NSPCC Repository September 2024

In September 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including eating disorders, child sexual abuse, child neglect, and domestic abuse
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: BSCP 2019-20/01

Death of a 3-month-old baby in May 2019. The baby was found deceased, and it was apparent that death had occurred significantly earlier. Both parents were arrested on suspicion of neglect.

Key learning points include: practitioners, including those working with adults, should be familiar with expectations and requirements in respect of information-sharing in line with 'Right Help, Right Time' guidance; there should be arrangements in place for effective communication between HMP offender managers, sex offender managers, and all other relevant agencies on the release of a prisoner who may pose a risk to children; all agencies working with men need to consider whether those men have children in their lives, or a pregnant partner, and the strengths and risks the individual may present to those children to inform what action should follow; probation are a key partner within MASH to help facilitate effective information-sharing and co-ordination of support; the exchange of information within MASH should receive prompt responses from all agencies to enable professionals to make timely and proportionate decisions; the Early Help and Support arrangements should highlight the importance of the lead professional role in coordinating the work of agencies involved with the child and the family; the quality of referrals should be consistent with sufficient understanding of the 'Resolution and Escalation Protocol'; all professionals working with children and their families need to have some understanding of substance misuse and the barriers for parents/carers being honest about their drug use; and children and their families must be a priority for housing providers.

Other resources Read practice review (PDF)

2. Child Practice Review Report: Concise child practice review: re CPR 03/2019

Infant girl was admitted to hospital in April 2019 with bruising to her neck and jaw area with an initial medical assessment of acute, severe hypoxic ischaemic brain injury, with CT imaging showing features of physical abuse. The child survived the injuries but is likely to live with the effects of lifelong brain damage as a result.

Recommendations include: assurance that practitioners and relevant partners, understand their duty to report children at risk, by confirmation that the referral documentation is fit for purpose by ensuring that all known relevant information regarding the child and the family is provided with sufficient detail to enable the receiving team to consider the impact on the child/ren; practitioners reviewing a referral into Children Services should consider the current referral

within the wider family context, including previous referrals/assessments and case notes as well as actuarial risk factors; practitioners are aware of their duty to request specialist medical examination of all injuries of a non-mobile child and that clear referral pathways are maintained to avoid delay; practitioners understand the association between domestic abuse and child abuse and are aware of their organisation's policies and procedures in relation to domestic abuse; understand the association between parental non-engagement and unwarranted lack of consent and child abuse and review their organisation's policies and procedures in relation to working with families with such risk factors; understand the association between the parent's vulnerabilities and child abuse and review their organisation's policies to ensure such vulnerabilities are considered as part of the assessment process; and develop guidance for practitioners on describing and recording home conditions that pose a potential threat of harm to children.

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

3. Local Child Safeguarding Practice Review: Case A

Conviction of an adult male in 2023 for over 30 sexual offences involving both children and adults. He had previously been found guilty of possessing indecent images of children and given a suspended sentence.

Learning includes: the sufficiency of the arrangements in place to risk assess and manage Mr A as a 'Registered Sex Offender'; effectiveness of multi-agency practice at the point it was established that Mr A had children; the sufficiency of the arrangements in place to engage relevant agencies and share information about known child sex offenders; and the extent that practitioners across all agencies understand the potential risks posed by viewers of child sex abuse material.

Recommendations include: in all cases where known child sex offenders are having contact with children, the Metropolitan Police service (MPS) should ensure that referrals are always made to children's social care. Both the MPS and the Safeguarding Children Partnership should review their guidance on the risk management of known offenders and as required, strengthen the clarity on triggering a Section 47 enquiry when known child sex offenders are believed to be in contact with children; the MPS should consider the sufficiency of its arrangements covering the disclosure of an offender's details to third parties; the Child Safeguarding Practice Review Panel should look at the potential for the secure and routine information sharing of Level 1 MAPPA Offenders with other key agencies, particularly GPs; and the Partnership should commission context specific training on child sex offenders and include this as part of its annual programme open to all practitioners.

Other resources Read practice review (PDF)

4. Briefing: Local Child Safeguarding Practice Review (LCSPR): Patricia

Sexual assault of a 13-year-old girl by an adult in the community in April 2020. Patricia was living in a children's home at the time, having experienced a number of placement moves since

entering care and over the course of the review period. The local authority initiated legal proceedings in respect of Patricia when she was aged 10-years-old.

Learning explores: trauma-informed approaches; personalising moves from one place to another for children; addressing factors that create placement instability; paperwork; and partnership working.

Recommendations explore: supporting training and development around the use of trauma informed language; developing personalised, child and behavioural specific care plans to support children, and carers in meeting their needs; a process enabling better consideration of a child or young person's experiences and histories, and how this can be taken forwards to inform any planning around future placements; developing a child friendly Looked After Child Care Plan; and consideration of the network around the child.

Other resources Read practice review (PDF)

5. A combined local child safeguarding practice and domestic homicide review concerning the deaths of Bethany and Darren in May 2021

Murder of a 26-year-old woman and her 9-year-old son by her former partner in May 2021, following a period of physical and psychological abuse. The perpetrator had a history of violence, including a conviction for domestic assault on a former partner.

Learning considers: a child's lived experience of domestic abuse; recognising key indicators of domestic abuse escalation to inform risk assessments and safety planning; how domestic abuse perpetrator history is transferred between areas, made accessible to those working to safeguard children, and used to inform current assessments of risk; policies and procedures for domestic abuse and safeguarding; and professional curiosity.

Recommendations include: partnership use and knowledge of the domestic violence disclosure scheme, domestic violence protection notices and domestic violence protection orders processes; partnership understanding of stalking, harassment and coercive controlling behaviour; partnership understanding that domestic abuse is always harmful to children; engagement by agencies to ensure they have strategies to interact effectively with reluctant and vulnerable victims; understanding and reducing the risks of perpetrators to victims and their children of domestic abuse, including a greater understanding of the homicide timeline; improvements to local child in need processes and inclusion of multi-agency partners, in particular those delivering adult services; and improvements to multi-agency information sharing to also include the voluntary sector information.

Other resources Read review (PDF)

6. Thematic review – executive summary: Child N, Child R and Child S

Concerns three similar cases of non-accidental injury to non-mobile infants from different families. Child R presented with a swelling to the thigh aged 4-weeks-old, Child S with breathing difficulties aged 7-weeks-old, and Child N with unexplained seizures aged 3-months-old.

Learning themes include: developing professional skills to work collaboratively with families and colleagues and to formulate a holistic assessment; management of the 'unsettled infant', including perceived feeding difficulties and crying behaviour; and pathways to support parents with mental health difficulties.

Recommendations for the partnership include: reinvigoration of the ICON work on coping with crying behaviour to encourage practitioners to tailor this to individual need; development of guidelines for the management of the 'unsettled infant' to reflect both potential feeding problems, as well as normal infant crying patterns, and sources of help and support for practitioners and families; development of a resource which describes how to assess the impact of parental mental health on parenting; and resources available to support parents who are experiencing emotional or mental health problems, with particular consideration given to available sources of support for men.

Other resources Read executive summary (PDF)

7. Local Child Safeguarding Practice Review: Tristan

Hospitalisation of a 17-year-old boy in 2023 due to a very low BMI and a decline in his physical and mental health. In 2022 Tristan disclosed physical and emotional abuse by his father to school staff. Concerns escalated around Tristan's weight, mental health and school attendance.

Learning themes include: response of agencies to poor school attendance, weight management and physical health needs, mental health needs and concerns around self-neglect, and support for young carers; parenting capacity, parental health and adopting a whole family approach; risk assessment in relation to health and appropriate use of escalation procedures; and the application of the Mental Capacity Act 2005, adultification, and transition planning for adulthood.

Recommendations include: children's services to consider how to promote understanding of the needs and rights of young carers; the partnership to develop an adolescent safeguarding framework, to support practitioners to recognise and assess the harm experienced by older children; the local integrated care board to review the commissioning arrangements for young people with avoidant restrictive eating disorder (ARFID); the partnership to ensure that learning from this case is used to educate the professional network in respect of recognising and responding to the needs of boys with disordered eating; the partnership to review how the inter-agency escalation policy is being used and whether this is resulting in timely resolution on areas of dispute between agencies; and in complex cases, practitioners should collaborate to formulate a shared analysis of how the individual's cognition function is impacted in different circumstances, to support frontline practitioners in undertaking mental capacity assessments that are decision and time specific.

Other resources Read practice review (PDF)

8. Local Child Safeguarding Practice Review: Rachel, Andy and Dean

Removal of three children, Rachel (7), Andy (10), and Dean (3), from their mother's care in April 2020, following concerns that they were at risk of sexual abuse. At the time of their removal the children had suffered significant neglect.

Key findings include: despite professional concerns, there was limited understanding of the children's day-to-day lived experiences, and an apparent lack of curiosity from professionals to understand what the children's presentation and behaviour may be communicating; professionals in universal services commonly do not know how they should engage with either the parent/carers or the children when concerns arise; the emotional harm of mixed heritage children is often unaddressed because of an unconscious bias of professionals that limits recognition of racist treatment of mixed-heritage children by family members; and there is no consistent training to enable professionals to recognise and address the impact of unresolved multi-generational trauma on parents and children.

Considerations for the Partnership include: ensure that practice across the children's workforce identifies multi-generational child abuse and neglect; ensure first line management provide supervision, supporting and encouraging curiosity by asking the right questions which seek to identify historical concerns; ensure professionals are confident in having respectful, robust conversation with families, colleagues, and partners when they are concerned about neglect and abuse and discover what prevents them from talking directly to a child or parents; ensure that safeguarding practice proactively identifies, assesses, challenges, and responds to racism within the family in the context of harm and abuse; set priorities around anti-discriminatory practice; and embed a trauma informed approach across the system.

Other resources Read practice review (PDF)