Nottinghamshire Safeguarding Children Partnership

Learning from Rapid Reviews and Local Child Safeguarding Practice Reviews 2022

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RR 1/22

This was a review of the death of a fourteen-year-old boy who was a Nottinghamshire looked after child living at an independent children's home in Northumberland. Prior to this he lived in Nottingham city where he had been the subject of a Child Protection Plan in the category of neglect for three months prior to his death. He had a diagnosis of ADHD, attachment disorder and gender identity disorder. Two months after moving to his new home under a Section 20 arrangement he was found in his room by staff, having hung himself from the back of the door using bedsheets.

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Good practice was identified in that practitioners from all agencies had worked hard to engage with the child and his family, and to understand his complex needs. The careful transfer process between Nottingham City and Nottinghamshire was identified as good, child centred practice.

Learning identified included the importance of child protection visits taking place at home in addition to at school, of responding proactively when children are not brought to appointments and of staff to have access to resources and support for working with young people with gender identity issues.

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RR 2/22

A three-month-old baby boy, was assessed as having non-accidental injuries in terms of bruising to the back, right thigh and right upper arm. It was subsequently found that he had fractures to fifteen of his ribs and a fracture to his collar bone. There was very little involvement with the baby and his family with CSC and police prior to this, and health agencies had not identified any concerns.

Good practice was identified in that the GP was kept fully up to date with clinic letters and entries by the Healthy Families Team. The Healthy Families Team demonstrated robust practice, being proactive in their contact with the family, and rearranging appointments cancelled by the family to avoid any drift in care.

Missed opportunities were identified for hospital staff following the baby's admission to hospital prior to being seen by the consultant paediatrician the next day. The father was permitted to care for the baby unsupervised despite admission for further tests due to unexplained bruising, and some concerns were expressed by staff regarding the father's behaviour on the ward. An internal serious incident investigation is ongoing.

RR 3/22

A baby girl was born in the bathroom at her mother's home and died shortly afterwards. Her mother had identified vulnerabilities including learning difficulties, and she may not have been aware that she was pregnant at the point at which she gave birth. Considerations include whether the baby could have lived if help had been summoned earlier and the mental capacity of mother at the time.

Good practice was identified when the mother was admitted after giving birth, when a body map recorded bruises and marks to her body as well as her having significant head lice. Hospital staff liaised with police regarding domestic abuse and the mother was given the opportunity to disclose abuse from her partner.

Learning identified included the value of the then recently introduced "3 conversations approach" in adult social care which encourages tenacity in working with vulnerable adults. If this approach had been used with the mother a more holistic service would have been provided. The need for health services to be professionally curious when risk indicators are present regarding the possibility of domestic abuse was also identified.

RR 4/22

This review was for a nine-month-old baby boy who suffered a number of abusive injuries including nineteen bruises to his face, neck, shoulder, arms and hip, and fractures to both ankles, right upper leg and wrist. The review involved Derbyshire, Nottingham City and Nottinghamshire Safeguarding Children Partnerships.

Good practice was identified in the following areas:

- A strong and consistent focus was maintained by all Partnerships involved on safeguarding the children in general terms and this baby specifically. There is no evidence that the circumstances, and relatively complex needs of the mother as an adult, compromised or prevented proper attention being paid to the baby and his sisters. Agencies worked together to support the children effectively.
- Strong communication and appropriate information sharing were maintained throughout, with clear recording, evidence of supervision and evidenced based decision making.
- Agencies worked restoratively with the mother and her family, to the extent that this was commensurate with the children's safeguarding.

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Learning identified included:

- CPPs need to be SMART in respect of both immediate and longer-term safeguarding needs that are sustainable for families, in particular regarding the accommodation needs of this family.
- In any circumstance where social workers are alerted to bruising having been seen on children by medical staff but are unable to confirm this through their own direct observation, advice should be sought from the on-duty safeguarding paediatrician.
- Further investigation of the circumstances around the referral of the child by a GP to the MASH rather than to the designated Social Worker needs to be concluded as a priority to determine if there any systemic reasons for the delay found here, or if this was because of simple error and misunderstanding.

RR 05/22

This review followed a report of rape and sexual assault of a thirteen-year-old girl, who was a Nottinghamshire looked after child living in a residential home in Derbyshire. She had additional vulnerabilities in terms of a diagnosis of ADHD with autistic traits. The rape and sexual assault was by two boys during a school trip. All three children attended the same independent school providing specialist provision for pupils with special educational needs.

Learning was identified in the following areas:

- the lack of effective risk assessment and recording within the school
- the need for Derbyshire and Nottinghamshire to review their current guidance and staff training around strategy discussions
- cross border issues between Derbyshire and Nottinghamshire police forces

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Feedback received from the Child Safeguarding Practice Review Panel

"We thought your rapid review was good, identifying relevant learning around risk assessments, strategy meetings and cross-border issues. We agreed with your approach in setting up a cross-partnership group to take forward work on strategy discussions and your plan for disseminating learning, including separate learning points for the school."

RR 6/22

This review was for a 16-year-old Nottinghamshire looked after child who was living with foster carers in Leicester until a physical altercation between her and her female carer resulted in her asking to move to different carers. After moving to her new home she discovered she was pregnant and said that her former male carer is the father. The review involved Leicestershire and Warwickshire safeguarding partners.

Learning was identified for Leicestershire GPs as follows

- The need to transfer notes promptly by GP practices following a change of address.
- The need for GPs to understand the health issues for LAC and the increased vulnerabilities of these children and young people and that advice and guidance is available from the Named GPs and Designated Nurses at the ICB.
- Earlier conversations with CSC when a child is looked after can represent opportunities for better safeguarding practice

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Feedback received from the Child Safeguarding Practice Review Panel

"… we thought this was a clear and concise rapid review exploring several important issues such as the role of professionals, including GPs, in safeguarding children as well as the importance of effective information sharing. We also discussed the way in which she might have been treated as if she were an adult rather than a vulnerable child."

RR 7/22

This review was for a baby boy who died when asleep in a room with three other children under the age of ten, and one adult. His death was originally considered to be sudden infant death syndrome however the rapid review was undertaken following the post-mortem report showing significant bleeding into the lungs which may have been indicative of smothering. The review involved Lincolnshire safeguarding partners. At the time of death the baby was not known to Nottinghamshire Children's Social Care

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An action was identified in the review for NHCFT to review the guidance for moving an expectant mother from universal services to an enhanced service, to ensure the guidance is sufficient to identify parents with mental health issues and any concerning pattern of ED attendances

Good practice was identified in terms of good, persistent work done by the Children's Centre worker to engage with the mother, despite the antipathy shown by the father at this time. While the work was ostensibly around a sibling's sleep patterns it provided wider support to the mother.

LCSPR TN20 "Tom"

This review was for an 18-day-old baby who died when co-sleeping with a parent who was under the influence of drugs. Both parents were subsequently convicted of neglect offences. The baby's parents and his five siblings had been known to services, including Childrens Social Care, for many years in relation to parental neglect. The review has focused on how agencies work together to deal with cumulative neglect and how we can embed the "safer sleep for babies" message into the routine work of all agencies.

The identified areas for learning were as follows:

- safe sleeping is an issue for services broader than health visiting and midwifery
- The need to see and record the world as seen through the eyes of children
- relationship-based practice; the importance of parents having an effective relationship with key health and social care professionals; timely trauma-informed early intensive help
- domestic abuse in professional assessments and discussion
- using chronologies and enquiring into relevant history
- using tool kits and evidence-based frameworks
- influence of group decision-making

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Feedback received from the Child Safeguarding Practice Review Panel

"We…welcomed the approach of relating the report findings to relevant literature and reviews. We thought it contained some interesting analysis and was helpful in the way it acknowledged the impact of the dissemination of learning from the previous rapid review."

LCSPR SN20 "Jean"

This review was for a seventeen- month-old baby girl who was scalded at home and died from her injuries. Her mother was subsequently convicted of murder. The focus of concern was the mother's vulnerability due to mental health and substance misuse problems and the impact these might have on her baby's care. The child's mother made repeated non-specific threats to harm strangers although at no time did she give any indication that she would deliberately cause harm to her child.

- The review highlighted issues in how children and adult health and social services work together.
- A need for better joint working to improve access to the expertise held within each service and to improve the quality of assessments of adults with parental responsibilities was identified.
- Improved assessments will help the implications of adult issues to be fully considered in relation to an adult's parental responsibilities and appropriate help provided.
- The review also highlighted the negative impact of long waiting lists for service in adult mental health services.
- NSCP has begun work to explore models of integration or ways to develop closer working between adult and children's health and social care services so that the services can undertake joint assessments of adults with parental responsibilities who have adult issues such as mental health problems, substance misuse, or being a victim or perpetrator of domestic abuse.

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Feedback received from the Child Safeguarding Practice Review Panel

"We thought the review was clear and included helpful descriptions of practice and analysis of decision making at key points."

"The themes were explored in a thorough and meaningful manner, helpfully drawing on relevant research, policy, and other reviews to inform the analysis and learning. The analysis was thoughtful and grounded in the realities of everyday practice and of family life."