NSPCC Repository February 2024

In February 2024 six case reviews were published to the NSPCC Repository featuring a number of issues including neurodiversity, sudden infant death, disguised compliance 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: Lilo

Fatal stabbing of a 17-year-old in 2021. At the time of his death, Lilo was a Child in Need who had a diagnosis of autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), as well as limited mobility because of a moped accident.

Learning themes include: access to education and delays in assessments for Education Health and Care Plans (EHCPs) and the experiences of neurodiverse Black boys in education; recognising and responding to risk in the context of extra-familial harm; understanding the impact of trauma in the context of extra-familial harm and wider trauma; and understanding the impact of trauma on the workforce.

Recommendations include: education must undertake a review of the EHCP process; the local safeguarding children's partnership should commission further learning to improve professional understanding across all agencies to ensure a better understanding of trauma, intersectionality, adultification bias and neurodiverse children in the context of extra-familial harm, always considering language and framing of children; ensure that the voice of the child is heard and integrated into planning; ensure that all social workers and managers can recognise and respond to extrafamilial harm, especially for children with additional needs; improve the quality of support and child protection responses, with increased understanding of the role of a statutory safeguarding partner; improve the quality of record keeping and assessments; child and adolescent mental health services should introduce multi-disciplinary review meetings when a child is referred more than three times and does not meet threshold for intervention as well as monitor and improve access and support for Black and ethnic minoritised children.

Other resources Read practice review (PDF)

2. Local child safeguarding practice review: Isabel

Death of a 3-month-old infant in March 2022. It is thought Isabel's death was an accident linked to an unplanned sleeping environment where drugs and alcohol were present. The mother's extended family were known to services regarding domestic abuse.

Learning themes include: responding to the needs of the child, including the unborn child; safeguarding procedures around co-sleeping; considerations of the pre-birth assessment pathway; male figures in the family and father's engagement with antenatal and post-natal services; recognition of potential indicators of abuse; issues arising from moving to different local

authorities; parents' previous involvement with adult or children's services; disguised compliance; response to lack of engagement and Did Not Attends (DNA); interaction of services during the antenatal and perinatal period; and assessment of parental needs including domestic abuse, mental health issues, substance misuse and difficulties with housing.

Recommendations for the local safeguarding partnership include: review the antenatal pathway to ensure the referral system identifies concerning families of unborn babies; oversee a review of the local maternity safeguarding hub; ensure all partner agencies have systems to actively consider fathers and other significant males in assessments; review practices about how safe sleeping messages are delivered; oversee an audit of multi-agency practice in relation to domestic abuse at the front door; oversee partner agencies' reviews of their supervision practices and ensure managerial oversight of decisions in relation to children and unborn babies where there are safeguarding concerns; and ensure robust liaison between Midwifery services and GPs for pregnant women, including exchanging information about both parents (and partners) during pregnancy.

Other resources Read practice review (PDF)

3. Child safeguarding practice review: Harry (TT)

Possible neglect of a boy since birth until an incident in January 2019 when he was 11-years-old. Harry was seen with facial injuries by staff at a local leisure centre where he attended alone. Police were initially unable to contact his mother and she was later arrested for neglect.

Learning themes include: the voice of the child; recognising the signs and symptoms of neglect in children, the assessment of risk and enhanced professional curiosity; supervision, sharing information, communication and record keeping; professionals working together, compliance to policies and procedures and escalation processes; disguised and varied compliance; and child protection medical examinations.

Recommendations to the Safeguarding Practice Review Group include: be assured that all partners keep focussed on the child or young person, and that a professional meeting can be called by any partner to ensure communication and challenge of safeguarding concerns; review and update the local 'Multi-Agency Threshold Guidance '; make sure all staff utilise the available 'Neglect Strategy and Tool' to assist in identifying the signs and symptoms of neglect and abuse and to take immediate and necessary action if required; ensure agencies' record keeping systems are robust, accurate and efficient for purpose and staff are complying with policy; ensure staff are supported and trained in dealing with difficult and confrontational parents or guardians; include within child protection training the range of options practitioners can take, including legal advice when a parent or guardian refuses consent to a child protection medical.

Other resources Read practice review (PDF)

4. Child safeguarding practice review: Child 'Rowan'

Death of a 4-month-old-boy in Spring 2022. A post-mortem found that Rowan died from Sudden Unexpected Infant Death Syndrome. His parents were children themselves at the time of Rowan's birth. Mother was 13 and father was 14-years-old.

Learning themes include: the importance of parenting and pre-birth assessments; recognising that the parents were themselves children and the support offered to young parents; child protection planning; and professional advice on safe sleeping.

Recommendations to the partnership include: ensure all practitioners read the briefing 'Learning from Pre-Birth Assessments'; if a vulnerable baby is living in the care of grandparents (with or without the presence of their parent), an assessment of their parenting capabilities and skills should be a pre-requisite before any such placement is made, especially if the child is subject to a child protection plan; when parents are children themselves, their needs and wellbeing should be recognised, and considered a priority, together with that of the need to safeguard their child; explore the possibility of young, teenage mothers being offered the services of the perinatal mental health team when it is evident that their health and wellbeing is at risk; GP practices should be informed when a child is subject to a child in need plan, to ensure that relevant safeguarding information is shared; seek assurance that the framework concerning safe sleeping is embedded for use by practitioners and that it includes a requirement that professionals visiting the home ask to see where a baby is sleeping.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: Child P

Death of a 13-year-old girl in September 2019 from suicide five days before her 14th birthday. Learning is embedded in the recommendations.

Recommendations include: be able to articulate what the barriers might be to hearing the voice of the child at a system and practice level; make clear the expectation that all working with vulnerable children are alert to the depth and breadth of knowledge that they hold about the child's history and current networks and ensure that this is incorporated into ongoing assessments and plans; where there is a significant change in a child's circumstances a swift meeting should take place with relevant practitioners and family members in order to agree a multi-agency response and any adaptations to the Child in Need plan; work with partner agencies to clarify the expected steps to take when young people engage in sexually harmful behaviour; ensure that staff have the knowledge and skills to work confidently with young people and support families, where there are risks associated with their engagement in the digital world; ensure that strategy meetings/discussions are child focused and separately identify the vulnerabilities of the young person alongside risks to others; promote a balanced approach to discussions about whether a child should become looked after; clarify the process for the provision of financial support for family and friend carers and make sure that this is used creatively to prevent children becoming looked after; and review the training and development

opportunities for staff who are expected to chair Child in Need meetings to ensure that all staff are adequately supported to undertake this task.

Other resources Read practice review (PDF)

6. Child safeguarding practice review: learning identified from considering Ted

Non-accidental injury to the leg of a 1-year-old boy who was identified with significant emerging health needs prior to the injury. He is developmentally delayed and was described as 'non-mobile'.

Learning includes: the importance of knowing and understanding the impact of a parent's vulnerabilities and history on their parenting; parental substance misuse, mental health, and prescribed pain medication; working with homeless families; exploring and understanding a disabled child's likely and actual lived experience; considering absent parents, even when domestic abuse is alleged; considering what support is required to ensure a lone, non-birthing parent acquires 'parental responsibility'; referring/ transferring a child in need plan across local authority borders; and the need to consider if the parent requires an assessment or support due to their own needs or as a care leaver.

Recommendations include: the partnership should request that agencies review their practice in respect of ensuring that the person caring for a child has parental responsibility and provide feedback on what recent progress has been made; the MASH to be asked to consider their expectations and processes regarding transfers from other Local Authorities in respect of children subject to a Child in Need plan; and the partnership to consider how it can promote the responsibilities of partner agencies to care leavers.

Other resources Read practice review (PDF)