NSPCC Repository June 2024

In June 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including contextual safeguarding, infant deaths, child 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. Eva: Child safeguarding practice review

Non-accidental injuries to a 4-month-old girl in June 2023. Baby Eva was taken to hospital by both parents, with a pain in her right arm. Examination revealed a spiral fracture and further examination revealed multiple fractures, including rib fractures of varying ages. Both parents were subsequently arrested and remain under investigation, with Baby Eva's mother later alleging domestic abuse by the father.

Learning themes include: assessment of the impact of previous learning; the impact of systems on the quality and response to information sharing; responding to information about fathers and other children.

Recommendations to the Partnership include: ensure partner agencies review and enhance their systems and practices to facilitate effective information sharing, particularly concerning fathers or male partners; share the findings of this review with the out of area hospital where Eva's mother attended antenatally and gave birth, to enable them to consider what action they need to take in response to the identified factors that impacted upon safeguarding; seek assurance that the "normalisation" of parental/carer aggression is not happening routinely and there are appropriate systems in place to support professionals who may be at risk of vicarious trauma; and consider whether there is a need for the Integrated Care Board to undertake an assessment to gain assurance across the borough that GP practices are applying a system of coding that facilitates the immediate identification and sharing of safeguarding concerns for different health practitioners working within the practice, staff who may work in multiple practices, and for when patients transfer surgeries.

Other resources Read practice review (PDF)

2. Child F: Local child safeguarding practice review

Assault to a teenage boy in 2022 by a group of males. This was believed to be a targeted assault, possibly linked to criminal exploitation. Child F was a looked after child and had police and youth justice involvement. Child F's mother had involvement from services for mental health and substance misuse.

Learning includes: information sharing and communication, specifically how complex decision making and rationale is explained to families; relationship building and professional curiosity around potential safeguarding concerns; recognising exploitation risks; the potential relevance of

'adultification' in safeguarding teenagers; Think Family approach in relation to safeguarding, contextual risk and lived experience of a child; and identifying young carers.

Recommendations include: agencies working with adults and/or children to provide assurance to the partnership that they have effective joint working practices when working with members of the same family, recognise how the needs of each person in the family affect each other, and respond appropriately; the partnership to revisit the multi-agency training content to incorporate 'adultification' into appropriate courses to raise awareness of this concept so practitioners can understand how this can relate to practice and professional curiosity; and the partnership should strengthen communications to ensure that professionals are aware of their responsibilities in identifying and ensuring that there is assessment of young carers.

Other resources Read practice review (PDF)

3. David: Local child safeguarding practice review: Learning for the system in the management of asthma in children informed by 'David'

Death of a child in 2022 following an asthma attack. David was home educated and at the time of the incident, it was unclear what medication he was taking regularly and how his asthma was being monitored. David's mother was arrested for neglect but later refused charge.

Learning themes include: medical neglect; 'was not brought' policies; secondary, primary and community interface and plans in place for children with asthma or allergies; engagement of wider professionals, including pharmacies, schools and public health; and engagement with families to ensure they understand asthma or allergy plans and medication.

Recommendations include: the partnership's neglect strategy and associated training should emphasise the impact of medical neglect relating to chronic, potentially life threatening conditions on children with the wider children's workforce; the adoption of standard templates for asthma and allergy plans; encouraging health and education professionals to discuss with parents the expectation that asthma/allergy plans are shared with other key professionals and the impact of any subsequent refusal of consent on the child is considered; public health to consider expanding the remit of the school nursing service so it is available for children with chronic medical conditions who become electively home educated; and the integrated care board to support all health providers to routinely review and audit their 'was not brought' policies to measure compliance and effectiveness.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Child E1

Death of a 3-week-old baby in January 2021. Child E1 was conveyed to hospital by ambulance after their mother reported that the baby was unresponsive after having difficulty breathing. Child E1 later died from a head injury typical of being violently shaken.

Learning themes consider: professional understanding of maternal mental health needs, their impact upon parenting capacity and parental ability to manage the challenges of a newborn baby with a disability; professional consideration of an Early Help assessment when it was revealed

that Child E1 had cleft lip and palate; and consistent and co-ordinated postnatal support and safe sleeping advice to help parents cope with crying and reduce the risk of abusive head trauma.

Recommendations to the Partnership include: ensure that all relevant professionals are aware of circumstances which indicate an increased risk to an unborn child and may require a pre-birth assessment, and the requirement to make a referral to children's social care if there is increased risk; that the safeguarding policy on pre-birth assessments is amended to identify a diagnosis of a disability in an unborn baby as a factor which may be an indicator of increased risk; when referrals are made to the cleft lip and palate team, any information held in respect of parental mental health is shared with that team; advise the National Safeguarding Children Panel of the lack of abusive head trauma prevention advice and propose that appropriate abusive head trauma advice is provided to parents across other cleft lip and palate networks.

Other resources Read practice review (PDF)

5. Thematic child safeguarding practice review – Serious Youth Violence and Extra-Familial Harm

Two separate incidents of serious youth violence in 2022. The first occurred in January, where a young person under the care of the Local Authority inflicted serious harm on another. In August, a fight between rival groups involving knives and machetes, left three individuals with stab wounds.

Learning themes include: intersectionality and adultification; exploitation strategy and the understanding of gangs; disruption activity; threshold criteria; early help and community organisations; and education.

Recommendations to the Partnership include: consider agreeing a strategic approach to practice with the Safeguarding Adults board that includes ACEs and a Trauma Informed approach; review the existing language matters guide and disseminate across the partnership, aiming it at frontline practitioners and managers with a focus on upskilling the workforce around use of language and approaches to working with young people who are the victims of exploitation; promote effective supervision with an emphasis on diversity, reflective discussions and unconscious bias; review and re-launch the 'Thematic Exploitation Communication Strategy'; review the Multi-Agency Procedures with particular attention to the contextual safeguarding approaches and to ensure the pathway for receiving referrals, assessing, planning and interventions for places, spaces, and peer groups is clear; develop a greater understanding of the activity of organised crime groups both locally and cross border to identify entrenched and emerging networks and establish robust risk outside the home / extra familial harm pathways; foster flexibility in early help pathways to enable the practitioner that is most trusted by the family to remain as the lead practitioner and capture this within procedures and process documentation.

Other resources Read thematic review (PDF)

6. Child safeguarding practice review: Baby known as Alfie

Non-accidental injuries to a 4-month-old infant in 2021 whilst in the care of their parents. Bruising was identified during a routine health appointment and a later skeletal survey identified significant internal injuries. Alfie's mother and father reported experiencing anxiety and depression at the time of the incident. Alfie's father was subsequently convicted of grievous bodily harm and neglect.

Learning includes: the impact of COVID-19 on parental mental health; the need to 'see' fathers; information sharing and consent; and responses to risk.

Recommendations to the partnership include: all efforts are undertaken to ensure fathers/partners are fully known and engaged in their unborn/new-born babies lives across universal and specialist services, and that father's demographic details are checked regularly; fathers/partners are offered support and parenting intervention, particularly during the perinatal period; adult mental health services should work with children's services to ensure consent to share information reflects the family's situation, any support needs, and impact on parenting and children; consideration of the family's situation and confidence in engaging in online or in-person therapies should inform the agreed intervention in a timely way; and policies on bruising in non-mobile infants should be reviewed to check for consistency with the evidence base and national guidelines.

Other resources Read practice review (PDF)

7. Child practice review report: Concise child practice review re: CTMB 5/2020 Child O

Death of 3-month-old child from sudden infant death syndrome in April 2020.

Key themes include: understanding the relevance and importance of chronologies; explore if there were any missed opportunities for important intervention by agencies; the relevance of good communication and handover of care/information between professionals/agencies; routine enquiry and the opportunity to explore any concerns; and the impact of COVID restrictions and challenges for all agencies.

Learning includes: midwifery and health visiting services need to develop a regular, consistent information sharing process; review and update their guidance in relation to public protection notices and the assessment of the impact/risks posed to children from domestic abuse; health visiting and midwifery services to complete an audit of routine enquiries to establish compliance; use of chronologies to help identify risks, patterns, and issues in a child's life; referrals to agencies were treated in isolation, and did not fully consider previous contacts, as individual referrals these were not sufficient to meet thresholds for child protection; be alert to patterns of coercive or controlling behaviour, as well as incidents of abuse; remain professionally curious when working with individuals and families; assist professionals to recognise when individuals are resisting engagement with services and how this can manifest itself; and ensure that information relating to anti-social behaviour is submitted to relevant agencies in line with South Wales Police anti-social behaviour process and without unreasonable delay.

Other resources Read online CPR CTMSB 05-2020 (cwmtafmorgannwgsafeguardingboard.co.uk)

8. Report from the multi-agency practitioner reflective learning eent held on 14th September 2022 following the rapid review of Child SD

Serious injury resulting in a permanent disability to a 17-year-old male in 2022. No suspects were identified after a thorough police investigation. At the time SD was under a Youth Rehabilitation Order for motoring offenses and had recently become a father.

Key learning themes include: real-time information sharing; coordination of support among multiple agencies; the challenge of engaging with families involved in criminal activity; transitions between services as youth turn 18; and the role of education in early prevention by detecting reduced school attendance and behavioural changes.

Recommendations to the Partnership include: reinstating read-only access to children's case files for Adult Social Care; ensuring visibility of involvement and interventions across agencies through the Early Help system; clarifying the Lead Professional's role in co-ordinating support across multiple agencies; establishing a 'learning offer' to increase understanding of 'adultification'; provide briefings on the impact of exploitation; ensure that education practitioners are trained in the use of GCP2; and subgroups should work together to evaluate the effectiveness of information sharing for exploited young people, including their National Referral Mechanism status.

Other resources Read practice review (PDF)