Torbay Safeguarding Children Partnership

NSPCC Repository March 2024

In March 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including child neglect, intra-familial sexual abuse, school inspection, and unknown men
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: Baby Y

Serious non-accidental injuries to a 9-month-old baby in July 2022. Adult A, the partner of Baby Y's mother, was arrested on suspicion of causing the injuries.

Learning considers: assessment of neglect; physical and mental ill health in the family; parents'/carers' background and history; issues of domestic abuse; ethnicity and issues arising from intersectionality and diversity; working with uncertainty and gut feeling; working with fathers and other significant males; and assessing risk to children from men who join vulnerable families.

Recommendations to the partnership include: to oversee the completion of an evaluation of the use of the multi-agency neglect toolkit; to develop a seven minute briefing and tips for practitioners about how to act on gut feelings and professional curiosity; to seek assurances from all member agencies that their training strategy includes awareness raising about the importance of including fathers and other male family members in assessments and ongoing work; and to ensure that professionals have the knowledge and understanding of intersectionality to identify and consider issues around families who experience multiple oppressions and disadvantage, when assessing and managing the risk to children.

Other resources Read practice review (PDF)

2. Child safeguarding practice review: Child V

Death of a young boy in the summer of 2021, thought to be due to a chronic health condition. At the time of Child V's death there was also evidence of malnutrition.

Learning themes include: awareness and management of Child V's health condition; response to medical neglect including not being brought to medical appointments/accessing support offered; and response to domestic abuse.

Recommendations for the Partnership include: ensure all practitioners working with children with health conditions have a good understanding of how it affects the health and development of the child, and any risks of mismanagement; adapt safeguarding processes and procedures to support practitioners to request information about the needs of children with medical conditions through each stage of safeguarding activity; support practitioners to have the skills to confidently explore how the cultural background, attitudes and beliefs of any carer, affects care of the child, including each parent's attitude to health conditions and treatment; ensure there are clear

arrangements to ensure the co-ordination of healthcare for those children with complex health conditions who are particularly vulnerable or where there are emerging concerns about medical neglect; consider best practice in parental education about health problems and how to recognise and respond when parents are struggling to meet a child's health care needs, including exploring the reasons for missed appointments; make representations to NHS digital about the benefits of adding a Was Not Brought (WNB) code to all NHS recording systems to help identify those children who may be vulnerable to medical neglect.

Other resources Read practice review (PDF)

3. Review of safeguarding practice in response to events at Harlow Academy

An Ofsted inspection of a special educational needs school carried out in January 2022 raised a number of serious safeguarding matters. Ofsted concluded that pupils were not being kept safe and were at risk of immediate and imminent harm.

Learning includes: a need for the Department for Education (DfE) to strengthen processes for matching academy sponsors to special schools; there was sufficient information for Ofsted to decide to undertake a no notice inspection of the academy earlier; the need to put in place a process to address the multiple safeguarding concerns about the care of children in the academy; and a need for agencies to recognise that regardless of what Ofsted would do they have a responsibility to take action to safeguard the children.

Recommendations include: the DfE to revise its process for identifying academy sponsors for special schools; professionals should always consider what other routes they should explore when a referral about a child or about the behaviour of an adult does not meet the safeguarding criteria they use; and the partnership should agree a document for parents and carers that outlines how to raise concerns in relation to children with disabilities and what to do if these concerns are not responded to.

Other resources Read review (PDF)

4. Intra-familial sexual abuse (IFSA): a thematic review of Oxfordshire local child safeguarding reviews

Summarises key findings and learning points from cases of intra-familial sexual abuse (IFSA), including sibling sexual abuse.

Learning points include: acting on early concerns, using the Strengths and Needs Form; remaining alert to the possibility of all types of bias including ‘unconscious gender bias’ and female abusers; awareness of how practice can be influenced by family social status; considering the viewing and sharing sexual images online in the context of family history and response to trauma; effective communication, with practitioners both sharing and seeking information, and using clear language; using available tools to identify different types of IFSA, for example a multi-agency chronology; ensuring that assessments consider and include the whole family and that all children in the family have been seen individually and had their voices heard; analysing parental motivations and capacity as part of risk assessments; reflecting on the impact of inter-generational abuse on parenting capacity and the need for practitioners to be trauma aware;

understanding practitioners' confidence levels around specific types of IFSA, especially sibling sexual abuse; consideration of what additional support may be needed when ending work with a family if parents are vulnerable; encouraging fathers to be included and participate in discussions; the impact of Covid-19 on families and service delivery; and the need to update the national practice of categorising abuse in the child protection process when there are multiple risk factors, for older children, or where there is intra-familial (sibling) abuse.

Recommendations are embedded in the learning points.

Other resources Read thematic review (PDF)

5. Child safeguarding practice review: Uma

Rape of a 14-year-old in 2022. Uma was vulnerable due to a history of being sexually abused in the family environment.

Learning themes include: early identification of those at risk of exploitation; the importance of seeking information about a child's history when they have lived in another area; language used about vulnerable children; retracted allegations; impact on the child when professionals change; and responding to children at risk of exploitation when they go missing.

Recommendations for the Partnership include: ensure that the learning from this review informs the other work being undertaken on a similar theme; consider what can be done differently to ensure the early identification of children on a trajectory to exploitation and provision of multi-agency support and preventative/educative work; raise with other local safeguarding children's partnerships and agency partners the need for system wide support for practitioners in respect of good practice when working with children who are exploring their gender identity; get detailed feedback from the police on the work being undertaken in respect of missing children; ask agencies to provide information on progress and challenge in respect of the language used in respect of vulnerable children; ask the relevant partner agencies to provide assurance regarding what is being done to prevent school exclusion for children who are at risk of exploitation.

Other resources Read practice review (PDF)

6. Local Child safeguarding practice review: Molly

Assault of a teenage girl in a residential children's home. The incident is subject to an ongoing police investigation at the time of the review. Learning themes include: managing the risk of harmful sexual behaviour (HSB) in residential settings; support for adoptive parents; support available for families where child to parent violence is a feature; child blaming language used by professionals; and placement sufficiency and impact on finding placements for children with complex needs. Recommendations include: the national working group reviewing the adoption support arrangements should take action to ensure that the needs of adopted children are addressed at key transition points such as when they move area or school; consider developing a pathway to support an effective professional response to child to parent violence; seek assurance that partner agencies have guidance which addresses victim blaming language and ensures that professionals record with the child in mind on the understanding that the child may one day ask to see their records; suggest to the National Panel that they consider concerns about the impact

on children and young people of the cost and shortage of appropriate placements for traumatised children; when seeking placements for children the commissioning team should seek reassurance about harmful sexual behaviours; propose that the children's home develop a harmful sexual behaviours policy and systematic approach to keeping children safe from sexual harm; identify whether other LSCPR's have highlighted a lack of guidance within children's homes about HSB and whether this issue is currently being sufficiently addressed through Regulation 44 Visits.

Other resources Read practice review (PDF)

7. Alternative learning review: Anna

Suicide of a 21-year-old mother in October 2019. Anna had a baby at 15-years-old and both Anna and her daughter were considered as 'children in care'. Anna had long-term physical and emotional difficulties, including personality disorder.

Learning considers: effective information sharing to support both the parent and child; a 'Think Family' approach; collective consideration of the bigger picture; assessing a parent's physical and mental health needs; non-attendance of appointments and the decision to discharge; a trauma-informed approach; and the role of corporate parent.

Recommendations include: children's services to consider how they have the skills and knowledge to support people with personality disorder and for all front-facing staff to have appropriate training; the establishment of a multi-agency task and finish group to address the gap in information sharing and better embed the 'Think Family' approach; relevant agencies, including the police, to consider the impact of their actions related to the protection of children on vulnerable adult family members; those working with children to be aware of the role that social care can play in supporting adults with care and support needs; seek assurance that the Escalation Protocol is fully embedded and being used effectively across all agencies; consider reviewing existing supervision methods, with a focus on the use of reflective practice and evidence-based processes; the partnership to produce short briefings on the issues of disguised compliance, the rule of optimism (around 'new partners' joining vulnerable families) and the poor care of pets; and to ensure step up/down processes are effective in cases where family mental health concerns have been identified.

Other resources Read learning review (PDF)

8. Child practice review report: Concise child practice review: re WG N56 2020

Covers the period from December 2018 to December 2019 when Child X attended the hospital following identification of his injuries which were consistent with shaking.

Learning themes include: multi-agency working; information sharing between health professionals; the importance of separating fact from opinion when recording; domestic violence; professional curiosity; and use of the strategy meeting.

Recommendations include: agencies should strengthen their guidance and training provided in respect of recording information to ensure relevant individuals are identified clearly in recordings whilst also differentiating between self-reported information and diagnosed conditions; midwifery and health visiting services should be reminded of the guidance and importance of

effective communication and information sharing between their services; all key agencies should be reminded of the importance of their involvement at the Initial Strategy Meeting; training around working with families who are experiencing domestic abuse should include the importance of involving fathers and extended family to fully assess risk and maximise opportunities for better outcomes; if the referring agencies are not content with the proposed action they must challenge the decision and if necessary escalate their concerns by implementing the Multi-Agency Protocol for the Resolution of Professional Differences; and panel members should be reminded of their responsibilities in the Child Practice Review process which includes that all key professionals involved in the case are invited to the learning event to maximise discussion and learning.

Other resources Read online: www.wgsb.wales/31268