NSPCC Repository April 2024

In April 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including youth violence, infant deaths, optimistic behaviour, and suicide
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 Thematic Review: Serious Youth Violence

Thematic review focussing on seven children/young people who were charged in association with the unlinked deaths of three children in 2021. Recognises that children or young people involved in serious youth violence often experience the dynamic interplay of being both a victim and a perpetrator.

Learning considers: the children's experiences of involvement with statutory services at an early age; domestic abuse; difficulties in parental/carer relationships; mental ill health; exclusion from education; offending behaviour; missing episodes; poverty; intersectionality; adultification; support provided to the children/young people and reasons why support ceased; the voice of the child, their daily life, and reasons why support may not have been accessed or effective; the experiences of the children's families (including the families of the children who died); community support provision; and the experiences of front-line practitioners.

Recommendations include: the partnership to actively seek evidence to demonstrate how the 10 key principles of K.I.D.S. V.O.I.C.E.S. (knowledge, identity, duplication, stick with it, voice, outcomes, innovate, community, education, spaces) are being applied across multi-agency services, schools, panels and strategy forums, and seek evidence of impact; the voices of children and young people, family members and the community should be actively sought to achieve co-production in the future design of services; and the partnership to highlight the national issues raised in this CSPR with relevant national bodies such as the Child Safeguarding Practice Review Panel.

Other resources Read thematic review (PDF)

2. 'Franklyn': Child Safeguarding Practice review

Death of a 4-month-old boy in 2022 from an out-of-hospital cardiac arrest. Franklyn was born with a life-limiting disability and complex health needs. At the time of death Franklyn had been subject to a child protection plan for seven weeks due to concerns relating to domestic abuse and parental/significant adult substance misuse.

Learning includes: the importance of a holistic trauma-informed practice model as a planned action by the network of professionals; a need to continually build strong relationships with families, adopting a family-focused, compassionate approach which accords parents respect and

recognition; and an intersectional approach is needed to understand the unique challenges faced by families.

Recommendations include: the adoption of a trauma-informed model of support; gather and analyse feedback from those with lived experience in the ongoing development of bereavement and loss services; family focused communication in assessment practice; and the partnership to take note of issues of bias and how they play out in safeguarding around children with complex needs.

Other resources Read practice review (PDF)

3. Concise child Practice Review Report: Cysur 2/2020

Sudden unexplained death of a 12-week-old infant in spring 2019.

Learning themes include: the cumulative risk factors of domestic violence, substance misuse and mental health; assessment and support of Children of Looked After Children and Care Leavers; co-sleeping; and housing.

Recommendations include: develop further policy and practice guidance in respect of the professional responsibilities for referral, assessment and support provided to young parents in and leaving care; all areas who support statutory childcare teams (including support to parents) should ensure that an understanding of safeguarding responsibilities and the statutory duty to report concerns for children or adults at risk is embedded in day to day practice, including domestic abuse incidents and referrals for unborn children; Children's Services should review the process of recording and responding to multi-agency referral forms (MARFs) on open cases to ensure they are formally recorded on the child's record; the Safeguarding Board should ensure that all agencies' internal information sharing policies and practice guides are up to date in line with current legislation, policy and procedures, and all staff are able to access ongoing training in the context of safeguarding; there should be a housing strategy for Care Leavers that ensures a holistic response and robust multi agency partnerships to meet the support needs for individuals and families; the Teaching Health Board should provide clear, service specific guidance for practitioners to follow in response to Domestic Incident Notifications; ensure that there is an effective local response to reduce the risk of SUDI to support local/regional multi agency learning and development in this area of work.

Read online here

4. Child Safeguardgin Practice Review: Final report: Beta

Covers the period Sept 2018 until June 2021 when there was a disclosure of sexual abuse by a girl against her stepfather. The family had been well known to services since 2012. Beta and her siblings had been subject to child protection plans historically and there had been a previous Serious Case Review following the death of a sibling.

Learning themes include: the need for conversations around risk, including people's perception of risk, the different risk assessments, and the interface between them; ensuring all partners are informed, and a multi-agency approach taken when a local authority contests a Special

Guardianship Order (SGO), or there is a change in circumstances within a family unit; making sure children always remain the focus and are central to processes so that if adults caring for children experience medical issues, grief etc, consideration should always be given to the impact on the children; ensuring all partners are aware of a family being involved in a SCR/CSPR and that records reflect that; building trust, providing opportunities for children to disclose, and asking the right questions at the right time; professional curiosity and considering issue of disguised compliance; where multiple types of abuse are taking place, making sure attention is given to each form of abuse rather than allowing one type of abuse to overshadow the other; and ensuring the voice of the child is heard.

Recommendations are embedded in the learning. Highlights examples of good practice.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: Ash

Suicide of a 17-year-old boy in 2021. Police found prescribed and unprescribed medication, a 'burner phone' and a BB gun in Ash's room. Ash had an ADHD diagnosis and was known to children's social care and police due to concerns around criminal exploitation.

Learning themes include: multi-agency understanding of the child's lived experience, mental health and the impact of parental conflict; effectiveness of information sharing; criminal exploitation and contextual/adolescent safeguarding; elective home education and child protection; medical or psychological assessments in the private sector; cross border working; understanding known behaviours in relation to past trauma and present risks; and impact of ADHD on learning and daily functioning.

Recommendations include: partnerships to work with parents to explore barriers to open dialogue with statutory agencies; all agencies to evaluate the quality of supervision, particularly around professional curiosity, elective home education, and consulting all adults with parental responsibility when parents are separated; relevant bodies to remind private consultants to comply with GMC and NICE guidance on who must contribute to the safe transfer of patients between healthcare providers; ask the Department for Education to consider placing a duty on parents to inform the local authority when a child is being home educated and if the child moves to a different local authority; develop multiagency elective home education safeguarding procedures for children at risk of criminal exploitation and ensure practitioners can recognise the signs of exploitation; and where there are concerns, ensure that risk assessments are based on the full facts of the case and the voice of the child is obtained.

Other resources Read practice review (PDF)

6. Serious Case Review: Baby Mary: review report

Death of a 10-week-old infant in February 2018 from significant non-accidental injuries whilst in the care of her parents. Mary was born prematurely and spent several weeks in a special care baby unit prior to discharge home.

Learning themes include: information seeking, sharing and usage to inform assessments, decision making and intervention; over-optimism in parenting capacity; professional challenge and escalation; cross border working arrangements; parents' engagement with the professional network; transient lifestyle and housing difficulties; and practitioners and managers' knowledge and confidence in understanding risk of harm, abuse and neglect.

Recommendations include: to seek assurance that professionals across the partnership have knowledge about how to respond to professional challenge, professional disagreements and the use of the escalation policy; to review arrangements for discharge planning from hospital when there are concerns about a child's safety and welfare, and where there are multiple statutory agencies involved; to seek an update about the progress made regarding efforts to unify and promote consistency of practice for children and families moving across London boroughs; to promote a dialogue with relevant partner agencies about how to consistently interpret, apply and evidence threshold decisions when making referrals, with the use of scaling being one tool for achieving this; and to seek assurance that the local housing service is fulfilling its statutory obligations under the Housing Act 1996 regarding notifications to other housing authorities when placing families, or pregnant women, outside of their borough, and their responsibilities under the Children Act 2004 in relation to sharing information with other professionals.

Other resources Read practice review (PDF)

7. Serious Case Review: Child J

Serious non-accidental injuries to a 7-month-old child in July 2015. Both of Child J's parents were charged with causing grievous bodily harm. Child J had been placed in foster care from birth and was returned to the care of the parents aged six months.

Learning points include: responding robustly to domestic abuse within a safeguarding plan requires an approach that works with both victims and perpetrators to support robust analysis of risk and change; comprehensive assessment of risk and planning for children is best supported through adopting a common model of assessing motivation and capacity for change; management oversight at critical points of assessment needs to support practitioners to utilise critical thinking techniques to draw confident conclusions and develop plans that appropriately address risk; for children reviewed within looked after children arrangements, systems to support multi-agency working should remain a priority where more than two agencies continue to be involved with the child and family; and the local authority must carefully and robustly exercise its parental responsibility for children placed with parents.

Recommendations include: the local safeguarding children board (LSCB) should promote the use of a model of change within partnership agencies to assist single and multi-agency assessment of parenting capacity; the LSCB should require children's social care (CSC) to ensure that every child for whom they share parental responsibility and is placed with parents is subject to 'placement with parents' regulations reviewed alongside the child's care plan; and CSC should review and report to the LSCB how multi-agency work is promoted through systems that support children subject to care orders.

Other resources Read full overview (PDF)

8. Executive Summary: Learning Review: taking forward findings from initial and significant case reviews

Presents findings from two significant case reviews involving two children from different families between 2018-2021. Child C was removed from their mother's care after attending hospital with a fractured skull. The details of Child D are not shared.

Learning includes: the interaction of child protection with adult services when parents experience mental health problems or learning difficulties; formal assessments of parents' capacity balanced against the safety of the child; recognising adolescents as vulnerable from neglect or other harm, and not solely focussing on their presenting behaviour; male carers living in the family home; careful consideration of historical information; engaging with families and over optimism; multi-agency planning and the role of lead professional; and multiple referrals to screening groups or other services for support.

Recommendations: there are no formal recommendations. Provides reflections from a survey of 128 respondents (incorporating all agencies working with children and families) and three discussion groups to obtain views of how learning is embedded into practice.

Other resources Read review online: publicprotectionwestlothian.org.uk/article/41489/Significant-Case-Reviews