NSPCC Repository November 2024

In November 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including physical abuse, child neglect, suicide, and parental mental health
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 2021-22/01

Disclosure of physical abuse at home by a 14-year-old girl in June 2021. There had been concerns of physical abuse dating back to 2014 and the family has a history of involvement with agencies following previous disclosures from the child and her siblings about being beaten by their parents.

Learning themes include: barriers and enablers to enhancing cultural competency and confidence; effective engagement and support for children in elective home education; responding to allegations of physical abuse; how understanding historic and contextual information enhances decision making and assessment of risk; and maximising protective factors by engaging communities in safeguarding children.

Recommendations include: ensure that all frontline safeguarding professionals have the necessary skills, experience and confidence to work with and support children and families of all cultures, faiths, backgrounds and communities; provide training, resources, support and supervision to enhance professionals' cultural knowledge and confidence; make it mandatory for tuition centres to register with Ofsted and strengthen the formal engagement and information sharing between local authorities and tuition centres; ensure that the child protection medical assessment pathway is always adhered to and monitor its effectiveness; ensure that all relevant agencies are consulted on whether sustainable change has been demonstrated before closing a child protection case; and promote a cohesive community and agency response to physical abuse by increasing engagement with minoritised communities through relationships with religious leaders, faith organisations and community groups.

Other resources Read practice review (PDF)

2. Final report of the safeguarding children practice review regarding Leo

Death of a 4-month-old boy in October 2021. Leo was found by paramedics in cardiac arrest. He was taken to hospital and died a few days later. Medical examinations showed serious injuries including rib fractures that occurred roughly two weeks earlier. Leo's father was subsequently convicted of murder.

Learning themes include: involving and assessing fathers and identifying strengths or risks they bring to parenting; the importance of the effective provision of early help services; recognising parental misuse of prescription and non-prescription drugs; feeding difficulties as a trigger to harm; the importance of following 'was not brought' procedures; and the need to identify and meet the needs of care experienced parents.

Recommendations to the partnership include: ensure that where information is requested by health and midwifery services, this is completed in line with protocols, and information held on expectant mothers and fathers is disclosed; relevant integrated care boards (ICB) to provide assurance that children who are not brought to appointments are responded to in a timely manner; health visitors and GP training pathways to raise awareness of the impact of feeding difficulties on child safety, and provide assurances that feeding difficulties and unsettled infants are recognised as potential triggers to harm; ensure all agencies are clear on their responsibilities in relation to assessment of early help needs and provision of services; create a pathways plan for care experienced parents with the local care experienced parent group; and ensure that training for professionals enables them to understand the prevalence of the misuse of prescription drugs.

Other resources Read practice review (PDF)

3. Extended child practice review re: Child F

Suicide of a 13-year-old girl in September 2021. Child F was a child looked after (CLA) who had been in foster placement out of area since March 2021.

Learning themes include: domestic abuse; substance misuse; mental health support and assessment; communication and information sharing; and how agencies maintain family relationships and support.

Recommendations include: information from specialists (such as forensic psychology) should be shared with foster carers, health and education colleagues to ensure a holistic approach for the child; pathways for CAMHS referrals should be clear and communicated to all relevant professionals with risk assessments and safety plans in place before discharge, particularly with a CLA or if previous history; interventions around care-experienced children's needs should be prioritised for further consideration and escalation; where staff changes occur there should be a detailed handover including chronologies and there should be a robust supervision process to support complex cases; all foster carers should 'check in' with children prior to sleep each night to provide an opportunity for emotional support. Recommendations specific to CLA placed out of area include: the health care needs notification form should be completed and include a risk assessment undertaken by the CLA nurse; appropriate education provision should be identified and school placement arranged as soon as possible; police should be notified of any identified risks or concerns; there should be robust arrangements for maintaining contact with family and friends and advocacy for the CLA must be offered by the allocated social worker; and the child death review group should explore work around child suicide in this group.

Other resources Read practice review online: www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/PracticeReview/CPRCTMSB082021.pdf

4. Learning review executive summary report: child 3 - 2024

Death of a 4-year-old boy and his father in May 2023. Due to the father's history of mental ill health, Child 3 and his father were both in receipt of a multi-agency package of support from child protection and adult support services.

Learning themes include: parenting assessments; the voice and rights of the child; parental mental ill health; the role of the extended family; liaison between child and adult services; and the identification of risk patterns.

Recommendations include: consider how histories of domestic abuse and parental mental ill health may impact parenting over time; include adult mental health services in parenting assessments; outline contingency plans for potential risks identified in parenting assessments; ensure the voice of the child is highly visible in records after agency contact; ensure chronological data is kept up-to-date and is thoroughly analysed to identify and act upon emerging patterns of risk; develop workforce understanding about mental health diagnoses and how symptoms may present in a parent at risk of repeated illness or a relapse in wellbeing; promote knowledge of the formal process of information sharing, assessment, analysis and decision-making when a child may be at increased risk of harm; take a whole family wellbeing approach to child protection, considering family in its widest context and, where possible, including extended family in supporting the parent and child; and ensure ongoing collaboration and information sharing between child protection and adult mental health services.

Other resources Read learning review online: www.renfrewshire.gov.uk/media/16759/Learning-Review-Executive-Summary-Report/pdf/Learning_Review_Executive_Summary_Report_2024.pdf?m=1724938567840

5. LSPR strategic response to tackling neglect

Details the partnership's strategic commitment to tackling neglect as a response to the death of a newborn baby in summer 2023. The cause of death was unascertained. Describes the implementation of a 2023-25 neglect strategy and action plan and the responsibilities of the tackling neglect subgroup, including: appointing a named strategic lead from all partner agencies; implementing a neglect strategy which includes supplementary toolkit and action plan, and outlines expectations; updating and continuing to maintain the neglect toolkit with up-to-date research, interventions, tools, and good practice case studies; ensuring strategic leads brief all staff within their agencies about updated processes and expectations; delivering multi-agency training to support professionals in identifying neglect and understanding threshold criteria and intervention options; ensuring clear communication pathways between agencies; implementing robust and varied monitoring and scrutiny of the quality of practice and performance regarding child neglect; and ensuring assessments and work with families is timely, effective, family-focused, strengths-based, relational, and trauma-informed.

Other resources Read practice review (PDF)

6. Local Child Safeguarding Practice Review: Isaac

Isaac was arrested on suspicion of murder of an elderly man in February 2023. Isaac was 17-years-old at the time with complex physical, medical and mental health needs.

Recommendations include: improve understanding and early identification of autism in schools and to promote an inclusive culture; promote understanding of the integrated care system's responsibility to develop a package of care that meets the needs of young people whose primary need relates to challenging behaviour or emotional and psychological needs; learning from this review should be used to inform the development of the all age autism outreach service, to support people with autism at risk of hospitalisation; in circumstances where young people with

complex needs may pose a risk to practitioners, clear risk management plans need to be devised and shared, giving specific advice in relation to the young persons' needs and triggers; assurance about the robustness of the competency and accountability framework for mental capacity in use across children's services; partner agencies should collaborate to formulate a shared analysis of how the individual's cognition function is impacted in different circumstances; improve access to secure beds and therapeutic accommodation that meet the needs of autistic young people; ensure that when a child in their care, who is placed at a distance and attending court, clear arrangements are in place for an appropriate adult to be in attendance to support them; and ensure that communication and consultation with parents of children in care is timely and proactive in respect of their care plan or developments with respect to their welfare.

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7. Local Child Safeguarding Practice Review: siblings known as children C and D

Murder of an 11-year-old boy and his 7-year-old sister by their mother in June 2023.

Learning themes include: the importance of the role of fathers/male caregivers for children and how they can be engaged; consideration of possible cultural bias as a barrier to accessing services; understanding risk and behaviours in domestic abuse including female perpetrators; understanding of the impact of parental mental health issues on children and family functioning; and the significance of children not being brought for health and education appointments.

Recommendations to the Partnership include: ensure that professional development allows staff to strengthen their skills in 'professional curiosity', including an exploration of any possible cultural, gender and/or neurodiversity barriers to accessing services; ensure there are regular opportunities to reflect on the role of fathers; provide training to strengthen knowledge in understanding risk characteristics and behaviours in domestic abuse, including coercive control, gender bias and consideration of male victims; ensure practitioners are alert to the need for early help for children and families who have additional needs and there are clear systems that identify emerging problems and unmet needs; ensure that when families access support services there are systems in place that identify and meet individual communication needs; establish clear guidance, and principles about working with the whole family and identifying support for adults with child-caring responsibilities; GPs should review in-person adult mental health medication at least annually; and the police should ensure that in situations of domestic abuse all children in the household are considered as victims and a clear risk management process means protective processes are in place while multi-agency risk assessment is undertaken.

Other resources Read practice review (PDF)

8. Local Child Safeguarding Practice Review: Child 20

Serious accident involving an unsupervised 4-year-old outside of the home who sustained a head injury in June 2022.

Thematic analysis includes: think family; response to mother's health, care and support needs, and to half sibling; the effectiveness of referral, care planning and escalation processes from early help to child in need or child protection; the response to neglect, including for adolescents; and the impact of Covid and any other organisational issue.

Recommendations: consider how best to ensure that practitioners have access to information about parental health conditions during assessments and care planning especially for those conditions which are

unusual or which may impact on their parenting; arrange multi-agency audits regarding safety plans, that they are developed and shared with other agencies, put into writing, effectively monitored and any lack of compliance is promptly addressed; arrange multi-agency audits regarding the response to contact with First Response about children who are open to the integrated family support service or a social worker; all agencies working with children to review recording and communication systems to ensure that requests for escalation by other agencies, or internally within the council by IFS, are included in the child's record in a way that facilitates management oversight of cumulative and/or chronic concerns; raise awareness that senior managers from other agencies other than social care can request that an initial child protection conference be convened; ensure social workers seek consent to share child and family assessments with other practitioners involved with the family; child and family assessments are repeated when the circumstances of individual children or their family changes significantly; and review the implementation of the introduction of impact chronologies.

Other resources Read practice review (PDF)