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Hartlepool and Stockton-On-Tees Safeguarding Children Partnership

Learning from HSSCP Child Safeguarding Practice Reviews

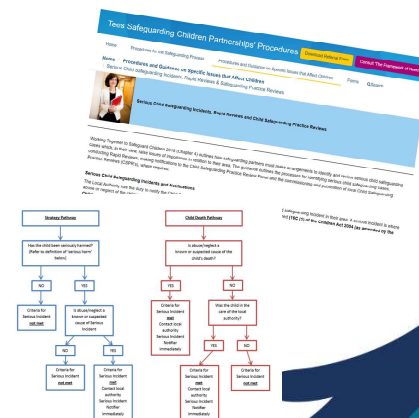
March 2023



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Role of the Safeguarding Children Partnership

- Duty for partners to identify serious safeguarding incidents
- Duty for the partnership to undertake Rapid Reviews of serious safeguarding incidents and determine whether a LCSPP needs to be undertaken



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Serious Safeguarding Incident Notifications and Rapid Reviews

- Since going live in early 2019, HSSCP have received fifteen Serious Incident Notifications and have conducted a Rapid Review for each of these notifications made.
- Of the fifteen Rapid Reviews undertaken, eight have progressed to a Local Child Safeguarding Practice Review.
- One HSSCP LCSPP's has also been part of a National thematic review on NAI under 1's*



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Local Child Safeguarding Practice Reviews (LCSPP's)

- LCSPP's replace Serious Case Reviews
- Safeguarding Children Partnerships have 6 months to complete a LCSPP once a Rapid Review has confirmed that the criteria has been met for one to be undertaken.
- HSSCP have undertaken eight LCSPP's to date



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- 60%** • 9/15 were children under 3
- 33%** • In 5/15, the child died (3 of the 5 who died were babies).
- 33%** • 5/15 involved non-accidental injury or physical abuse
- 100%** • Neglect featured in all 15 cases and in 7 / 15 was the
- 47%** cause of the significant incident or death.
- 80%** • 12/15 featured Domestic Abuse
- 60%** • 9/15 had recently closed to children's social care
- 67%** • 10/ 15 were Stockton children and 5/15 were Hartlepool children
- 60%** • 9/15 featured hidden fathers or partners



LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS/ RAPID REVIEWS



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Child O LCSPR

Context

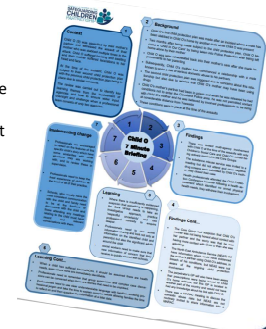
- Child O (aged 9) was assaulted by their mother's partner and witnessed the assault of their mother who was stabbed multiple times in the attack. Child O suffered bruising and swelling and their mother suffered lacerations to her head and face.
- At the time of the incident, Child O was subject to their second child protection plan with the previous child protection plan being in place due to similar concerns.
- The review was carried out to identify key learning themes from the involvement of agencies and how to ensure wider input, oversight and challenge when a professional team consists of only two agencies.



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Findings and Learning

- Where there is insufficiently evidenced suspicion that something is happening, the Core Group needs to take an investigative approach, practice 'respectful uncertainty' and use professional curiosity to enquire deeper.
- Professionals need to use active information sharing and look not only at information on the identified child and parent(s) but also the significant adults around the child.
- Social workers need to make sure that new information of concern that they receive is quickly shared with schools.
- When a child has suffered trauma/ACEs, it should be assumed there are health needs, even where none are immediately identifiable.
- Professionals need to remember that group supervision and complex case discussions can be convened when there are worries that need to be unpicked.
- Professionals need to use clear understandable language with families, avoiding professional jargon and take the time to explain complex issues allowing families the time to reflect on and then question the information at a later date.



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Child Q LCSPR

Context

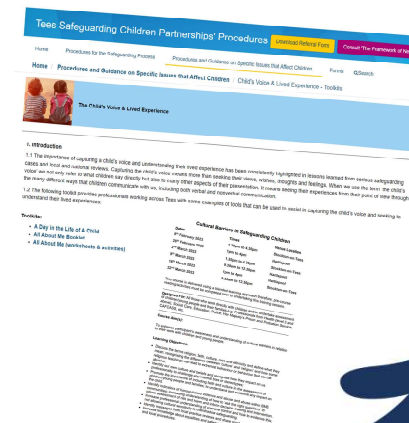
- Child Q was 14 months old when she was admitted to the A&E department due to concerns raised by Social Care and the Police following a welfare visit that Child Q was severely underweight.
- She was subsequently assessed by health as being severely malnourished, with mother having followed a diet of milk and honey both during her pregnancy with Child Q and beyond; impacting significantly on the growth and development of Child Q. Child Q was reported to have severe Vitamin D deficiency, advanced rickets, severe metabolic bone disease with multiple fractures and iron deficiency anaemia.
- Upon discharge from hospital Child Q was placed in foster care subject of S.20 (Children Act 1989). CP medicals were undertaken on Child Q's older siblings at this time and no health concerns were identified. The Local Authority issued immediate care proceedings in relation to all of the children.



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Findings and Learning

- Over optimism
- Lack of professional challenge – particularly in relation to the decision not to initiate care proceedings
- Lack of professional curiosity
- Poor information sharing
- Cumulative vulnerabilities were not considered
- Assessments were not holistic in nature
- Lack of understanding around the impact of religious and cultural issues
- Difficulties and need for specialist support when dealing with complex cases
- What to do when cases are 'stuck' or engagement from families is poor.



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Riley LCSPR

Context

- Riley (17 years old) - hit by a car and suffered significant life-threatening injuries. The driver then assaulted Riley before driving away.
- Found with cannabis - admitted to having taken this from a cannabis farm before being followed and attacked by the perpetrator of the incident.
- Suffered a fractured eye socket and a perforated pancreas - initially refused to engage with the necessary treatment for his injuries.
- Eldest child - two younger half-siblings whose father is step-father to Riley.
- Open to children's social care on a child in need basis at the time of the incident, had a number of missing from home episodes and had been recently referred to MACE (Multi-Agency Child Exploitation) Hub
- Living in supported accommodation at time due to having been arrested and bail conditions stipulating that he could not enter his parental address; due to being involved in stealing a neighbour's car.



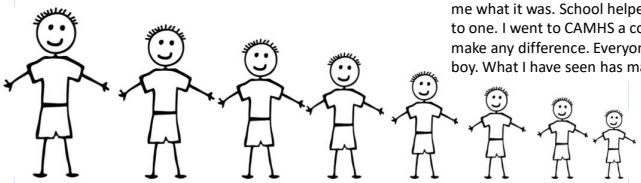
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Findings and Learning

- Riley's behaviours and response to situations are as a result of his childhood experiences.
- Riley was seen through a "troublesome lens". This means that any potential support/ intervention was ineffective due to a lack of understanding of Riley's needs
- There were early indications of vulnerability such as domestic abuse incidents, possible lack of supervision, early signs of neglect and these were not sufficiently explored or addressed to reduce harm.
- Workers did not understand Riley's learning needs - Early emerging needs were not properly assessed and therefore not met. Assessments undertaken were single agency with limited sharing of information across agencies to understand Riley's lived experiences.
- The workforce were expecting a "diagnosis" to enable them to support Riley. It is clear from Riley's voice that he just wanted people to listen to him and understand what his life looked like.
- The lived experience of Riley in his childhood has made him vulnerable to poor outcomes. This may not have been exploitation but his vulnerabilities made him at more risk from harm than his peers. These early vulnerabilities were not considered as he grew up and therefore not addressed to reduce his risk to exploitation.


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The Life of the Child and the Child's lived Experience



"I knew something was wrong with me but no-one told me what it was. School helped me as they gave me a one to one. I went to CAMHS a couple of times but it didn't make any difference. Everyone thought I was a naughty boy. What I have seen has made me." Riley, 2022.

Identifying Need **Responding to Need** **Meaningful and Effective Engagement**



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CT Rapid Review

Context

- CT was involved in a road traffic collision involving two vehicles. CT had been a passenger in the vehicle responsible for the collision and was pronounced dead at the scene.
- The incident occurred in the early hours of the morning and CT had not been reported as missing from home.

Background


- CT lived with mother, father and three siblings (all female, one older and two younger).
- The child and family had previously been open to children's social care with the last period of involvement ending eight months prior to the incident.
- During an Early Help meeting held in respect of CT's elder sister, Father gave consent to work with CT due to concerns around anti-social behaviour. CT was open to the Preventions and Outreach Team for 12 months - engagement was limited
- A referral for Social Care involvement was received from the preventions worker following Mother advising that she no longer wanted CT living in the family home. This resulted in a period of Child in Need
- Concern about potential links to OCGs and CCE.
- History of MFH episodes and returning home of his own accord; with no knowledge of his location/associations during these periods. Known to Cleveland Complex Exploitation Team and discussed within MACE.
- CT was away from education

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Need to think about:

1. No understanding of CT's lived experience
2. Parents appearing to engage but this being superficial
3. Threshold of exploitation (work in progress) re: what is 'evidence' of exploitation
4. Multi-agency working – talking to each other at the right time
5. VEMT / MACE processes – Effective intelligence sharing and analysis, disruption of sources of risk
6. and sources of harm (locations and perpetrators) – linked to agreed threshold
7. Effective engagement of young people
8. School attendance – managing the response



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NT Rapid Review

Context

- Parents advise that they fed NT at 12.30 am and placed him sleeping in his crib downstairs. Parents were also downstairs.
- Mother said that she woke at 5.15 am to go to the toilet and when checking on NT found that he was not breathing and rang the ambulance.
- The cause of death is unknown. There is no medical evidence to indicate harm, however, Police are investigating situational factors that indicate neglect.
- An unknown substance, believed to be a Class A drug, was found in the property and officers in attendance described the property as smelling extremely strongly of cigarette smoke. Staining found on the back of the baby grow was inconsistent with the extremely clean crib in which NT was said to have been sleeping.
- Both parents were arrested on suspicion of causing or allowing the death of a child and released under investigation.

Background

- NT became known to Social Care as an unborn baby. Concerns were around capacity to care for the baby given the late presentation (26 weeks) and social care history pertaining to NT's three older half siblings, who are cared for by family members under SGO's.
- A pre-birth assessment was undertaken and, as per UBB protocol, a Strategy Meeting was convened. All professionals who attended the Strategy Meeting (which included 3 x health professionals, a Police Officer and the SW and SW Team Manager) were of the view that the case did not need to progress to an Initial Child Protection Conference and should remain open to social care on a Child In Need basis due to progress having been made.
- NT's case remained open on a Child In Need basis until 3 weeks prior to the incident. The case was closed as there was no further identified role for Child and Adult services. There was a safety plan in place for family to address worries or concerns with the appropriate services.

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- A photograph of a woman and a young girl. The woman, with long brown hair, is smiling and looking down at the girl. The girl, with short brown hair, is also smiling and is in the process of putting a coin into a pink piggy bank. The piggy bank is shaped like a pig and has a small green plant growing out of its back. The background is a plain, light-colored wall.

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