NSPCC Repository December 2024

In December 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including youth violence, children as carers, culture, and parents who have learning disabilities
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: Serious youth violence – breaking the cycle: BSCP 2022-23/02

Death of a 16-year-old male in the Summer of 2022, by a stab wound to his chest. The police commenced a murder investigation. One of the individuals was a 16-year-old male who following trial received nine years imprisonment for manslaughter.

Learning themes include: governance of serious youth violence; assessments - traditional safeguarding - child criminal exploitation (CCE) and serious youth violence (SYV); place; trusted adult-mentoring-reachable moments; and unregulated premises.

Recommendations include: that all relevant statutory and voluntary sector organisations at both strategic and operational levels are committed and actively involved in the long-term implementing of the reducing serious violence strategy; all strategic leaders, managers and practitioners understand their role in preventing SYV; there is a need for individual children that may be at risk of SYV (either as a victim or perpetrator, or both) to be identified at the earliest opportunity; review the current screening tool so that they ensure that they pick out SYV where it is a separate risk to CCE; develop a model that looks at alternative but complementary pathways for SYV and CCE to those that are currently used in child protection cases if they are deemed not suitable for an individual child; a lead professional in place to coordinate multi-agency activity for children who are at risk of SYV; support education efforts to raise awareness of the dangers of knife crime in secondary, primary schools and in those settings providing alternative school provision; and awareness of the range of community-based support within neighbourhoods and availability of mentoring services across the city and their effectiveness in supporting children at risk of SYV and CCE.

Other resources Read practice review (PDF)

2. Concise child practice review: CTMSB 06/2021

Death of a 9-year-old girl in September 2021. Child C was found in the bath, submerged under water having been left unsupervised. Child C had global delay, epilepsy and learning disabilities, culminating in complex needs. The family have been known to Social Services since 2010 with Child C and siblings names placed on the CPR on two separate occasions.

Learning themes include: multi-agency sharing of information to identify child protection concerns; quoracy and the quality of information being presented at Child Protection Conferences; management of multi-agency responsibilities for a disabled child outside of child protection processes.

Recommendations include: the LA should ensure that, where quoracy is not observed, the Child Protection Conference Chairs fully consider postponing the meeting or alternatively the rationale for it still going ahead; all agencies should identify the correct professionals to attend conferences; all contributing agencies should ensure that Care and Support Reviews are sufficiently robust in terms of attendance and contribution; the Safeguarding Board should consider reviewing guidance for professionals for reporting to conferences to ensure that relevant critical information is captured; the LA should review their process for social worker allocation when a team is already involved in the family and child protection concerns are identified; the Safeguarding Board should review how the adult at risk and child protection enquiries pertaining to the same family can sit under one point of contact; all agencies must ensure that support is available to professionals facing challenging situations at work; and the Welsh government should consider commissioning a full review of health, social care, education and police recording, information gathering and sharing systems.

Other resources Read practice review online: www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/PracticeReview/CPRCTMSB062021.pdf

3. Zac: Local Child safeguarding Practice Review

Death of an 11-year-old boy in June 2022 following a fatal injury (severe liver trauma) which was initially thought to be because of an unwitnessed accidental fall from a tree. The fatal injury was later found to be the result of a physical attack by the child's father which took place at the family home.

Learning themes include: coercive control; recognising and safeguarding vulnerable children; impact of Covid 19; Elective Home Education; transient families and cross border issues; and Child Death Review processes.

Recommendations to the Partnerships include: audit early help arrangements with a focus on the quality and content of assessment and analysis; seek evidence from partner agencies about the measures they have in place for safeguarding cases to assure themselves of the quality of management oversight and supervision including evidence that training on domestic abuse and coercive control is promoted and monitored; the LA to provide a scrutiny report to the Partnership which focuses on the impact and effectiveness of communication and information sharing arrangements between schools, the Elective Home Education Service, 0-19 Children's Service, and the Children Missing from Education Service (including cross border arrangements); and child death leads should facilitate a specific meeting to include Integrated Care Boards, Local Authority and Police members, to consider how the Joint Agency Response guidance can be strengthened to promote cross border working in relevant situations when a child dies suddenly and unexpectedly, as well as include the specifics of when children die following unwitnessed injury.

Other resources Read practice review (PDF)

4. Child Safeguarding Practice Review; Child AF

This review concerns Child AF and her mother Sophie. Child AF was born at approximately 24 weeks gestation following her mother going into early labour. Child AF died at one day old, her prematurity being such that her survival prospects were poor from birth. This was Sophie's sixth

pregnancy, her other children and Child AF's siblings did not reside in her care due to concerns that they would be at risk of significant harm.

Learning is embedded in the recommendations.

Recommendations include: all practitioners across Children's Social Care and Mental Health need to have a good working understanding of termination of pregnancy procedures within their local area; safeguarding information should be shared effectively between health professionals and Children's Social Care especially where there are safeguarding concerns and where the expectant mother has chosen to terminate the pregnancy; communication between partner agencies should be explicitly clear to reduce any misinterpretation around the confirmation (or not) of termination of pregnancy; develop and utilise a mechanism by which their case management system can show information regarding a parent's learning disability on the child's digital file; review relevant files when cases are allocated to them to ensure that they are they are working with parents in line with their identified learning needs; develop a robust definition to identify which expectant mothers should be treated as 'vulnerable'; and information regarding the termination of pregnancies should be conveyed to women's GPs with consent and as part of a patient's health record unless there are expressed reasons for not doing so.

Other resources Read practice review (PDF)

5. 'Vamp': Local Child Safeguarding Practice Review

Death of a 13-year-old girl in July 2022. Vamp had been subject to a child protection plan since March 2022 under the category of neglect.

Learning themes include: understanding the lived experience of adolescents, for example around risk-taking behaviour, going missing, risk of exploitation, and being a young carer; ensuring services, including mental health support, are accessible and adaptative to adolescents; and working effectively across boroughs.

Recommendations to the Partnership include: strengthen working together approaches across agencies; consider strategies to ensure children who go missing are protected within the community, such as by empowering community members to share information with agencies; utilise a trauma-informed approach to identify and support children and young people (CYP) at risk of exploitation; support professionals in engaging CYP in relationships of trust, enabling CYP to explore and address risky behaviours, situations, and relationships; stop referring to CYP's 'non-engagement' with agencies and prioritise reaching the child; ensure all agencies have a plan for how they will adapt their services to meet the needs of CYP; work with neighbouring Partnerships to influence stronger commissioning arrangements across boroughs;; strengthen information sharing and working relationships between services, including between boroughs; liaise with other southwest London Partnerships to develop a consistent approach to detached youth work services; develop Partnership understanding of the experience of young carers and how they are identified and supported by agencies, including education and mental health services providers; and when there are allegations of sexual assault, all efforts should be made by the police to confirm the age of the victim and perpetrator.

Other resources Read practice review (PDF)

6. Child Safeguarding Practice Review: James

Death of a 1-day-old infant in March 2023. James was born at home and died from an infection. James' mother has a moderate learning disability.

Learning themes include: working with parents with a learning disability; antenatal care; and making and responding to referrals.

Recommendations include: the partnership should develop a multi-agency action plan to provide better support for parents who have a learning disability; practitioners should be able to understand the difference between learning difficulties and learning disabilities, the different degrees and aspects of learning disability, including the concept of 'executive functioning', and how to find out if a person has a learning disability diagnosis, and get appropriate support; the local integrated care board (ICB) should lead a multi-agency evaluation of the maternity hubs; and the ICB should promote GPs offering proactive support to pregnant women who have a learning disability, to facilitate prompt booking in for antenatal care and sharing information about their learning disability with midwifery services, and entering information on the patient record.

Other resources **Read practice review**

7. Warwickshire Safeguarding Partnership Local Child Safeguarding Practice Review: Fara

Death of a 1-year-old infant in August 2020. Fara drowned at the family home whilst both parents were under the influence of drugs.

Learning themes include: parental substance misuse; asylum-seeking adults; engagement with fathers; importance of single assessment; cumulative impact of parental difficulties; professional curiosity; late presentation/potential concealed pregnancy; liaison between health and drug misuse services; role of GPs: role of housing providers; and criminal activity/anti-social behaviour.

Recommendations include: the partnership should continue to monitor the effectiveness of the family front door arrangement; multi-agency guidance for dealing with late presentations / concealed pregnancies should be prepared and awareness raised across agencies; a protocol should be developed to co-ordinate the involvement of substance misuse/drug treatment and health services pre and post-birth; the child death overview panel should consider how to raise awareness of the risks of serious harm and death to children when parents have consumed drugs or alcohol, from neglect and lack of care and of the dangers of children being left unsupervised; the partnership should prepare a seven minute briefing to develop practitioners' understanding of the challenges facing asylum-seeking adults and their families; the partnership should seek assurance from partner agencies that they are meeting their legal requirements to provide interpretation, translation and signing services; and the police should report to the partnership regarding the resourcing and effectiveness of the intelligence processing unit, the safer neighbourhood team and the harm assessment unit.

Other resources Read practice review (PDF)

8. Local Child Safeguarding Practice Review: A thematic review for two children known as Diallo and Katie

Thematic review based on the deaths of two children from different families aged 3-years-old and under from head injuries. Diallo's mother and Katie's mother's partner were charged with murder. The timeframe includes the period of national lockdown between March 2020 and March 2021.

Learning themes include: knowing the children and understanding their experiences; cross-boundary working and information sharing; professional curiosity and critical thinking; and race, ethnicity, and culture.

Recommendations include: the partnership to strengthen practitioner skills that enable respectful enquiry and curiosity and facilitate open conversations with families about parenting, relationships, and their own

lived experiences; the partnership to ensure services that support adults who are parents follow a 'whole family' approach, with clear pathways to early help and preventative services; the partnership to consider how early opportunities to share information and triage family needs can be most effectively used across early help, health visiting and GPs; the partnership to ensure practitioners and systems can demonstrate in records, assessments, and interventions that race, ethnicity, and culture directly inform the family's narrative; the police to assure the partnership that its decision-making and outcomes relating to 'Clare's law' and 'Sarah's law' disclosures where children are identified, comply with national police standards and legislation; the local multi-agency service to ensure it demonstrates professional curiosity when separated fathers share worries about their children; and the local NHS foundation trust to raise the recording issue of the child electronic system removing a record of tasks nationally.

Other resources Read thematic review (PDF)