NSPCC Repository July 2024

In July 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including professional curiosity, sexual abuse, domestic abuse, and non-accidental head injuries
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: Alex

Serious accidental injuries to a 7-year-old boy whilst in the care of his mother in February 2021. Alex's mother failed to seek medical treatment and the consequences could have been life threatening. She has since been prosecuted for neglect.

Learning themes include: how agencies work together; making and responding to referrals; response to neglect and substance misuse; consideration of the role of the stepfather; risks and protective factors; consideration of child's identity; and the impact of Covid and other organisational issues.

Recommendations for the Partnership include: arrange a multi-agency audit that considers the effectiveness of the service provided to children who are referred to Children Single Point of Contact (CSPoA) late in the day where there are potential concerns about significant harm; arrange a multi-agency audit regarding whether fathers' names and dates of birth are being recorded by practitioners, including mother's presenting for antenatal care and all referrals to CSPoA; seek evidence from social housing providers that they will contact CSPoA if they become aware that any utilities for a household containing children may or have been disconnected; address any challenges that frontline practitioners experience in identifying whether a child protection medical is required and then offering and/or securing one; seek assurance from the police that they will ensure increased oversight of the use of Police Powers of Protection, and that they will continue their ongoing partnership intelligence sharing pilot, and arrange for a multi-agency appraisal of the pilot at the conclusion, whose findings will be shared with the MASH board partnership.

Other resources Read practice review (PDF)

2. Local Child Safeguarding Practice Review regarding Emily

Alleged rape and drugging of a 16-year-old girl in December 2022 by a perpetrator encountered whilst online gaming. Emily was in care from 4-years-old due to neglect and experienced placement instability. She has a diagnosis of autism, global developmental delay and ADHD.

Learning themes include: planning to prevent the escalation of risk; effectiveness of multi-agency practice in risk assessing a child's changing needs and risks alongside balancing the prevention of harm against Deprivation of Liberties Safeguards (DoLS); online safety and use of social media by children with additional needs; how a child's capacity to make decisions and give informed

consent is understood and influences care planning and decisions; and assessment and planning for transition to adulthood.

Recommendations include: partner agencies to develop a tool that supports more consistent and effective risk assessment and planning for children with complex needs; where there are children who are discussed at the dynamic risk register meeting, it should be considered to share relevant risks with the police; the partnership to flag the lack of suitable placements for children with complex needs to the national panel; and provide further guidance on transition planning to all children's practitioners so they are clear what the pathways are for children approaching adulthood.

Other resources **Read practice review (PDF)**

3. Child X: Local Child Safeguarding Practice Review

Sexual abuse of a 15-year-old girl in care with complex emotional and behavioural needs. Child X was the subject of a Deprivation of Liberty order and was cared for in an unregistered placement. Child X became pregnant in this setting, which was thought to be the result of grooming and sexual abuse by a male carer.

Learning themes include: crisis placements; the child's voice, culture and identity; commissioning of placements and care packages for children with complex needs; quality assurance arrangements for placements and care packages including the quality and competence of professionals commissioned to look after children with complex needs; and managing allegations against staff working with children.

Recommendations to the Partnership include: the Safeguarding Children Partnership Executive should have oversight of all children placed in unregistered settings and ensure that there is good quality governance and accountability; the children in care nursing service must be involved when a child is placed out of authority to support careful and consistent health and care planning; all agencies must develop a robust and informed approach to assessing and meeting children's cultural, race and identity needs; all agencies must ensure that there is an understanding of racism and bias that can lead to the adultification of some children where their vulnerability and support needs are not understood; and awareness should be raised of the Local Authority designated Officer (LADO) role and ensure that partners understand their responsibility in contacting the LADO when there are concerns that an adult may cause a child harm through abuse or professional neglect.

Other resources Read practice review (PDF)

4. Arthur Labinjo Hughes: a focused review of local practice

Provides evidence-based opinion on the actions of practitioners involved in the case of 6-year-old Arthur Labinjo-Hughes, who was murdered in June 2020 by his father and his then partner.

Focuses on the specific period from 15 April 2020, when Arthur's paternal grandmother contacted the local emergency duty team (EDT) regarding bruising to Arthur, to when the case was closed by children's social care on 27 April 2020. Examines the actions and decisions of the local emergency duty team (EDT) following contact from Arthur's grandmother; the police in response to EDT's request for a welfare check and on receipt of photographs of bruising; MASH in response to EDT's referral and on receipt of the photographs; and the local authority social worker and

family support worker during and after a home visit. Identifies three missed opportunities for sharper practice, largely centred around the photographs of the bruising to Arthur's back.

Other resources Read review (PDF)

5. Sophia's Safeguarding Practice Review

Hospitalisation of a 13-year-old girl in March 2023. Sophia was unresponsive, had very low blood sugar, bone marrow failure and malnutrition. She weighed 13.8kg.

Learning themes include: the need to see a child and think about situations from their perspective in all interactions; the need to work together when a child has more than one developmental need or when a situation significantly impacts on how a child functions and develops; the need to share information and be curious; the need to have a co-ordinated multi-agency plan when there is one or more agency working with a child and their family; the need to have a discharge planning meeting following lengthy, complex or safeguarding hospital stays; and the need for everybody to use clear and simple communication.

Recommendations to the Partnership include: consider how it can introduce shame sensitivity and shame sensitive practice into learning and development opportunities; encourage workers to gather a detailed history with parents and carers to identify roles and responsibilities; encourage agencies to record information in a child's record as if they are writing to children and their family; review its information sharing procedures; develop a framework that supports people to feel confident in the role as a lead professional for any type of plan; provide guidance about child developmental milestones and growth charts; support designated safeguarding leads (DSLs) to have access to regular and accessible safeguarding supervision from an experienced worker; support ongoing multi-agency opportunities to reflect as a group on a specific circumstance for a child.

Other resources Read practice review (PDF)

6. Child Safeguarding Practice Review: Samantha

Murder of a 12-year-old girl and her mother in September 2022. Samantha's father was found guilty of both murders.

Learning themes include: risk analysis in respect of domestic abuse; recognition of Samantha's verbal and non-verbal cues; support for parents; impact of the Covid-19 pandemic; and exploring cultural issues.

Recommendations include: conduct a multi-agency audit in respect of domestic abuse case referrals to determine whether thresholds are being appropriately applied; provide guidance for children's practitioners on where to record information which relates to one parent and is not to be shared with the other parent for confidentiality reasons; where a parent's perception of the level of risk to a child is relied on to formulate the professional risk analysis or safety plan, this should be carefully explored and challenged by the Multi-agency Risk Assessment Conference (MARAC); all partner agencies should refresh their training offer in respect of domestic abuse to ensure practitioners are equipped to look for and identify patterns of coercive and controlling behaviour and how this may present in the context of a child's situation and learning needs; the Integrated Care Board should review what mental health, mediation and counselling services are available across the wider partnership to perpetrators of domestic abuse; partner agencies

should use supervision and training to challenge stereotypes in respect of parenting roles for men and women; develop a strategic approach to tackling extremist misogyny and toxic masculinity; and ensure that frontline practitioners can access advice in respect of the cultural experiences of people from different countries or religions.

Other resources Read practice review (PDF)

7. Child Practice Review Report: Concise Child Practice Review: Elena

Death of an 8-month-old girl in August 2020. She was born with a serious heart condition identified antenatally and fitted with a naso-gastric tube for the feeding and medication routine.

Learnings include: agency arrangements for responding to vulnerable families during the pandemic could have been better promoted across partners; a discharge planning meeting or multi-agency disciplinary meeting could have improved better information sharing and coordination of community and hospital-based services; health service records are fragmented with some not being recorded and stored electronically; a sleep environment assessment was not undertaken; when working with complex families, there can be misconception about the roles and responsibilities of statutory and non-statutory support, which includes, misconception about threshold criteria for access to each service.

Recommendations include: in the event of significant service disruption, individual agency service delivery plans for responding to vulnerable families, are shared with partner agencies; further training in relation to recognising and responding to concerns in respect of vulnerable individuals and families and on the quality of the information submitted; promote the utilisation of multi-disciplinary meetings in cases of children with complex needs requiring care in the community and where there has been cross health board involvement; improve the systems in which information is recorded, stored and shared; and ensure awareness regarding the duties, roles, and responsibilities of statutory and non-statutory services.

Other resources Read online: www.gwentsafeguarding.org.uk/en/practice-reviews/published-gwent-case-reviews

8. Significant Case Review: Child P

Death of a 7-week-old boy in November 2017 following abusive head trauma. His father was convicted of his culpable homicide.

Learning themes explore: child health surveillance practice – relating to the examination of the baby and support for parents; short stay paediatric assessment unit standards; child protection training – relates to the assurance arrangements and coverage of training for particular groups of clinical staff; and effective multi-agency working around child deaths.

Recommendations include: need for audit of clinical standards to guide future training/supervision for child health surveillance; need for action to involve fathers by maternity and community child health services; instigation of programme of support for new parents of crying babies; discussion needed to consider amending online revalidation system to require GP refresher courses in child protection; learning needs analysis to clarify training coverage and guide future policy; need to ensure awareness/significance of multiple contacts with NHS by parents seeking help; and need to

ensure Ministry of Defence understands importance of making veteran's records available in terms of their experience in service and later possible mental health issues. **Other resources** Read review online: hscp.south-ayrshire.gov.uk/article/36100/Significant-Case-Reviews