Torbay Safeguarding Children Partnership

NSPCC Repository October 2024

In October 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including youth violence, adolescent psychiatry, assessments, and contextual safeguarding
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Children B and C: Child Safeguarding Practice Review

Removal of a 10-year-old boy (Child B) and his 9-year-old sister (Child C) from their home in July 2022. Officers were so concerned about the presentation of Child B and poor home conditions that they exercised their powers of protection and took the children to hospital. Child B was found to be severely dehydrated and malnourished. It was subsequently discovered that he had an extremely rare and undiagnosed chronic health condition.

Learning themes include: parental consent; stepping cases up and down between early help and children's services; the recognition of neglect; working with parents and carers who are resistant to accepting services and working with professionals; educational neglect; issues around monitoring the health of young children and distinguishing when medical concerns become safeguarding concerns.

Recommendations to the partnership include: undertake further work to overcome the barriers in sharing information about parents and carers as well as children in the 'Integrated front door' screening process; consider how to further promote the use of genograms and chronologies by all agencies; review how much detail about referrals is shared by social workers with other agencies in the screening process and when assessments are completed to ensure that professionals working with a child are fully aware of the risks and needs reported; assure itself of the take up and implementation of the neglect toolkit in practice and to include educational neglect in more detail when it updates the neglect strategy; and implement a strategy to improve take up of training (particularly by social workers).

Other resources Read practice review

2. Child Safeguarding Practice Review: Overview report and addendum: Child Aiden

Suicide of a 17-year-old boy in May 2020. Aiden was not in education at the time of his death and had a history of suffering with mental illness. He had been diagnosed with treatment resistant unidentified schizophrenia, psychosis, and depression. He was twice detained under the Mental Health Act and had been an inpatient at a specialist mental health inpatient unit for young people.

Learning themes include: consideration of a parent's ability to care for a child with severe mental health problems; capacity and parental consent; specialist mental health inpatient care; home leave planning; and discharge planning.

Recommendations to the Children's Safeguarding Assurance Panel (CSAP) include: ensure that decisions concerning the welfare of children takes account of the ability of those with responsibility to care for them, including any effects on the wider family; make sure that a process is in place to plan to manage patients' periods of home leave including a clear process to ensure effective communication; make sure that discharge planning is robust, involves all relevant agencies, and documents risk plans; ensure that the 'Resolving professional disagreements procedure' is understood and used by professionals from all agencies; and ensure that staff have been trained and feel confident to raise any concerns that they have.

Other resources Read practice review

3. Local Child Safeguarding Practice Review: Child C and D

Sexual abuse of two girls by one of their foster carers. Child C was a teenager at the time of the allegations and Child D was of junior school age.

Learning themes explore: children's voice and disclosing abuse; recognising and addressing children's vulnerability to sexual abuse; assessment of foster carers, support, monitoring and matching; management of incidents, concerns, complaints and allegations about foster carers; and support for the children.

Recommendations include: that the partnership involves looked after children in a wide-ranging "help me tell you anything" initiative to support children recognising and expressing concerns to practitioners; that the partnership updates its sexual abuse procedure to "think the unthinkable" and remind staff that abusers can include foster carers; that the partnership seeks reassurance from fostering services that arrangements are in place so that essential activities to minimise risk of abuse are monitored and any deficits addressed; and that the partnership seeks reassurance from fostering services that any professionals' meetings convened to discuss emerging concerns are multi-agency.

Other resources Read practice review

4. Concise Child Practice Review Report: CYSUR 1/2021

Death of a 2-year-old girl in July 2020 following a violent attack by her mother's partner. The family were known to services after Child A's older sibling was born due to referrals regarding domestic abuse.

Learning considers: adult needs assessments; child assessment and sickness absence of assessors; health visitors responding to failure by parents/carers to engage; professional curiosity; information sharing; use of specific language in documentation; and record keeping.

Recommendations include: training for practitioners and managers in children's services on the assessment/sign off process, including a robust process for the auditing of assessments; ensure a policy is in place regarding how staff are supported when sickness issues arise and how cases are managed when staff are on sick leave; multi-agency training on completing a multi-agency referral form (MARF); agencies consider mechanisms, such as multi-agency safeguarding hubs, to facilitate decision making and collaborative practice for cases that fall below the threshold of significant harm; information sharing on siblings between compulsory education and early years

settings; training/managerial support for professionals when faced with parents who do not engage; regional police implement a flagging mechanism for addresses where there is a wider history of safeguarding concerns linked to the address; and supervision sessions with practitioners to address the importance of using specific terminology when completing records/reports, and for records to be sufficiently detailed.

Other resources Read review online: cysur.wales/child-practice-reviews/cysur-1-2021-concise-child-practice-review/

5. Local Child Safeguarding Practice Review: Edie

Death of a 15-year-old girl who was electrocuted when walking home via a train track late at night in March 2023. Prior to her death, Edie was repeatedly missing from home and briefly from care, and was considered on four occasions at strategy discussions due to thresholds of significant harm including child criminal exploitation. Edie was considered to have mental health and neurodiversity needs.

Learning themes include: understanding adolescent contexts; relational practice to understand a child's world; working with parental barriers; holistic approaches to intra- and extra-familial harm; trauma informed services and interventions; education provisions for children with a complexity of needs; responding to critical incidents involving children; keeping children safe in their local communities; and working with marginalised young people.

Recommendations to the partnership include: the National Child Safeguarding Practice Review Panel and Department for Education should consider arm's length-bodies such as Network Rail being included within the statutory 'Working together guidance'; ensure all children's social care staff are trained in motivational interviewing techniques and this continues to be embedded to support practitioners when there is resistance from parents; continue to support statutory agencies in developing trauma informed approaches; ensure specific work is undertaken by relevant statutory partners on the safety of railway tracks, with a targeted approach towards marginalised or vulnerable children and young people; and children's services lead on further targeted outreach work with groups of marginalised young people to hear their views and ensure their participation to address extra-familial harms, and consider how to address drug and alcohol issues and non-school engagement.

Other resources Read practice review (PDF)

6. Child Safeguarding Practice Review: Children exposed to serious youth violence

Fatal stabbing of an adolescent boy in 2023, resulting in a conviction for murder for one boy and manslaughter for another two.

Learning includes: the importance of identifying and sharing 'intelligence' about children who have a history of serious youth violence, and recognising that there may still be a risk without evidence of involvement; the need to engage with all family members; effectiveness of responses to national referral mechanism; monitoring a child's drill music; difficulty in knowing and understanding the child's lived experience; and the need for a clear serious incident response.

Recommendations to the partnership include: develop a critical incident plan with other partnerships in the local area; change the current status and terminology of multi-agency risk management plan (MARM) to child protection plan - risk outside of the home (CP-ROTH) to provide clarity that these children are subjects of statutory child protection planning; seek assurance about the outcome of the partnership intelligence management meetings (PIMM) review, to include an update on capacity, membership, remit, and focus; request that partner agencies consider how they will support staff to ensure that child victims of exploitation are prevented from being 'criminalised', including improved promotion of and uptake of relevant training; seek assurance around the work of the violence reduction partnership (VRP) in the local area, including consideration to how information on specific children, and perpetrators is shared regularly as well as the impact of the Online Safety Bill 2023 across the system. Also recommends that the national panel requests that government considers the need for a national standard operational procedure for responding to a critical incident.

Other resources Read practice review (PDF)

7. Serious Case Management Review: Family K: redacted report

Homicide of Mrs K and serious assault of Mr K by their son. Mark was mentally ill at the time of the incident. He was convicted for the manslaughter of his mother and remains in secure care. In the weeks leading up to the homicide, Mrs K and a friend of Mark's had contacted mental health services on five occasions with concerns about his behaviour.

Learning themes include: the context of adult family violence; mental health issues; substance misuse issues; caring relationships; instability, dependence, and social isolation; the lack of a clearly defined 'primary' victim; absence of 'visible' high risk and lack of engagement; the role of GPs in safeguarding adults and children; and responding to domestic abuse in the Isle of Man.

Recommendations include: The Isle of Man Safeguarding Board should ensure that there are robust measures in place for responding to incidents of domestic abuse, which consider the risks and vulnerabilities of all people within the household, particularly children and young people; Manx Care Social Care should lead an awareness raising campaign about being a young carer which provides information on the impact of being a young carer and tools and aids to help agencies generate support plans and signpost to support services; DHSC and Manx Care should assure there are robust processes in place to correctly identify the adult/child's registered GP; assurance should be sought that GP's are involved as key multi-agency partners in responses to safeguarding and domestic abuse concerns and that information is shared in line with policies and professional guidance.

Other resources Read review online: www.safeguardingboard.im/learning-from-reviews/manx-learning/

8. Local Child Safeguarding Practice Review: Alvah

Presentation of a 3-month-old boy at a hospital in August 2020. Alvah was brought to the hospital by his mother, due to swelling in his left leg. Examination revealed facial bruising and fractures to the tibia and foot. Professionals concluded that the injuries were possibly caused by non-accidental injury. Alvah, and

his 20-month-old brother Rafa, were immediately subject to Child Protection procedures and placed in foster care.

Key findings include: safeguarding professionals struggle to hold babies in mind when identifying vulnerabilities and risks, particularly those who are non-mobile and too young to speak for themselves; there is no standardised approach to information sharing between urgent care and primary/community services, and to primary care triage of the information as it comes in; and the history of the family can be lost when situations change, particularly when a family is mobile between boroughs.

Considerations for the partnership include: seek assurance that practitioners know what to do in response to a pre-mobile baby with injuries; primary and urgent health care processes for identifying children who may have been abused; is there the need for a standardised liaison process from hospitals to GP and HV services?; is there is a robust process for triaging information coming into GP practices that will identify and flag injuries in non-mobiles babies?; do health information systems and processes support robust information sharing when vulnerability is identified in pregnancy, and settings or situations change?; and the impact and implication for new ways of working implemented during the Covid-19 pandemic.

Other resources Read practice review (PDF)