NSPCC Repository January 2025

In January 2025 eight case reviews were published to the NSPCC Repository featuring a number of issues including adultification, foster care, children with chronic illness, and non-accidental head injuries. Previous NSPCC Repositories and published Torbay local child safeguarding practice reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Domestic homicide review into the deaths of Emma, Lettie, and George

Murder-suicide in a family home in February 2023. Emma (45-years-old), Lettie (7-years-old) and George (39-years-old) had all died as a result of gunshot. Police investigations confirmed that George was a licensed shotgun holder, and that he had killed his partner, Emma, and their 7-year-old child, Lettie. No specific motive about why George acted in this way has been uncovered.

Recommendations include: several specific to strengthening gun licensing guidance; The Home Office and the Domestic Abuse Commissioner's Office should promote the Public Health England and Business in The Community Domestic Abuse Employer Toolkit which helps employers of all sizes and sectors make a commitment to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse; the Partnership should raise the profile of this toolkit and the Employers Initiative on Domestic Abuse across all partner agencies, to raise awareness that supports all employees, regardless of role, status and position held, to seek help if they are a victim of domestic abuse; and The Epsom and Ewell Community Safety Partnership should work with relevant agencies and other strategic partnerships to examine methods for reaching into local communities that encourage adults (particularly adult males) to seek support about emotional or mental health worries or any mental distress they may be troubled by.

Other resources Read review (PDF)

2. Child Safeguarding Practice Review: BSCP 2020-21/01

Serious head injuries and bruising to the body of a 1-month-old infant in June 2020. These were believed to be non-accidental, and possibly because of a shaking incident. Agencies were involved soon after the baby's birth when there was a witnessed episode of domestic abuse at the hospital. Following a criminal trial both parents were found guilty of causing or allowing serious physical harm to a child.

Learning themes include: assessment in the pre-birth period and planning support for after birth; the initial response to domestic abuse and strategy planning; attempts at escalation and professional challenge; and early help assessment and response to domestic abuse following discharge.

Actions have been taken to improve the following areas of practice: MASH Health practitioners are able to access both parents' GP health information when screening referrals; strengthening the

engagement, referral and assessment of fathers during pregnancy and infancy; improved response to parental conflict, coercive control and domestic abuse in pregnancy and infancy to ensure consistent agency responses to domestic abuse; increased support for parents where parental neurodiversity, learning disability and emotional dysregulation may impact on parental capacity using a 'Think Family' approach, through appropriate policies, procedures and training provision; practitioner understanding of the effect of adverse childhood experiences on parenting ability and use of trauma informed approaches in interventions; practitioners' understanding of confirmation bias as well as their application of professional curiosity; ensuring the timeliness of information sharing, accuracy of information in referrals and understanding of parental history is embedded in practice.

Other resources Read practice review (PDF)

3. Local Child Safeguarding Practice Review: Child I

Death of a 16-year-old boy in October 2023. Child I had been subject to a full care order since February 2023, and had previously been subject to a child protection plan. He had multiple missing episodes from home and from care, and was known to have gang affiliations.

Learning themes include: the impact of placement insufficiency; strategic responses to child criminal exploitation and child sexual exploitation; the role and relevance of the national referral mechanism (NRM); the family as a system; and managing risk that escalates rapidly.

Recommendations to the Partnership include: develop a strategic approach to adultification in the context of intra- and extra-familial risk; ensure approaches to adultification consider the intersection of ethnicity and gender, with a particular focus on how these factors influence the way risk is understood and responded to; increase understanding of the risk of criminal and sexual exploitation in the context of family and community systems; consider how services can work together to hold the 'system' around a child in mind when responding to individual incidents; update, share and promote local practice guidance on the NRM; ensure practice guidance reflects the limitations of the NRM and gives suitable weight to risk assessments and safety planning outside of the NRM; review opportunities for regional commissioning of placements to establish a range of local placement options for children experiencing exploitation; and explore local arrangements to allow for child mental health services to hold responsibility for children experiencing exploitation across neighbouring boroughs.

Other resources Read practice review (PDF)

4. Child Safeguarding Practice Review; Executive Summary: Child Cameron

Admittance to hospital of a 16-year-old-boy in December 2022, due to poor management of severe obesity. Cameron was suffering from Diabetic Ketoacidosis (DKA)1, septic shock and was in peri-cardiac arrest, and was also Covid-19 positive.

Learning themes include: cross border working of partner agencies; professional understanding of the long-term health impact of obesity; response to self-harming; engaging young people with social anxiety disorder; transgender support services; and the role of the mother in supporting the young person to access services.

Recommendations to Lancashire and Greater Manchester partnerships include: with partners, GP Practices should develop a system which enables them to maintain an appropriate level of contact with child and young person patients living with severe obesity; review guidance available to professionals when a child living with obesity could represent a safeguarding concern and consider developing a Safeguarding Pathway; relevant agencies to review their 'Was not brought' policies to ensure they consider the impact of social anxiety on the ability of a young person to be supported to attend appointments and set out reasonable adjustments if a young person continues not to be brought, including a multi-agency risk assessment; professionals working with young people are made aware of self-neglect policy and practice and are provided with the necessary training including in relation to the Mental Capacity Act; and introduce a requirement to conduct a multiagency risk assessment when closing the case of a child being supported at Level 2 or Level 3 as result of lack of parental engagement.

Other resources Read practice review (PDF)

5. Child Safeguarding Practice Review: Child 'Julia'

Explores the death of a 5-year-old girl who was found to have drowned in the bath after being left unsupervised. Julia was in the care of her local authority and had been living with her four siblings in a foster home provided by an independent fostering agency.

Learning is embedded in the recommendations.

Recommendations include: audit their records to ensure that the most recent information is provided in foster carer profiles to ensure the matching process for looked after children is fully informed; consider the learning around delay in the provision of key basic safety equipment for the children and audit to ensure that these issues are addressed in a timely manner and recorded in placement planning meetings; ensure that the terminology of 'short term' in relation to the placement of looked after children is fully understood by practitioners or foster carers/other practitioners within the children's workforce; consider using existing mechanisms such as professional network meetings to reflect on situations where emergency placements and/or large sibling groups are placed; address the delays to the initial health assessment process identified in this review; review their procedures to ensure that there are no additional delays caused by the request for ongoing delegated consent forms or the attendance of the social worker which are not statutory requirements; and assure that the current process involving the transfer of health information between the local authority/ICB/health trusts in relation to looked after children is effective and the procedure updated.

Other resources Read practice review (PDF)

6. Concise Child Practice Review: NWSCB/1/2022 Child A

Death of a 13-year-old girl in September 2021 after contracting Covid-19. Child A had mitochondrial disease and experienced multiple health conditions. There were concerns about the impact of quarantine on Child A's health following a family stay in Pakistan.

Learning themes include: the importance of a multi-agency approach to working with a child with a life-limiting condition and their global family; a holistic view of the child's needs; and the impact of the Covid-19 pandemic, including the impact of UK Government imposed hotel-based quarantine.

Recommendations include: all professionals working with children and families to receive cultural diversity and intersectionality training with a specific focus on working with global families whose

children have life-limiting conditions; information about a child's significant health condition and prognosis should be provided to parents in both their first language and English; the Welsh Government to consider how future quarantine facilities will be suitable for children with life-limiting complex health needs; consideration to be given to alternative provision of school-based health services when children are absent from school for a period that would impinge on their health and wellbeing; and the promotion of counselling and wellbeing support to be provided and promoted for practitioners who are working with children with life-limiting conditions.

Other resources Read practice review online: www.northwalessafeguardingboard.wales/document/nwscb-1-2022-child-practice-review/

7. Thematic Child Safeguarding Practice Review: Supporting the workforce in Sandwell to respond effectively to child neglect – challenges and opportunities

Outlines the findings of a Child Safeguarding Practice Review (CSPR) that examined the effectiveness of the Partnership's response to child neglect. The thematic CSPR was commissioned following the death of a 5-year-old and two further separate serious child safeguarding incidents where neglect was a feature.

Learning themes include: knowledge, understanding and implementation of the Partnership's neglect strategy; the use of child-centred assessment tools, practice models and frameworks; the need for a shared, multi-agency understanding of neglect and thresholds for intervention; professional confidence; cultural competence; and intersectionality, including the effects of poverty, deprivation and additional needs or disabilities.

Recommendations to the Partnership include: develop and disseminate a suite of accessible briefings, targeting specific sectors, which support frontline practitioners in operationalising the neglect strategy into day-to-day work; incorporate the Partnership's strategic aims into all safeguarding and child protection training courses; develop a single suite of tiered multi-agency assessment tools; monitor the use and impact of these assessment tools, alongside staff confidence in using them; develop simplified threshold guidance; expand the guidance, resources and examples available to practitioners; conduct a multi-agency audit of safeguards for children already known to agencies due to concerns about neglect, that are electively home educated, classed as missing education, or have disabilities or special educational needs; raise awareness about parental consent for information sharing and what action to take if concerns remain when consent is withdrawn or not given; and seek out and consider the views of families with previous agency involvement due to concerns about child neglect.

Other resources Read practice review (PDF)

8. Local Child Safeguarding Practice Review: Child B and siblings

Near-fatal incident to a 5-year-old male child in November 2022. Following a seizure, Child B was found to have adult medication in his system. Subsequent toxicology showed Child B's two siblings had adult medication in their systems.

Learning themes include: family history and understanding predisposing vulnerabilities and risks; impact of adult issues on parenting and assessment of support needs; impact of adult medication on parenting; recognising neglect across universal and early help services; clear information-sharing and recording

systems to inform threshold decisions; patterns of attendance for health and education provision; coordination of services, support, and information across universal services for children with additional needs; and understanding the child's lived experienced.

Recommendations for the partnership include: evaluate the effectiveness of how learning about neglect is being embedded in practice, including good practice concerning predisposing and coexisting factors; strengthen practitioner skills that enable critical thinking and respectful challenge about neglect; ensure that previous referrals and historical information are used to triangulate information with all services involved with the family to consider the right level of need in threshold decisions; ensure professionals have knowledge of safeguarding the unborn baby procedures and are aware when to refer; review how the multi-disciplinary early years forum can be strengthened to improve the identification of neglect for children with additional needs and disabilities; and seek assurance from the integrated care board that there are robust systems in place to consider neglect by ensuring that children not brought for health appointments are regularly reviewed.

Other resources Read practice review (PDF)