NSPCC Repository August 2024

In August 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including child sexual abuse, child criminal exploitation, suicide, and infant deaths
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Thematic safeguarding practice review: Child suicide or death through undetermined intent

The children considered as part of this review all died as a result of a deliberate act of self-harm. Some deaths have been concluded as suicide or undetermined intent.

Themes include: recognition of bullying; think family in blended families; child's voice: how could a child present so differently between school and home; child to parent violence: adult issues versus the focus on the child, and multi-agency communication and consent as a barrier.

Recommendations include: undertake scrutiny of how consent for information sharing is addressed by agencies to ensure that the best interests of children are maintained; when there are concerns about violence or behaviour that is challenging to the parents, professionals must be able to explore why the child is behaving in a particular way and develop an action plan based on this knowledge; policy must be able to make a difference to children across all localities to reduce inequalities of access to therapeutic support; ensure that local policy and procedures emphasise the need for assessments, including school admission, to incorporate any parent or carer, especially biological fathers, male carers, and male partners, this should include the requirement to record the status of the adult in the child's life, parental responsibility, and how they are involved in the care of the child; and undertake an audit of cases which are at the level of early help or team around the family, and explore the views of children and young people in relation to sharing information.

Other resources Read thematic review (PDF)

2. Operation ACORNE key findings and actions

Operation ACORNE was a large scale and complex multi-agency investigation into child sexual abuse. It was initiated in June 2017 in response to concerns about the behaviour of multiple children. The case in question developed over several years and encompassed multiple children and adults from four families within a tightly controlled family network, including close family friends.

Recommendations include: highlight the findings of this and other relevant reviews with regard to sexual abuse; highlight to the Department for Education (DfE) the lack of guidance for staff managing sexually harmful behaviour in primary schools, "peer on peer abuse" is not appropriate for children of this age group; develop local guidance for practitioners in all agencies in managing

sexually harmful behaviour; identify appropriate assessment tools for children demonstrating sexualised behaviour; ensure that working with sexual abuse and harmful sexualised behaviour are part of the inter-agency safeguarding training programme; local guidance regarding complex abuse inquiries to be clarified to explicitly state that all relevant agencies should be represented at a senior level from the outset; the constabulary and children's services should review the numbers of achieving best evidence trained staff and commission new training programmes to train new staff and refresh those who may have undertaken the training some time ago; review how both strategy meetings and child protection medicals are carried out more rigorously and holistically; undertake a thematic review of cases where there has been concerns about sexual abuse; review how cases are managed when there are concerns about both children and vulnerable adults; and undertake a review of how cases where children are subject to child protection plans are "stepped down" and reassert the rigour with which children in need plans need to be managed.

Other resources **Read report (PDF)**

3. Local Child Safeguarding Practice Review: Child G

Death of a 1-year-old infant in October 2022. Child G had a cardiac arrest after being left unattended in bath water. There were concerns around Child G's mother's mental health and lack of engagement with services.

Learning considers: when to refer or signpost parents to agencies or services; vulnerable babies hidden from or missed by services; the impact of COVID-19 on new parents; and encouraging parental engagement in universal services.

Recommendations include: the partnership to ensure that commissioned services are represented in its work to increase an understanding of safeguarding across the system and assure itself that health visitor providers and commissioners work closely together to ensure that case information is actioned during transition periods; the partnership to continue to promote information about home safety and water safety; and health visiting services to ensure home safety information is circulated when one-year checks are cancelled or delayed.

Other resources Read practice review (PDF)

4. Child safeguarding practice review: a thematic review examining the quality of child protection investigations in Bristol

Death of a 4-month-old child in December 2022 which was determined not to be the result of abuse or neglect. The family had previous periods of agency contact including early help, child in need and child protection involvement with the older siblings. Explores key barriers and system pressures that impact on consistently achieving good quality child protection investigations.

Learning includes: professionals involved in the initial stages of child protection investigations want to work together more efficiently and more effectively; chairing of strategy discussions is seen as critical to the initial stages of achieving consistently good quality child protection investigations; a call for greater knowledge and skills about how to conduct multi-agency child protection investigations; a need for mapping and explaining the different agency roles and

responsibilities; and the development of quality standards, or descriptors relating to the child protection process could be helpful to the multi-agency network.

Recommendations include: seek assurance that there is information and data available which supports the regular review of the quality and standard of child protection investigations; the development of a three to five year workforce strategy specifically for those professionals involved in child protection work; compile a selection of analysis tools to support practitioners and managers achieve stronger analysis for use from the point of strategy discussions onwards; and develop a resource, which easily explains the different agency roles, responsibilities and expectations.

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

5. Local child safeguarding practice review: 'Iman': Executive summary report

Suspected non-accidental injuries to an 8-month-old boy. Iman was admitted to hospital with seizures at the age of 8 months following rolling off the bed. The criminal proceedings process concluded in February 2024 with no charge as it was decided non accidental injury could not be proved beyond reasonable doubt.

Learning themes include: risk assessment and decision making; accommodation for care leavers; cultural competence; and cross boundary communication.

Recommendations to the Partnerships include: consider the availability of support/advocacy services for all parents following removal of their children and during care proceedings; review the effectiveness of the current processes for sharing background information on families with universal services when the decision is to close the case to Children's Social Care following a Children and Families assessment; ensure practitioner's understanding of trauma informed practice and the risk of specialist services not being taken up by a parent, as well as the impact of chronic pain on a parent are factored into risk assessments; ensure that practitioners are supported/challenged and have sufficient skill and understanding of trauma informed practice, sexual abuse, physical ill health and cultural competence factored into their direct work and assessments; raise with the National Child Safeguarding Practice Review Panel the national issue of the fragility of legislative support and local housing practice to support care leavers as they move into independence; ensure that universal service practitioners are confident in their understanding of cultural competence; ensure that practitioners are encouraged and supported to escalate concerns where children are placed in another local authority area.

Other resources Read practice review (PDF)

6. Learning lessons review: Child J1

The collapse of a boy in school in 2022 having ingested a bag of white powder, one of nine that he had brought into school in a kinder egg. He was transported to hospital where he was found to have cocaine in his system. He and sibling were removed from mother's care.

Learning themes include: the importance of understanding and using history to inform practice; there was an over reliance on self-report by mother; there was a lack of professional curiosity; child and family assessments lacked breadth and depth; fathers and the wider family were not

included; information was not triangulated; practice standards were not adhered to, leading to flawed assessments of risk; managerial oversight was not sufficiently robust to identify and challenge frontline practice; child in need / child protection plans were not robust; the voice of mother overshadowed the voice of the child; opportunities to gain a greater understanding of the child and siblings lived experience were missed; processes and tools designed to assist practitioners to keep children safe were not used effectively; and agencies were not working in true partnership, leading to disagreements that allowed mother to deflect and deceive some practitioners.

Recommendations are embedded in the learning.

Other resources Read learning review (PDF)

7. Child Practice Review Report: Concise Child Practice Review: CVSB CPR05/2019

Fatal stabbing of a 17-year-old boy in August 2019. Four individuals were subsequently convicted of murder, and three individuals were found guilty of manslaughter. Prior to his death there had been numerous safeguarding concerns around Toby's involvement in and continued risk of child criminal exploitation (CCE).

Learning themes include: safeguarding during adolescence; information sharing and early intervention; reporting concerns, challenging decision making and escalating when required; young person's disengagement from education, employment and training; and public protection notices submission and sharing.

Recommendations to Cardiff and Vale Safeguarding Board include: develop training to include guidance on safeguarding concerns that arise during adolescence, and how a young person develops to understand risk and consequences; children's services must consider the impact of exploitation on siblings as part of referral and assessment; review current support available for young people at risk of exploitation; education must always be part of safeguarding considerations, particularly where a young person is educated outside of mainstream school placements; all agencies must ensure appropriate follow up when they make a referral in relation to a young person at risk and consider appropriate professional challenge if they do not agree with the decision making; all agencies involved in meetings considering young people at risk of CCE must consider relevant historical information, mapping of associations and identified escalations in concerning behaviours held by their own agencies which must then be considered jointly by all involved agencies.

Other resources Read review online: www.cardiffandvalersb.co.uk/children/professionals-and-employers/child-practice-reviews/

8. Child safeguarding practice review: Learning identified from considering Willow

In January 2023, a 16-year-old made a number of non-recent reports of sexual assault and rape against adult males. All of these reported incidents took place whilst Willow was in care.

Learning explores: the reporting and review of missing child episodes, including appropriate use of the Philomena protocol, the grading of missing episodes, and use of the '3 in 90' procedure; the use and grading of the Child Exploitation Risk Assessment Framework (CERAF) tool; listening to the voice of the child or young person; the convening of strategy discussions and compliance with Working Together to

Safeguard Children 2023; and the support and training of carers with regards to the Risks Outside The Home (ROTH) for vulnerable children or young people.

Recommendations include: assurance from statutory partners of compliance with Working Together to Safeguard Children 2023 to ensure that the appropriate professionals are invited to and are attending strategy discussions; allocated social workers and supervising social workers to ensure that alongside generic training for carers, each young person has a package of support in place tailored to their individual needs; assurance that the language used in respect of children, young people and their families is appropriate and not derogatory or victim blaming; and asks 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)