NSPCC Repository – April 2023

In April 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including violent crime, serious injuries, and unsafe sleeping

1. Children C and D: LCSPR report

Death of two children as a result of a house fire, believed to have been started by their mother, in March 2021.

Learning includes: practitioners to think more holistically about families and consider all the presenting needs; recognition of practitioners' role and responsibilities for parents caring for children with disabilities and how legislation and guidance can support their work; assessment of the impact of domestic abuse and its emotional effects on family members; practitioners to be cognisant of the impact of intrusive thoughts and for those to be risk assessed at an early stage; understand children's day to day lived experiences; and the support that families receive from their faith and from their church should be assessed as a vital part of their support network.

Recommendations include: ensure awareness of revisions to the existing protocol with front-line practitioner events, audits of practice, visual aids etc; ensure that carer's needs are sufficiently considered and assessed in line with the expectations of parent carers assessments; review training strategy to ensure that all partners equip their practitioners to be confident when dealing with families where domestic abuse is (or has been) a factor; ensure assessments and ongoing work includes the child's experience and emotional impact of these experiences as well as the child's voice; and professionals should be equipped with cultural competency together with an understanding of intersectionality to properly identify and consider these factors when assessing and managing the risk to children.

Other resources Read practice review (PDF)

2. Local thematic child safeguarding practice review: Young Person SC

Death of a 17-year-old boy as a result of multiple stab wounds. Learning is embedded in the recommendations.

Recommendations include: seek assurance that there are formal processes to collect and analyse data around fixed or permanent exclusions and managed transitions; undertake a review of the themes and patterns of behaviour which constitutes a 'persistent breach of school behaviour policies' and provide evidence of the effectiveness of approaches used to prevent exclusions for those who are overrepresented and at risk of exclusion from education; undertake work to understand young people's experience of alternative provision in the borough, especially young people with complex needs, being exploited/at risk of exploitation or who are disproportionately affected by exclusions; undertake a consultation process with black and ethnic minority children, practitioners, community groups and families to understand the reluctance to engage with Early Help services and devise an action plan which addresses the barriers; undertake a review of referrals received, support offered and take-up of services for ethnic minority groups; and

assurance that school behaviour policies have clear guidance and a definition of 'persistent breaches and school exclusion' and that they are based on guidelines provided by the DfE regarding behaviour and discipline in schools.

Other resources Read practice review (PDF)

3. Child safeguarding practice review: learning identified from Family A

Mother of three children under 5-years-old convicted of Father's murder. Murder was witnessed by one of the children.

Learning includes: assumptions about domestic abuse can lead to plans for children that are not reflective of their experience and do not mitigate risk; fathers need to be considered and involved in assessments and plans for their children, even in cases of domestic abuse or where the father does not live with the children; professionals must have a full understanding of a parent's history and vulnerabilities and consider the impact of this when undertaking assessments and working with families; practice and systems need to be child centred and consider a child's lived experience so that work with a family is not dominated by adult issues; Covid-19 is likely to have had an impact on the family and support provided to them.

Recommendations include: consideration of the findings of the Child Safeguarding Practice Review Panel's "Multi-agency safeguarding and domestic abuse briefing paper" (2022); ensure that the requirement for timely assessments and the need to understand the nature of the abuse in each relationship is covered in domestic abuse training; ensure that partner agencies specifically request and record details of the GP for all children and adults in a household and that information is shared with all GPs; information about domestic abuse orders and plans should be shared with all professionals working with children in the family.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Child G: overview report

Injuries and hospitalisation of a 2-and-a-half-year-old boy in 2020. Child G was found to have a depressed skull fracture, resulting in a section 47 enquiry. Learning is embedded in the recommendations.

Recommendations include: decisions stated in MASH outcomes as 'necessary' need to be actioned; MASH decisions which are not the outcome of strategy discussions and require adjustment to reflect local considerations and knowledge of the family must have a clear rationale recorded; workers and agencies who are key to the understanding and progress of a case should always be kept updated; the possibility of non-accidental injury should always be considered in the case of multiple injuries and bruises and when parents' explanations for these are inconsistent; professionals should always check the history, past referrals and the social worker/social work team to ensure all relevant and significant information is gathered; social care should routinely update all agencies involved in a case; all professionals involved in a case should ask questions and get clarity about the key adults in a child's life, and these questions should be standard practice for supervisors and managers to ask at supervision; all professionals should be

guided to read the Child Safeguarding Practice Review Panel's report 'The myth of invisible men' (2021); supervision in social care must always allow for reflection by the social worker.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: Child X

Death of a 3-and-a-half-month-old girl in May 2021. Child X was in the care of foster parents when she was found unresponsive in an unsafe sleeping position.

Learning includes: joint working between midwives and social workers should be a core element of discharge planning for vulnerable new babies, even when they are going to foster carers; rigorous checks and assessments of foster carers taking on infants; gaps in supervision can occur when services use agency staff who might not have the appropriate knowledge and skills to undertake safe practice with vulnerable families; where there are concerns that a child has been harmed, there is a need for equivalent response when the child is in the care of foster carers as in the care of their birth parents.

Recommendations for the safeguarding partnership include: a campaign to raise awareness of safe sleeping arrangements for infants to include 'what if' questions; to seek assurance that independent fostering agencies comply with standard 10 of 'Fostering services national minimum standards' (2011), relating to suitable physical environments; to ensure managers and supervisors are aware of the importance of following up in supervision that safer sleeping arrangements have been checked by social workers and health professionals; all services ensure that their staff are aware of the neglect toolkit and bruising of non-mobile infants guidance.

Other resources Read practice review (PDF)

6. Local child safeguarding practice review: subject: Daisy

Life-threatening injuries to a 4-year-old girl who was struck by a road vehicle in June 2021. Police commenced an investigation into possible neglect following reports of mother being intoxicated at the time.

Learning includes: disproportionate/issues of professional optimism in the context of substance abuse addiction and domestic abuse; the voice of the child and the child's journey was not understood by all professionals; engagement and communication with the family was not always/could have been more robust and concerns raised by relatives were not given/could have been given adequate weight; the family's history, including an older sibling being subject to a Special Guardianship Order, should have been considered more when assessing parenting capacity; engagement and service delivery were impacted by Covid-19.

Recommendations include: ensure families are systematically used to inform decision-making, information sharing and managing risk, with extended families able to contribute to the plan for a child; ensure a full understanding of a family's history is collated and this is considered in all assessments; children placed on Special Guardianship Orders with family members must be comprehensively included in assessments and planning; police should ensure that incidents of domestic abuse are linked to the same family network so that the cumulative impact is

understood and risks can be assessed; partner agencies working with adults must share information with relevant children's professionals where there are concerns which could impact on parenting capacity.

Other resources Read practice review (PDF)