness of the multi-agency response to neglect as part of the Quality Assurance Framework; review and relaunch the inter-agency escalation policy and provide clarity for practitioners on when to use it; ensure ongoing work from all agencies includes the child's voice and experience (including family relationships); oversee the development of a 'Think Family' joint protocol with the partnership's safeguarding adult's board; ensure that all partners train their practitioners to be confident dealing with families where domestic abuse is a factor, and that the training strategy includes the importance of professional curiosity about all relationships and exploring potential ongoing risks when parents separate; and provide a training programme for practitioners covering intersectionality for families who experience multiple oppressions.

Other resources Read practice review (PDF)

2. Thematic review: Babies who sustained injuries

Three cases where babies sustained injuries believed to be non-accidental in 2022. Considers and compares the learning from previous reviews with the learning in respect of the 2022 babies, to enable reflection on the impact they have had on practice and safeguarding systems in the partnership, and where progress is still required.

Learning themes include: impact of a parent's own vulnerabilities, including their poor childhood experience of being parented and on-going mental health issues; domestic abuse and violent behaviour, both historic and on-going; thresholds for neglect, including consideration of accidental injuries as a sign of neglect and understanding of cumulative harm; consideration of the child's lived experience; the need to engage with and consider the father of a child, or the partner of a mother

who lives with, or spends a lot of time with the family (including same sex partners); the need for relationship-based practice, with children, with parents and the wider family and across agencies.

Recommendations for the partnership include: to ask the national Child Safeguarding Review Panel to request that the Department of Health provides clear clarification to GPs regarding how they can safely and legally record information on adult records when there has been domestic abuse; consider alternative models of professional challenge, for example Portsmouth Safeguarding Children Partnership's model 'Re-think'; help professionals to ensure that practice is both culturally and individual family sensitive and that safeguarding responses are consistent, including professionals working with families having a safe space to consider their own values and biases.

Other resources Read practice review (PDF)

3. Report of the serious case review regarding Child V

Non-accidental bruising and fractures to a 7-month-old infant in August 2018 leading to the arrest of Child V's parents. Child V's parents were living in temporary accommodation and both experienced difficult childhoods with domestic abuse a feature.

Learning themes include: the impact of living in temporary accommodation on the child; the impact of single-agency and multi-agency working; professional awareness of parental substance misuse; professional awareness of the legal processes concerning care proceedings; the role of GPs as part of the child protection planning process; recognising and understanding domestic abuse and the risks to small children; sympathy for parents leading to optimism; importance of full investigations of all injuries to infants; and workload pressures in the safeguarding system.

Recommendations for the LSCB include: receive progress reports from agencies where there were single-agency limitations, specifically regarding workload pressures, invitations to child protection conferences, GP recording practices and children under one being examined; improve practice regarding GP input to conferences, housing involvement in child protection plans, and the use and recording of strategy discussions; re-launch the protocol regarding 'Unexplained Injuries to Young Children' focussing on the importance of strategy discussions and medicals; consider whether safeguarding procedures around domestic abuse include enough focus on the risks of physical harm to young children and infants and how emotional harm may manifest; consider whether services for perpetrators of domestic violence include provision for couples where there is evidence of mutual abuse; and review whether current escalation policy is sufficiently understood by managers across all agencies.

Other resources Read full overview (PDF)

4. Child safeguarding practice review report: thematic review: which examines the multi-agency response in the Luton area, to keeping young people safe from risks related to exploitation, violent youth crime and gang associations

Fatal stabbing of a 16-year-old boy in June 2021. In the preceding months there were other assaults and multiple exclusions from school; gang associations and conflicts were also known about.

Learning considers: multi-agency response to risk, including sensitivity when working in a diverse population and understanding subtleties associated with gang networks; the background and profile

of the young people, including effective early intervention, recognising that complex cultural and relational dynamics require insight from those with lived experience, the importance of early identification of additional educational need and/or learning disability, and balancing the use of exclusions from school; and frameworks for assessing risk, threshold decisions and interventions, including acknowledging the cultural role of extended family and providing support for young people when taking a case to prosecution.

Recommendations include: to map and evaluate arrangements for identifying and responding to contextual safeguarding and safeguarding children at risk of violence and criminal exploitation, and examine whether there are differences in how some children might receive a 'safeguarding' response versus those that may receive a 'criminal justice' response; to understand whether there are other young people with unassessed or undiagnosed learning difficulties who are not having their needs met; to ensure that all key agencies are fully informed about core child protection processes; to refer children to the MASH who are on the cusp of being permanently excluded from education and where there are contextual safeguarding concerns; to improve the offer of mediation with young people and their families that are at high risk of harm through culturally competent service providers; and to ensure that processes are followed within educational settings where there are known risks to pupils from gang associations.

Other resources Read thematic review (PDF)

5. Local child safeguarding practice review: Samuel, Shay, and Joy

Three siblings, Samuel (17), Shay (15) and Joy (13), known to services as potential victims of criminal exploitation. In 2022 Samuel was involved in two altercations and received knife wounds. In December 2022, Shay was arrested regarding an assault with a knife which led to another arrest for class A drug possession.

Learning themes include: working with the family, alongside the wider contextual issues regarding child criminal exploitation and serious youth violence; evaluation of assessments and interventions; the role of schools; use of knives and police and criminal justice interventions; use of social media and agency assessment of its significance; extra-familial harm versus criminal activity; use of the National Referral Mechanism (NRM); and managing the needs and risks of siblings.

Recommendations for the Partnership include: adopt the term 'extra-familial harm' to describe 'child exploitation'; review the existing system of alerting senior managers to 'high risk' children in children's social care; ensure that front line practitioners have a clear understanding of adolescent development and the impact of ACE's/trauma; consider a multi-agency learning audit for children involved in the Section 47 process where there is an extra-familial harm concern; school leaders should review the effectiveness for children of separate 'on site' alternative learning provision; embed training on children's use of social media and its associated risk factors into existing training; ensure one safeguarding partner takes sole responsibility for tracking children subject to the NRM process; and where extra-familial harm is evidenced ensure siblings are appropriately assessed and interventions are put in place.

Other resources Read practice review (PDF)

6. Report of the safeguarding children practice review regarding C101

Femur fracture to an 8-week-old girl in December 2022. Medical investigations showed C101 had suffered multiple fractures that occurred on more than one occasion. C101's parents and older sibling were previously known to children's services.

Learning considers: recognition and response to domestic abuse and coercive control; effectiveness of communication and information sharing; the importance of good quality, SMART, multi-agency planning; the importance of professional curiosity when working with parents/carers accessing substance misuse services; and assessing the strengths and potential risks from male carers.

Recommendations include: training on domestic abuse to promote the recognition of abuse, coercive, controlling and stalking behaviours, and the consistent use of risk assessment tools; changes of worker to be kept to an absolute minimum in the child's journey through the services; health partners to consider enabling a safeguarding alert on information recording systems, to fully explore records on the family history, to improve handover between workers, and for indicators of domestic abuse in GP notes to be effectively communicated; children's services to provide assurance that the introduction of a child in need (CIN) reviewing officer impacts on the quality, timeliness and sharing of CIN plans and reviews; for providers of substance misuse services to be made aware of the learning regarding professional curiosity; to consider the introduction of a pre-birth tool to help workers identify the roles of each parent/carer in parenting and aid the identification of risk factors for newborn children; and for the research, 'The myth of invisible men' (2021) to be disseminated across midwifery, health visiting, early help and social work services.

Other resources Read practice review (PDF)