THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Rapid review examples

December 2022

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Purpose

This document from the Child Safeguarding Practice Review Panel (the Panel) contains anonymised examples of rapid reviews submitted to the Panel between 2019 and 2022. Its aim is to help safeguarding partners complete rapid reviews of serious safeguarding incidents by providing examples of how to set out the facts of the incident, immediate actions and learning for the partnership and practitioners. These examples are not intended to be comprehensive or prescriptive but aim to demonstrate a range of different types of incidents that regularly come to the Panel from safeguarding partners across England. Different formats and templates have been included to show the variation of how key information is conveyed in a concise and coordinated manner.

The examples provided are not intended to be 'perfect' rapid reviews. Rather, they illustrate points of good practice along with areas where the reviews could be further improved. The reviews have been anonymised and potentially identifiable material removed, but otherwise are approximately presented as submitted, along with comments from Panel members. We are grateful to the safeguarding partners who have allowed us to use their reviews.

Background

The Child Safeguarding Practice Review Panel reviews cases where children have died or been seriously harmed, and abuse or neglect is known or suspected.

The duty to notify serious incidents to the Panel sits with local authorities. Following a serious incident notification, local safeguarding partners are required to undertake a rapid review within fifteen working days.

Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

- For safeguarding partners, the rapid review should conclude with a decision about whether or not a Local Child Safeguarding Practice Review (LCSPR) should be commissioned using the criteria set out in Working Together (2018).

- If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the rapid review.

- Good practice is where partnerships identify what has been learned and how this learning will be disseminated and acted on across the local partnership.

This document should be read alongside the Panel's Guidance (September 2022), which contains the following advice on conducting rapid reviews.

We do ask as a minimum that the rapid review records:

- Date of birth, gender and ethnicity of the child who has been harmed or who has died and whether the child had any known disability.
- Family structure and relevant background information on the family – include all children not just the one(s) harmed or who died. A family tree (genogram) is often helpful. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability.
- Immediate safeguarding arrangements of any children involved.
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context.
- A clear decision as to whether the criteria for an LCSPR have been met and on what grounds, and if not, why not. Clear reasons are required.
- Any immediate learning already established and plans for their dissemination.
- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected.

Important issues to consider in rapid reviews:

- What was the child's lived experience and how can their voice be heard in the review?
- How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
- How did any disability, physical or mental health issues, and identity issues in the child and/or family impact on the child's lived experience and on practice?
- Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?
- Can any relevant national reviews be referenced and used to support local learning?
- Are there issues identified that are of national significance? Is a national review considered to be necessary following the rapid review? If so, why?
- Are there sufficient and sound reasons to proceed with an LCSPR? If it is decided to proceed with an LCSPR, an appropriate scope should be specified, with some identified key lines of enquiry.
- Does the review identify relevant good practice, and should this be disseminated across the system?
- Has the review identified clear agency and partnership actions to take forward, especially where there is no LCSPR recommended?

We recognise that time constraints may restrict the extent to which some of these areas are explored in significant depth. However, some of the points, such as considering relevant learning, including that from national reviews and the potential for further learning, should be standard when considering the need for an LCSPR.

List of examples

Example 1: Sudden Unexpected Death in Infancy

The following rapid review concerns the sudden unexpected infant death of a child under the age of 1. The Panel thought that the rapid review was clear, well-written and evidenced appropriate consideration of contextual factors, including in relation to the mother's mental health. The Panel remarked that it might have been helpful to reference and reflect on the Panel's national review into Sudden Unexpected Death in Infancy (SUDI) and agreed with the decision not to initiate a Local Child Safeguarding Practice Review.

Case information – individual and family

Name of Child: CHILD A
Date of Birth: [date] (7 weeks old at time of death)

> **Panel Comment:** Some identifying information has been removed from this section. However, it is important to include information about age, gender, ethnicity, and disability up front. For older children it would also be helpful to include information on schooling. Since the rapid review is not published, all these details can be set out without needing to be anonymised.

Summary of incident background

On [DATE], CHILD A was found unresponsive after a call to the Ambulance service that morning. The baby was subsequently found to have died. Following CHILD A's death, a full history was taken from the mother at hospital. She reported that, on [date], she was at home, drinking alcohol with a friend. She fed CHILD A a bottle of milk downstairs at approximately midnight. The mother then took CHILD A back upstairs and went to bed herself. Police enquiries note that the friend came into the property just after 8am on [date]. The friend went upstairs and saw CHILD A lying on the mother's left side, caught underneath her, in between her left arm and chest. The mother thought CHILD A looked dead so gently shook her to see if she would wake up, but she did not. An ambulance was called. The friend went and got another friend and they attempted resuscitation.

The ambulance service notes a call at [time] on [date]. It was from a female caller, who reported that the baby was not breathing. Twice during the call, the caller said she thought she had slept on the baby. The first response on the scene was from the emergency team. They commenced basic life support by putting an airway into the baby and Bag-Valve-Mask ventilations commenced. Basic life support continued and the team rapidly got the baby onto the ambulance. The baby was conveyed under blue lights, with the pre-alert sent to the hospital. There was no change to the baby's condition throughout ambulance contact. Breath sounds and a pulse was absent.

The Police requested a breath test from the mother in the morning, which was taken at [time]. It gave a reading which would have been over the drink drive limit at that time, which is 2/3 hours after the report of the incident and some time after the mother claims she went to bed with CHILD A.

Panel Comment: This is a helpful and succinct summary of the incident. Some details, such as the resuscitation details could have been removed without losing the context. In terms of immediate action (below) it might have been helpful to consider what support was offered to the family, and whether there might be any implications for future pregnancies.

The initial findings of the post-mortem are that there were no apparent fractures or injuries and no evidence of a natural cause of death. There was a small amount of reddening to the back of CHILD A's head. This could support the layover scenario. Police enquiries are continuing.

Immediate action: Not applicable - no siblings

Panel Comment: It is helpful to document who from each of the three safeguarding partners is taking executive responsibility for the decision making in the rapid review; it is also helpful to document sources of information to the rapid review and those who participated in it. However, this should always be done concisely.

List of agencies involved in rapid review process: [Details removed]

Overview of Multi-agency involvement

Summary of interventions:
There were no periods of coordinated multi-agency intervention during pregnancy or after CHILD A's birth. Services were primarily directed to support mother's mental health with a community psychiatric nurse and consultant psychiatrist allocated in response to bi-polar disorder. Some evidence of information sharing, and consideration of support needs were documented both in the pre-birth and post birth periods with standard health visiting interventions and GP support in place.

An overview of agency responses shared in the rapid review meeting is set out here:

Children's Social Care (CSC) had two contacts. In [DATE], Safeguarding Midwifery notified CSC of the pregnancy, including the service in place to support mother who had a diagnosis of bi-polar disorder. CSC reflected on the information and concluded that there was no evidence that the information shared met the statutory threshold for social work intervention. It seemed the mother was being managed successfully for her mental health needs by the appropriate health agencies and good family support was indicated. A history of alcohol use prior to pregnancy at 30 units was noted to have reduced in pregnancy and no specific role for CSC was identified.

The case was subsequently reviewed in a standard Pre-Birth Liaison Meeting that CSC has with Midwifery. This took place in [date]. The meeting confirmed that the situation remained stable; mental health and family support continued to be in place, and no action was required from CSC. CSC had no contact with the mother post pregnancy.

- **Single agency learning**: All agencies working with pregnant women (when additional vulnerabilities are identified) can consider exploring support offers from an Early Help Service and with consent referring direct to that service.

- CSC screening now consider this pathway when no role for CSC is identified.
- Providing information to families about early help services is being developed as part of the CSC outcome letter to promote families taking up services.
- Additionally, involving early help in the standard pre-birth liaison meeting with midwifery may be a way to further identify offers of support during pregnancy for mothers with identified potential vulnerabilities. This would add an extra layer of communication and support to women who might be vulnerable.

Adult Social Care (ASC) had one contact in respect of mother receiving a call and referral from the Ambulance Service in [date] about her mental health. ASC called the GP and informed them of the referral for follow up, because the mother did not meet the ASC criteria at the time. Her GP appeared to be aware of the mother's mental health needs. ASC acted promptly at that time. They had no contact with the mother during the scoping period.

- **Single agency learning**: Although the referral did not meet the threshold for direct intervention by ASC, it would have been good practice to check what had been done with the information shared with the GP.
- ASC will take this forward as a single agency learning point.

GP Practice: The GP had one telephone consultation and one face to face examination of CHILD A. On [date] advice was provided about regurgitating feeds, infant colic and a 2-day history of rash on her chest. Advice provided appropriately. On [date] CHILD A was seen by GP for 6-week baby check. Reported to be bottle-fed. Mother supported by maternal grandmother. Full examination within normal developmental range – no problems reported relating to feeding or sleeping. Although CHILD A was a premature, low birth weight baby they were gaining weight and the CCG presenter at the rapid review thought this was a testament to the care she had been given by her mother, who was a single parent. The records confirm that the mother had support from her family.

CHILD A's mother registered with practice in [date]. Confirmed diagnosis of bipolar disorder under Adult Mental Health consultant care**.** During pregnancy was in contact with practice nurse to follow up some concerns. Post-delivery follow up support by GP Nurse. [Date] Practitioner responded to mother's physical health, which included advice about drinking alcohol with a prescribed medication. On [date] mother had a 6-week post-natal examination and GP records note follow up with the Mental Health team the following day– reporting normal mood, able to cope and lower risk drinking.

Timely and appropriate responses were noted in response to both mother and CHILD A's health needs.

- **Single agency learning:** GP records do not show the recording of any anticipatory guidance in terms of offers of early support or any discussion around ICON messages.
- The presenter advised, for assurance, that the CCG continues to disseminate ICON messages to GP Practices.

NHS Trust: Provided primary support to manage mother's mental health with a community psychiatric nurse allocated and psychiatrist consultant care with medication in place under the Community Mental Health Team (CMHT).

The Trust also managed the Health Visiting services. There is evidence in the Trust records of liaison between the GP, Midwifery and Health Visiting. The Health Visiting Service could also see Adult Mental Health information and GP records to provide oversight to interventions meeting mothers' and babies' health needs.

The health visitor saw the family within 12 days of birth and then followed up with a 6-week review in line with expected practice. There were no identified concerns in respect of parenting or baby's health and development. The health visitor undertook a 'records review' before contact, noting mother's engagement with Adult Mental Health services and existing family support. In her contact with mother, she discussed smoking and offered smoking cessation, discussed domestic abuse, safe sleeping and sudden unexplained death risk reduction, drug and alcohol usage. ICON information was shared - all in line with standard safety advice practice. In addition, additional support options were explored (Early Help) in a telephone follow up but mother considered that family and mental health teams were offering all the support she needed. No safeguarding concerns were identified. [Date] The day before CHILD A's death, mother reported to her health visitor that she was 'wobbly' and felt her mood becoming unstable though no direct link to parenting was reported.

Mother was open to the Adult Mental Health team throughout the scoping period. A community psychiatric nurse had monthly telephone contact with mother. Her care did not meet the threshold for Care Programme Approach (CPA) but she was reported to engage well with treatment, missing only one appointment over the 12 month period in [date]. She was assessed to have insight into her condition and could identify when she was becoming unwell. Her medication was managed during and after her pregnancy. The community psychiatric nurse and consultant care was regularly reviewed with care plans and risk assessments updated. On [date] mother told her community psychiatric nurse that her bipolar had been unstable since she had the baby – this prompted a referral to perinatal mental health team. However, the team did not pick up the referral because there were no reported issues linked to bonding with the baby and the ongoing role of community psychiatric nurse. A review of medication was requested.

It was not clear if any increase in alcohol use was linked to the reports of emerging instability in mood from mother leading up to the incident, although her reports to both community psychiatric nurse and health visitor indicated some early changes in mood.

- **Single agency learning:** Health Visiting Services and Mental Health Services sit under one Trust. As part of the Trust's learning, whilst evidence of information sharing was in records, the review has noted that there was no direct contact between these two services and it is felt there should have been conversations, given they are under one organisation. This was particularly important as mother noted her mood becoming less stable in the days leading up to the incident.
- This has been picked up and the Trust has started work prior to this case being reviewed to strengthen communication. Work has also started with partners in Adult Mental Health Services around their awareness of child protection issues.

Hospital: Routine antenatal care was in place. Mother attended her antenatal appointments, and no concerns were raised. The hospital identified her mental health issues and noted excess alcohol intake prior to pregnancy though mother reported this had reduced during pregnancy. Midwifery shared information with CSC and followed this up in the established liaison forum with CSC later in pregnancy when no concerns were

highlighted.

The hospital's first interaction with CHILD A following birth was on arrival to the Emergency Department in cardiac arrest on [date].

- **Single agency learning:** It was identified at the booking appointment that mother reported consuming excess alcohol prior to pregnancy. Although mother said she had stopped drinking during her pregnancy it was not clear what help mothers who report excess alcohol consumption prior to pregnancy are signposted to. If necessary referrals to the local integrated substance misuse – including to provide support post birth.

Ambulance service: Noted the only contact with CHILD A was in response to the serious incident. Analysis shows that this was in line with expected practice standards including alert to police and CSC. Baby was transferred to the nearest Emergency Department.

- **Single agency learning:** There is no learning identified for the ambulance service in this case.

Police: Noted some prior information in relation to mother on the police recording system, prior to the scoping period none of significance for this review. In terms of the father, the police have nothing in relation to him. They do not believe he was involved in any of the dynamics of the relationship, and he is not on the birth certificate.

The one significant incident for the police is their attendance on the morning of CHILD A's death. Sudden Unexpected Death in Childhood (SUDIC) procedures were followed.

- **Single agency learning:** There is no learning identified for the police in this case.

Panel Comment: The learning for each agency is clearly set out, along with evidence of good practice and practical steps that can or will be taken. This approach of setting out individual agency involvement and learning before moving on to the overarching and multi-agency themes can be a very helpful approach to the rapid review. It runs the risk, however, of becoming long and repetitive if the same key practice episodes are covered in each agency's contribution.

Analysis – of multi-agency interventions - emerging themes

The information analysed within the rapid review noted two important factors:

1. Diagnosis of bipolar disorder
2. Reported high levels of alcohol pre-pregnancy

Both noted to have potential to increase vulnerability linked to parenting capacity.

Analysis of multi-agency information showed that in the period leading up to CHILD A's death, there was no specific evidence of emerging concern in relation to parenting linked to these themes.

With the police investigation continuing it is noted that whilst alcohol appears to have featured in the timeline of events directly contributing to the serious incident, there was no evidence of long-term neglect of CHILD A's needs following birth or during the pre-birth period. It remains unclear if the events leading to CHILD A's death were evidence of a pattern of behaviours linked to these themes i.e., deteriorating mental health and/or increased alcohol use, or if this was an isolated tragic accident.

Whilst mother had vulnerabilities mainly linked to her mental health needs, information shared showed that mother had well established support for her diagnosed bipolar disorder – that service provision fell in line with expected practice and mother was engaged with her treatment plan with reported good family support in place. No concern linked to parenting has been identified and she appeared to have good insight into her condition. Her self-reports relating to her being 'wobbly' in days leading up to CHILD A's death demonstrated this insight and exploration of perinatal mental health team support and a medication review was being requested at the time of the incident. Mother had not linked this to increase in use of alcohol or identified any impact on her parenting.

Discussion with mother about additional support services from Early Help are documented in Trust health visiting records and standard advice about safe sleeping were provided in line with standard health visiting practice.

Panel Comment: This section helpfully identified and explored the implications of two key themes. It appropriately considers the mother's needs and the support offered. This could have provided an opportunity to consider these issues more specifically from the perspective of the child's lived experience. These findings are in line with the Panel's national review into sudden unexpected infant death, and the rapid review could have drawn on the learning from that review more clearly.

No agency reported contact with CHILD A's father who, it is noted, had not involvement with CHILD A or mother from birth.

Analysis of rapid review information and key learning for both single and multi-agency working

The case information showed that mother was in receipt of support linked to her mental health needs during pregnancy and after birth.

Information sharing to provide opportunities to consider additional support to mother during her pregnancy was evidenced within the rapid review. This was both formal in the sharing of information with CSC and in an established information sharing meeting between Midwifery and CSC. Specific exploration of early support was made by the health visitor but declined.

There is evidence that agencies recognised the relevance of mother's diagnosis of bipolar disorder and her own self reporting around use of alcohol prior to her pregnancy. She was reported to have insight into her illness and to be open with practitioners supporting her. This was confirmed by her openness with midwifery when booking in her pregnancy and later in her engagement with both CPN and health visitor when in the days leading up to the incident, she self-reported a 'wobble' in her mood. She did not relate this to increased alcohol use and a review of her medication was being followed up at the time of CHILD A's

death. There was no evidence of delay in this response given that the conversations with professionals were within a week and within 24 hours of CHILD A's death – she continued to have support from her family, though the specifics of what that looked like in detail was not provided.

More generally, it is not clear from the information provided by agencies for this rapid review if professionals were engaging in ongoing communication with the mother about her alcohol use both during pregnancy and after she had CHILD A. There is evidence that early in her pregnancy she had expressed a desire to reduce her alcohol consumption but there is no evidence of any specific help being given, or further exploration of her ongoing alcohol intake, until her updates provided to the GP as part of her 6-week check – which based on that self-report noted alcohol use not to be problematic. The rapid review was unable to establish whether the use of alcohol leading up to CHILD A's death was part of ongoing and potentially reoccurring alcohol problems or a one-off event that had tragic consequences. It does seem linked to use of alcohol socially.

More generally the review considered systems that may support more specific offers to women who report high levels of alcohol prior to pregnancy so that they are signposted to support by health practitioners – this may be in the form of information sharing with the local substance misuse service and identification for follow up after baby is born. The meeting also considered how the structure of the current information sharing meeting between CSC and safeguarding midwives might be strengthened to link to Early Help or wider support services.

Additionally, it was noted that direct communication between health services working with women with mental health needs and services from health visiting to support parenting could be strengthened beyond the ability to access case notes and recording of activity. This is single agency learning followed up by the Trust.

Panel Comment: This summary shows appropriate consideration of contextual factors and identifies some relevant learning from the case.

Summary of key single agency learning

Single agency learning / work in progress (not as a result of this case but linked thematically).

- **Children's Social Care**

Consideration of directing pregnant women with vulnerabilities to an early help pathway when statutory threshold is not met – **This would happen under current processes in place since** [date]**.**

- **Adult Social Care**

ASC reflected on following up with GP services. The referral did not meet the threshold for ASC, but it would have been good practice to check what had been done with the information shared. **ASC will take this forward as a learning point.**

- **GP Practice**

In the GP records, there is no recording of any anticipatory guidance to the mother, in terms of offers of early support or any discussion around ICON messages. **The CCG continues to disseminate ICON messages to GP Practices following formal launch of the programme in [date].**

- **NHS Trust**

There was no direct contact between Health Visiting Services and Mental Health Services (both under the Trust). There could have been direct phone conversations about how the visits were going to be done and if they could / should have been done together with both services. **This learning point has been picked up, prior to this rapid review, and the Trust has started work to strengthen communication across services. Work is being undertaken with Adult Mental Health Services around their awareness of child protection issues and the Trust is working on the whole family approach.**

While work is being done on communication processes within the Trust, the message will be strengthened around offering support and signposting to the alcohol cessation service for mothers who have disclosed a high alcohol intake (prior to, during or after pregnancy). **A reminder will be included in the global newsletter that goes out Trust wide.**

- **Hospitals**

It was identified at the booking appointment that the mother consumed excess alcohol. Although the mother said she had stopped during her pregnancy, there could be a way, potentially, to help mothers who report excess alcohol consumption prior to pregnancy so that, following the birth of the child, they do not go back to excess alcohol consumption. A referral to the alcohol cessation service might be a possibility. **The Hospitals' Safeguarding Team will speak to the Substance Misuse Midwives about this to further explore current practice.**

Multi-agency learning

Learning point 1: The themes identified within the rapid review link to vulnerabilities for mothers with mental health needs and where use of alcohol prior to pregnancy may be excessive. The meeting explored how support to women with identified vulnerabilities could be systematically strengthened. It noted opportunities to strengthen an existing monthly information sharing meeting between CSC and Safeguarding midwifery to include representatives from Early Help services and other relevant support services.

Action:

- The existing [location] meeting will be included in the [location] Pre-Birth procedure.
- Formal Terms of Reference will be considered to bring clarity to the meeting's function.
- It will be considered if additional agencies, such as Early Help and the alcohol cessation service, could be invited to join these meetings.

Learning point 2: The case raises further reminders of the importance of safe sleep advice to parents and the risk of alcohol use around new babies and sleeping arrangements. This risk maybe increased in combination with other vulnerabilities such as mental health problems.

Action: Messages will be disseminated to practitioners focused on:

- Working with pregnant women and mothers who have disclosed a high alcohol intake (prior to, during or after pregnancy) and exploring the motivations and indicators for drinking.
- Working with pregnant women who express a wish to reduce their alcohol intake, considering how this is explored and supported post-birth to maintain reduced intake including signposting to support services.
- How professionals explore issues around mental health, including bipolar, drinking and

being a vulnerable adult with a young baby.
- All agencies to explore the details of 'family support' to women managing vulnerabilities including mental health needs and alcohol use so that safety plans can be made explicit particularly linked to safe sleeping.

COVID-19 Issues: The impact of COVID-19 was considered during this review; however no issues were identified as being a factor on the delivery of services in this case.

> **Panel Comment:** At the time of this rapid review, safeguarding partners were asked to specifically consider the impact of the COVID-19 pandemic and associated lockdown measures. Going forward, we would expect this to be considered only if relevant to case management.

Current situation: Police enquiries are continuing, and the CPS will be consulted for a decision about any criminal charges which might be brought in respect of this case.

Areas of good practice: It is noted that the current monthly information sharing between Midwifery and each of the Local Authorities across [location] provides an opportunity for information sharing and collaboration when considering thresholds for intervention. They are used to catch up and share information about women who have presented with issues or referrals that have been made and making sure the outcomes are discussed. It provides an opportunity to escalate concerns where this may be necessary. It is good practice that baby CHILD A was discussed in the [date] meeting to reinforce the threshold for intervention and confirm later in pregnancy that support to mothers and management of mental health needs was in place. Mother's CPN was made aware of CHILD A's death and was able to arrange follow up with the CPN to do a safe and well check to provide bereavement support.

Legal advisor: A legal advisor was present throughout the rapid review meeting and provided advice in relation to statutory duties.

Independent advisor: The Independent Advisor was present for the rapid review meeting and provided advice and challenge to promote wider ranging discussion and consideration of learning.

Decision of safeguarding partners regarding forward approach and rationale

The meeting concluded that whilst the criteria for an LCSPR have been met, there was consensus across agencies that the current information provided to the rapid review process has allowed a full evaluation of the case and identification of learning. On this basis the case **will not proceed to a full LCSPR**.

The Partnership is confident that aspects of learning have been completed and require no further action.

> **Panel Comment:** The summary of all the key learning points and actions is very helpful. It is clear from this thorough and considered rapid review that useful improvements to practice have been identified and, therefore, there is no need to undertake an LCSPR.

Example 2: Child neglect

The following rapid review concerns a young child who suffered severe burns from a house fire after being left alone in a house with a lit candle. The Panel agreed that there is significant learning to be drawn from this case, and also agreed with the decision to carry out an LCSPR. The rapid review is concise (7 pages), yet comprehensive enough to give a clear understanding of the background and context, as well as the rationale for deciding to undertake an LCSPR.

Background Information

Name of Child: CHILD B

Date of Birth: [date]

Date of Death / Serious Incident: [date]

Date notified to Ofsted: [date]

Date of Rapid Review: [date]

List of Participants in Rapid Review: [detailed list removed]

Section 1: Case Background

Details of Family Members and Significant Others

Name and Address	Relationship to Child	Date of Birth	Legal Status	Ethnic Origin

Panel Comment: This was an alternative local template for capturing the core information. While the details have been removed, it contained useful information about several children within the family, including CHILD B's half-siblings and step-siblings. The information about ethnicity was useful, although for some of the family members it was listed as 'unknown'. In addition to this, it would have been useful to include a column for information about any disabilities.

Case Summary:

At [time] on [date] a house fire consumed the upstairs rooms of [address]. The early indication is that the father was at work, the mother was at a neighbour's address for more than 20 minutes, leaving at least three of their five children in the house alone with a lit candle in the rear upstairs large bedroom. The [sibling] is suspected to have picked up the candle and dropped it on the bed. The eldest child [name], [age], pulled [sibling] away from the fire and ran out of the house to raise the alarm. Unfortunately, CHILD B in the smaller bedroom next door was left behind and when adults tried to get up the stairs to rescue CHILD B the fire was too strong for them. CHILD B was rescued by the fire service, two of them sustained injuries in doing so (a significant cut to a forearm and burning to an upper arm). The child needed resuscitation and was taken to [location] Children's hospital in a critical condition, unable to breathe unaided and with severe burns.

Following this report, the mother [name] was arrested on suspicion of child neglect. She was interviewed under caution before being released on conditional bail. She has been arrested and then released on bail with conditions preventing her from having any unsupervised contact with any child aged under 16. Police are currently seeking to re-interview mother and extend the bail conditions to assist their investigations and to ascertain the prognosis of CHILD B's delicate physical health in hospital care.

CHILD B's four siblings are currently staying with their [wider family member], who had regular contact with the children.

Panel Comment: This is a clear and succinct description of the serious incident.

Documentation available to this rapid review:

Based on the referral received, initial scoping information and chronologies were received from the following partner agencies to understand the extent of any historical/current involvement with the adults and children within this family setting and any prior safeguarding concerns and interventions:

Panel Comment: The list of partner agencies has been removed. However, it was a comprehensive bullet pointed list of 18 agencies, including children's services, health, housing, schools, and fire and rescue services.

Section 2: Consideration of Case, Criteria and Guidance

Immediate Action:

Has ALL appropriate immediate action been taken to ensure children's safety and share any learning appropriately?

Yes ☒ No ☐

Actions taken to date include:

- Mother's bail conditions following arrest for neglect of her children, include prohibiting contact with any child under the age of 16 years
- CHILD B: birth father is responsible for supervising this contact
- A private fostering arrangement is in place for the older two siblings [name] and [name] and they are under the care of the [wider family member]
- The other two children [name] and [name] are also in the care of [wider family member], allowing all four children to remain together
- All four children have been placed on Child Protection Plans for neglect
- CHILD B remains in hospital requiring on-going support and treatment for burns sustained through the fire

Identifying Improvements to Safeguard and Promote the Welfare of Children

Those present at the rapid review have considered whether to carry out a local child safeguarding practice review and have agreed that the case has the potential to meet the following criteria *from Working Together, 2018:*

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified ☒
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children ☒
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate
- safeguarding partners have cause for concern about the actions of a single agency

- there has been no agency involvement and this gives the safeguarding partners cause for concern
- the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings
- more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- none of the above

Panel Comment: While these points are important for the safeguarding partners to consider in relation to the decision about whether or not to undertake an LCSPR, it is not essential to include them as a checklist in the rapid review. The text below is more helpful to the Panel in enabling us to understand the rationale for the decision.

Rapid review discussions

The rapid review panel agreed that the case met the criteria for a local serious child safeguarding practice review given neglect of a child is suspected and the child has been seriously harmed.

CHILD B suffered significant harm both physical and potentially emotional which may need to be supported in the long-term up as part of their ongoing developmental needs.

The meeting agreed that there was evidence of neglect through this incident however, there were prior concerns noted by agencies about the children's presentation, their home environment and living conditions and failure to attend or maintain appointments. These do not appear to have been raised as concerns through referrals to Children's Social Care.

Two previous CAF/Early Help interventions were in place for short periods of time for two separate issues raised by the school. Parents engaged initially during the first CAF episode and this was closed. During the period of the second CAF the lead professional (School's Learning Mentor) was on extended absence leave; during this period parents appeared to disengage from the early help process and the CAF was closed.

There were two separate referrals made into the Multi-Agency Safeguarding Hub (MASH) but these did not include information about the children's presentation, living conditions and concerns held at the time by the Health Professional and School. The referrals were issue specific and the decision making by MASH was based on the presenting

safeguarding concern on the referral. These concerns were followed-up and closed without further action.

> **Panel Comment:** This analysis is succinct and focused on the rationale for the decision to undertake an LCSPR. Some further detail, for example, around the pre-existing concerns and how they were or were not appreciated by different professionals/ agencies, would have been helpful to fully understand the context of this case. There is a paucity of any reflection on the lived experience of the children in this family.

Immediate learning: In recognition of the circumstances leading to this incident and the proximity to the approaching festive period, it was considered to be helpful to request local public health services to promote safety warnings in terms of the alighting of candles within the home where young children are present.

The designated doctor for safeguarding will also pursue lines of enquiry with health partners involved with the family to explore level of concerns and how these were shared with the MASH regarding the children's living conditions and concerns about parental capacity to cope and non-attendance at medical appointments.

Legal advice: Council Legal Representative was part of the rapid review and was in agreement with the outcome of this review.

Section 3: Recommendation

After completing this rapid review it has been agreed that this case:

a) Meets the criteria for a national Child Safeguarding Practice Review ☐

b) Meets the criteria for a local Child Safeguarding Practice Review ☒

c) Does not meet the criteria but warrants an alternative Learning Review ☐

d) Warrants consideration of DHR, SAR, MAPPA SFO or other ☐
Please state: _____

e) Warrants a Single-Agency Review ☐

f) Warrants a Multi-Agency Audit ☐

g) Warrants a Single Agency Audit ☐

h) Needs no Further Action ☐

i) The Rapid Review has identified learning that has been acted upon, obviating the need for further review ☐

j) Other ☐
Please state: _____

Panel Comment: We are unclear what is intended by option (c), an 'alternative learning review'. If the case carries potential for further learning, then this should be through an LCSPR and labelled as such. Alongside the decision to undertake an LCSPR, it would be helpful to also clearly identify the learning that has already been identified through the rapid review and how that learning will be taken forward, including any immediate actions by different agencies.

Reasons for recommendation

The rapid review meeting agreed that this case presented a number of issues in terms of the way in which agencies worked together and the management of information sharing between partner agencies and the use of formal referral pathways. The safeguarding partnership will look to review the following areas of practice as part of an LCSPR:

- Professional's recognition of indicators of neglect
- Unconscious bias/professional curiosity
- Differentiating between conversations and formal referrals into MASH
- Application of Thresholds

Panel Comment: The decision-making is clear and well-articulated. The focus on four key areas of exploration is helpful, although it may have been useful to include a bit more detail on the terms of reference for the LCSPR.

Example 3: Extra-familial harm

The following rapid review concerns a young person who sustained a stab wound to their chest and subsequently died. During the period of this rapid review, the Panel published their first national review, which looked at safeguarding children at risk from criminal exploitation. Therefore, this rapid review uses this learning in its analysis. The Panel agreed with the decision not to initiate a Local Child Safeguarding Practice Review.

Child and family details

Subject: CHILD C [Age removed]

Mother: Mother (Living in the same household as subject)

Father: Father (Living elsewhere)

Siblings: CHILD C has four adult siblings. One half sibling lives within the household. All the others live independently in their own properties. (Full details have been redacted)

Introduction

This rapid review has been commissioned under the requirements set out in Working Together to Safeguard Children 2018 (Chapter 4), and with regard to; Child Safeguarding Practice Review Panel: practice guidance. (April 2019)

It is intended to:

a) Set out clearly the involvement of local organisations with the family. Provide a summary analysis of that involvement. Including a review of practice, application of procedure, analysis of risk and action taken.

b) Identify any learning and where appropriate make recommendations for immediate action.

c) Provide adequate information to enable consideration against the criteria for a National Child Safeguarding Practice Review.

Methodology

On completion of the Serious Incident Notification, the [name] safeguarding partnership manager and strategic lead for safeguarding, commissioned an immediate case audit, and analysis of practice from key organisations involved with CHILD C.

This request was directed to: the Chief Constable for Police; the Director for People at the Council and the Chief Nurse for the CCG.

A template was used to support the succinct collation of agency involvement and analysis of any practice issues the internal review raised.

Designated Nurse for Safeguarding Children for [name] CCG worked with health providers

to co-ordinate service specific reports and compile a health summary analysis report.

Head of [role] and the children's officer for the safeguarding partnership, were identified as the authors for the report. They were tasked to:

- Review all submissions
- Compile an early draft summary analysis for the rapid review meeting
- Identify learning and consider recommendations
- Complete the final report in collaboration with the review team

To support this process a multi-agency panel meeting was held on receipt of all report submissions, this facilitated multi-agency scrutiny of the information, collective analysis and partnership agreement of recommendations. All three safeguarding partners were represented, as well as colleagues from the Youth Justice Service and the relevant College.

The final report has been set out in line with the locally agreed Signs of Safety approach. The senior strategic leads as identified above have signed off the final report.

Scope

Due to the time constraints of a 15-day rapid review, it has been agreed in conjunction with partnership leads that the review will focus on the 12 months preceding the incident, from [date].

Historical information about the family was acknowledged and, where appropriate, taken into account by the review. A summary of this information has been included in the case summary section.

Contributors

- [Name] Council – Children's Integrated Services
- [Name] Youth Justice Service
- [Name] Police
- [Name] CCG, in conjunction with Health providers
    - Primary Care GP records (facilitated by the CCG safeguarding team)
    - [Name] Partnership
    - [Name] Hospital Trust
    - [Name] Healthcare NHS Foundation Trust
    - [Name] Ambulance Service
    - [Name] out of hours service
- [Name] College

Panel Comment: Overall this is a helpful rapid review which sets out a clear context and summary of the case. It does, however, lack some of the basic information needed to fully understand the context, including ethnicity and any information on disability. In contrast to an LCSPR, we would not normally expect the aims, methodology and scope to be spelt out in the rapid review. However, it is useful that the details of the senior safeguarding partners responsible for the review are included.

Case summary

Incident: On [date] CHILD C was out with a friend at a local retail park. He became involved in an altercation with two other young people, during which he sustained a stab wound to his chest. Emergency services were called at [time], ambulance arrived at [time] and a heli-med doctor attended the scene. Maximum life support was implemented but all attempts at resuscitation failed and death was declared at the scene. There is a live police investigation in relation to the incident.

Recent history

At the time of the incident CHILD C was subject to a Referral Order by [name] Youth Justice Service (YJS). He had an allocated YJS case manager.

Youth Justice Summary: CHILD C was made subject to a 12-month Intensive Referral Order in [date] for the offence Commit an act/series of acts with intent to pervert the course of justice. As part of the intensive Referral Order, CHILD C was also subject to daily contact and a doorstep curfew for the first 3 months. There were no recorded violations or breaches.

Whilst subject to this Referral Order CHILD C committed further offences; unauthorised reporting of proceedings during a crown court trial and being in possession of a knife/bladed article. Following pleading guilty to these offences he was sentenced to a further 12 months Referral Order in [date].

Education: CHILD C had been enrolled on an Entry 3 / Multi skills [course]; after successfully passing the previous year's [course] in [date]. This course began on the [date], however, on [date] the placement was withdrawn following a number of incidents relating to his behaviour and absences.

Health: CHILD C had no recent contacts with his GP. However during the scoping period he did have contact with health professionals:

- [date] - Mental health assessment by the Liaison and Diversion service following arrest. No mental health concerns highlighted.
- [date – Speech and Language assessment undertaken following referral by the YJS case worker.
- [date] – Independent contact with sexual health services.
- [date] – Young Person declined triage assessment by the Liaison and Diversion service following arrest.
- [date] – Heath assessment by the Youth Justice Learning and Disability Nurse.

Childrens Services Contacts and Referrals: Concerns were initially raised through a contact with Childrens Services on the [date] with regard to CHILD C's association with other young people who were known to be committing offences including acts of violence. A similar contact was made on [date] following CHILD C being arrested on suspicion of a number of offences. Five weeks later the police investigation led to additional concerns being highlighted, which triggered a referral to Children's Social Care and a Children's Assessment being undertaken. During this period of assessment CHILD C was arrested again with a number of peers on suspicion of murder and perverting the course of justice. This incident triggered a Section 47 Child Protection enquiry, which led to a period of services and support delivered within section 17 Children in Need framework (CIN). On

conclusion of the police investigation, CHILD C was not charged with murder, but was charged with perverting the course of justice.

Children's Social Care involvement ended in [date] following a CIN review meeting. A decision was made that the primary case responsibility for CHILD C would transfer to the YJS.

There were three further contacts made with Children's Social Care. Two contacts from Police one in [date], and one in [date]. On the first occasion he had been observed at the scene of an incident where a knife was later found. (He later pleaded guilty to this offence.) On the second occasion he was suspected of being involved in an incident where another young person received two minor wounds. Both contacts were discussed in detail between Social Care and the YJS and with agreement referred to the YJS case manager to address within the ongoing care plan.

The third contact was in [date] when a referral was received from a Sexual Health Nurse, following contact with their service.

Historical context: In [year] CHILD C was seen by the community paediatric service due to behaviour problems. He was considered to display some traits of ADHD. Though a formal diagnosis was not given he was offered medication, which his mother declined. At a later point this was revisited and medication was provided though all reports indicate that he did not take it. He was discharged from the service in [year] and had little contact with health professionals thereafter.

Panel Comment: The summary of the case above provides a concise overview of the key incidents and engagement with agencies. This sets a helpful context for moving on to the analysis below. One of the limitations of this review is the emphasis on the child's history of criminality as the opening focus, rather than seeing him as a young person with both gifts and needs and recognising his behaviour and criminal involvement as arising from those needs and his background experiences. A more sensitive portrayal is provided in the analysis section later in the review.

Summary of information submitted by agencies - Full analysis of these points below can be found in section 7.

What we found was working well

- Out of scope but of note: In [date], CHILD C's school referred him to the early intervention team, based within the Youth Justice Service. As a result, he received a three-month intervention.

- Youth Justice Service – Referral Order management. During the course of the two Referral Orders, CHILD C engaged well with his case manager and attended interventions identified for him, as set out below:
    - Twice monthly Change Grow Live Substance misuse appointments (this work was ongoing)
    - Boys Healthy Relationship Programme, requirement 2 weeks (completed)
    - Knife Crime Programme, requirement 7 weeks (completed)

  - Victim Awareness Programme requirement 2 weeks (completed)
  - Reparation – 15 hours (this work was ongoing)

- Voluntary interventions offered to CHILD C are as follows:
  - [Name] mentoring programme - Employment & Training (Good engagement)
  - [Name] Programme - (Engaged, but not completed, ongoing at time of death)
  - Speech Language Communication Needs (SLCN) Screening (completed)

- CHILD C was also engaged with a trusted community group who work with hard to reach young people and those young people involved or at risk of being involved in gang issues.

- Consistency of case manager within the YJS. CHILD C had the same case manager throughout the period of time he was supervised by the YJS. This supported the development of a positive relationship, which was considered on review, as contributing to his mostly positive engagement during the Order.

- Evidence of positive and effective relationships between CHILD C's family and the YJS worker. Records demonstrated open and honest communications, joint understanding of the challenges, and family being able to express their views.

- Continued assessment and referral in relation to CHILD C's learning and development needs, by the YJS worker, evidenced by the referral to Speech and Language Therapy. This resulted in a better understanding of his learning needs and information was shared with the college.

- Strong advocacy for CHILD C by the [Name] worker in challenging the decision made by the college to terminate his placement. Escalated to complaint process.

- During his first year at college there was early recognition that additional support was required to maintain the placement. This included an Emotional Behavioural Disability Specialist, achievement coach and tutor, and included meetings with his family.

- Good communication and joint working between the YJS worker and the [Name] worker.

- During Children's Social Care involvement, CHILD C was allocated a family support worker who knew CHILD C well. This supported consistent and more frequent engagement.

- Referral from Sexual Health Service to Children's Social Care following contact with CHILD C. This prompted discussion between social care and YJS, completion of a Child Sexual Exploitation (CSE) tool with CHILD C, to support risk assessment and consultation with the CSE specialist. The outcome being that sexual activity was consensual with young people over the age of 16.

- Police identified CHILD C as a "habitual knife risk." As such he was managed and monitored by division (Neighbourhood Policing Inspector). Police intelligence was shared appropriately with partner organisations and appropriate safeguarding referrals were made following arrests.

- In [date] at the time of the first contact with Children's Integrated Services, CHILD C was subject to a complex strategy meeting, along with several other young people, where a mapping exercise was conducted. This identified clear connections with County Lines activity for some of the young people but not CHILD C. It was positive that he was included within the mapping due to his associations but there was no evidence to indicate he was involved. There was excellent multi agency representation at this meeting including universal and specialist services, as well as CHILD C's school. CCE concerns were again considered in relation to CHILD C in [date] when CHILD C was the subject of a further multi agency complex strategy meeting.

- Following the case closing to Children's Social Care in [date], further referrals were received. These were discussed with the Youth Justice Service to consider the most appropriate response.

- During the period of CIN delivery, the GP was invited to the CIN meetings in [date], and to a complex strategy meeting in [date].

What we were worried about / areas for development

- That CHILD C was unable to retain his college placement. More effective and early communication from the college to the YJS worker and [Name] worker may have been beneficial before the decision had been made. The alternative college placement was in an area of the city in which CHILD C felt unsafe and consequently he did not pursue this. Out of city placements had been explored by the college, one course was considered as a possibility but not pursued by the college as the YJS had already begun to get him involved in the [course].

- The college identify that CHILD C's circumstances in the new [date] term were not raised with the Designated Safeguarding Lead (DSL) by the YJS and [Name] worker. Consequently, they were managed as a behaviour and attendance issue. It is not possible to say if involvement of the DSL would have made a difference but it should have been considered.

- The referrals in early [date] highlight gaps in service provision prior to the implementation of [local area] response to Child Criminal Exploitation. The initial response to these concerns was not robust.

- In Social Care, whilst the case was co-allocated to a social worker and family support worker, it was the family support worker who undertook most of the work with CHILD C. CHILD C was a child in need and therefore he should have received direct support by the social worker. This does not take away the good work undertaken by the family support worker.

- Following the contact with Children's Social Care in [date] there was a recommendation to convene a further complex strategy meeting. This did not occur; the review has been unable to establish the reason for this.

- The review has examined engagement with the GP as part of the professional network. The GP was invited to the CIN reviews, this is evident from a review of the GP records. However, they did not attend or acknowledge the invitation and were subsequently absent from the professional network response. No other health

representative was invited.

Panel Comment: This section gives a clear and sensitive outline of CHILD C's lived experience. The Panel noted that one of the services CHILD C was referred to was for 'hard to reach young people'. This language places a level of responsibility on the child as it assumes services are reachable and the child is not.

Analysis

CHILD C's profile / lived experience

CHILD C was [age], he lived with his mother who was not in good health, after experiencing strokes, and managing diabetes. CHILD C was supported by an extended family of older siblings, one adult sister in particular. CHILD C and his mother had a close relationship and she found it hard to identify her son with the criminal activity he was associated with. Records indicate that CHILD C had a close relationship with his sister and he talked to her about some of the things happening in his life, including activity with his friends and associates.

CHILD C knew his father and had contact with him throughout his life. His father has experienced significant mental health episodes resulting in him being sectioned under the Mental Health Act (he has a diagnosis of schizophrenia). CHILD C was aware of this and had witnessed his father being unwell. During conversations with professionals CHILD C had not fully opened up about how he felt about his father, though he had expressed an anxiety that he may develop a similar condition.

CHILD C was involved in criminal activity, including being in possession of a bladed article. He was known to have strong associations with other young people involved in criminality, demonstrated by his first Referral Order for providing a false alibi. What is less clear is whether there was a criminal exploitation element to his offending behaviour. The working hypothesis given the lack of evidence was that it was unlikely. He has not been arrested for any offence that would indicate County Lines involvement, either through location, possession of illegal substances, or large amounts of cash. He engaged very well in his first Referral Order, recognised by the referral order panel who recommended early revocation due to positive progress.

CHILD C's case manager at the YJS who knew him well, described him as demonstrating a good level of respect for adults and professionals. His attendance and engagement with the YJS was excellent.

CHILD C experienced friends being convicted for serious offences, including murder, which resulted in long custodial sentences. During work with the YJS he demonstrated an awareness that a number of his friends were involved in gang related activity and that association with these groups could place him at greater risk of harm, though he showed little motivation to distance himself from these groups.

CHILD C smoked cannabis and was open about this with professionals. He engaged in support services for substance misuse as part of his YJS interventions. This was twice monthly and was ongoing at the time of his death. It is likely that this was a common activity across his peers.

Though difficult and challenging at times CHILD C had, with support, completed his first year at college. This would indicate that he had some motivation that sustained his engagement. As part of the YJS assessment he was referred for a speech and language assessment. This identified that he did have some learning needs, the findings of this assessment were shared with his college in [date]. The College felt that the course and current programme of support in place, were appropriate to his educational level.

Panel Comment: Even at this early stage, the safeguarding partners have been able to consider the young person's lived experience, drawing on information from those who knew him. This provides an excellent base for understanding the practice issues presented below.

Practice issues

Childrens Social Care Statutory Interventions

The review has identified that the social worker allocated to work with CHILD C should have taken more of a lead role, instead the co-allocated family support worker took the lead role engaging very well with him. There is no indication that this is a systemic issue.

The rapid review has also highlighted some issues with record management in relation to the minutes of complex strategy meetings, where a number of young people are discussed. These were located in a central place and not showing on CHILD C's file in the electronic case management systems. Issues have also been identified with circulation of these minutes. Though having no direct impact on the outcomes for CHILD C, these systems would benefit from a review and process clarification.

As noted above, the initial response by Childrens Social Care in [date] was not as robust as it could have been. We acknowledge that it was very early in the development of our local response to Child Criminal Exploitation (CCE) and feel confident that a similar referral would follow a different pathway should it be referred now. This said, it was positive to note CHILD C's school referred him to the YJS early intervention programme as early as [date]. In addition, it was positive that CHILD C was included in a complex strategy meeting and mapping exercise in relation to CCE in [date].

Safeguarding Partners have developed a comprehensive response to Child Criminal Exploitation. This includes strengthening the training offer and increasing awareness of CCE. The development of a CCE toolkit and pathway to ensure indicators and risks are understood by partners and colleagues and that processes are in place to ensure an appropriate response. A programme management board and governance structure has been put in place for monitoring and reporting processes.

The Council have established a programme of work, with the aim of developing a cross authority approach to working with those young people deemed to be at risk of CCE and serious youth violence. The work has included developing community partnerships to deliver targeted and group activities for those at-risk children and young people. Targeted Youth Support Workers also regularly deliver work within schools and alternative provisions.

The Council also has a dedicated unit to coordinate activity across the county-wide

partnership. The unit is a partnership bringing together specialists from local government, health, education, policing and criminal justice to work with communities and the third sector to reduce serious violence and tackle its underlying causes.

> **Panel Comment:** This analysis addresses the key practice issues and considers to what extent they represent wider system issues. It identifies both good practice and areas for improvement, along with the steps that are being taken across agencies and with other services to address those issues.

Youth Justice Service Interventions

The review has not identified any immediate concerns in relation to the delivery of interventions and management of CHILD C within the YJS. However, an in-depth Critical Learning Review has been commissioned by the YJS. The review report will be presented to the YJS Board and the local Safeguarding Partners via the Child Safeguarding Practice Review subgroup. This will provide further opportunity to use learning to improve practice.

> **Panel Comment:** The safeguarding partners have taken a positive approach to working with the Youth Justice Service to ensure the focus is kept on learning.

Missing from Education

The report provided by the College to support the rapid review process clearly sets out the challenges faced by the staff team in supporting and maintaining CHILD C's education placement. During his first year the student tracker identifies a significant number of concerns relating to CHILD C's attendance, punctuality and attitude. There were seven causes for concern raised under the formal student disciplinary process, he was progressed to a stage two disciplinary. Towards the very end of the course his attendance had dropped to 20%. Despite this, the college did work with CHILD C and his family to enable him to complete the first year.

When he returned for his second year in [date], issues in relation to his behaviour were immediately apparent. On his first day he threatened another student with violence. He was observed associating with another student who was smoking cannabis on college premises. He had missed some classes and attended others late. He was spoken to by the Head of Facility, his Achievement Coach and the Security Manager in a bid to resolve the concerns, before the decision was made to withdraw his placement. As noted above, those involved at the time did not refer to the Designated Safeguarding Lead (DSL) during this period. The review agrees with the College's reflection that this would have been beneficial but cannot be certain it would have altered the outcome.

What we do know is that CHILD C's sister had expressed to the YJS worker just three weeks before his death that his attitude to education had deteriorated. She felt that he had lost hope to succeed in the period he had been out of education and spending more time not being involved in constructive activity. The [Name] programme lasts for eight weeks and requires two 3.5-hour sessions per week.

Panel Comment: The focus on practice issues above is helpful, identifying some points of learning, good practice and areas for improvement, as well as documenting learning and development work that has already been done locally.

Learning

Reflection against national learning.

During the period of this rapid review the Panel published their first review: "It was hard to escape, Safeguarding children at risk from criminal exploitation". The rapid review panel felt that it would be beneficial to consider the circumstances in this case against the key findings from the national review. The rapid review made the following observations.

Profile: Similarities in CHILD C's profile and that of the cohort in the national review, indicating increased vulnerability, including: gender, ethnicity and being out of education. Similarly to many in the cohort he had little contact with services prior to concerns in relation to criminal activity being raised.

Exclusion: The national review identified permanent exclusion as a trigger for significant escalation of risk. CHILD C had been permanently excluded from mainstream school and attended an alternative provision prior to attending college. Since [date] [Name] Council have implemented 'Targeted Family Support (TFS) - Team around Schools Meeting' with an offer of providing a named Family Support Worker attached to all primary and secondary schools. One of the key tasks is to support a reduction in exclusions. By sharing information about pupils at risk of exclusion, wrap around support can be put in place early to avoid escalation to further or permanent exclusion.

Trusted relationships: The national review stressed the importance of trusted relationships between children and practitioners being essential to effective communication and risk management. CHILD C did have opportunity to build relationships with his YJS worker and [Name] s worker, who were consistent supports. He also engaged with workers from [Name] mentoring group.

Parental engagement is nearly always a protective factor: CHILD C's parents were supportive of him, although his mother struggled to accept he was involved in any offending behaviour. His sister was also a support and he spoke with her openly. Both his mother and sister communicated and shared information with the YJS and [Name] worker. The Local Authority and Safeguarding Partners should consider within their response to the national review how we could incorporate a Family Group Conference model.

Disrupting perpetrator activity: Whilst [local area] response has included elements of disruption, this is an area we should consider further and give priority.

Flexible delivery: CHILD C was engaged in support that provided an out of hours service. A wider approach to out of hour's delivery should be considered further as part of the partnership response to the national review.

Panel Comment: This is a helpful approach to take, that is flexible and specific to the case, draws on national learning and enables local reflection.

Response / Action already identified or taken

Children's Social Care

- Follow up sessions to be undertaken with the practitioners involved around the expectations of managing Child In Need cases in line with policy and best practice
- Child Death Strategy Meeting undertaken in line with local Child Death procedures.
- The gold standard for minute taking and circulation of complex meeting minutes has been updated.

Youth Justice Service

- Conduct a Youth Justice Service Critical Learning Review in relation to the case management of CHILD C. This will be presented to the YJS Board and Safeguarding Partners once completed.

Safeguarding Partnership

- In response to concerns for other young people who witnessed the incident and/or are known to have associations with CHILD C or the perpetrators. An intensive package of support has been delivered via the main school involved. This has been delivered through the safeguarding lead for education, the education directorate and [local area] Police. This has included support to individuals and their families, friendship group mapping and risk assessment in response to any concerns for safety expressed by the pupils.

[Name] College

- [Name] College will explore implementing a 'six week process' for the start of the new academic year to see whether a different approach to supporting managers with attendance and behaviour issues during the first six weeks of term may avoid decisions being made in isolation about at risk students. It is recognised that this is an exceptionally busy time with new students.

[Name] and [Name] CCGs

- The review of the multi-disciplinary meetings[1] that is currently underway should consider how information is shared for children or young people that have been discussed at complex strategy discussions.
- The CCG will work with providers and the LA in relation to ensuring effective storage of and access to minutes of meetings where groups of children/ young people are discussed.

Conclusion

The review has not identified any significant practice issues. At the time of his death CHILD C was known to and engaged with the YJS. He had been active in attending and completing relevant interventions identified for him. He did appear to have a consistent

[1] These meetings take place within the GP practice, with a focus on safeguarding. They are a multi-disciplinary meeting of the community health professionals involved with the case.

and trusted adult within his family and in the YJS case manager that he could talk to. His asset assessment was comprehensive and considered risks and needs including health needs.

He was out of formal education which his family believed had impacted on his motivation to achieve and succeed in this area.

The recently published national review does offer learning and insight, much of which resonated with this case. It will provide a helpful framework for the Local Authority and Safeguarding Partners in which to consider their response to this review.

Decision making

The rapid review panel does not recommend further review in the form of a Local or National CSPR. It is clear that greater learning in relation to wider practice will be better served by careful consideration of the **National review – Safeguarding children at risk of criminal exploitation**: Against this case and our framework for delivering a response to CCE locally.

Recommendations

I. That the local Safeguarding Partners consider the national review findings alongside the current agreed model of delivery and agree a response.

II. The SCP will agree a consistent approach for the safe storage of complex meeting minutes. A protocol will be developed and agreed that does not breach GDPR and indicates where the minutes are stored and how they can be accessed without breaching confidentiality. This is necessary as complex meetings will often involve children from more than one family.

Panel Comment: The rapid review concludes with a clear decision not to recommend a local or national CSPR; this is backed up by a clear proposal for learning from the national thematic review, and a specific recommendation in response to one of the learning points identified in the review.

Example 4: Child sexual exploitation

The following rapid review concerns a teenager who was raped, with wider concerns about their vulnerability and risk in relation to child sexual exploitation and criminal exploitation. The Panel agreed with the decision not to initiate a local child safeguarding practice review (LCSPR) into this case. Overall, the Panel thought that the rapid review was clear and concise, and identified good learning with a clear action plan linked to the learning points.

Introduction

Child Name: CHILD D
Date of Referral: [Removed]
Date of Case Discussion: [Removed]

> **Panel Comment:** This is a good rapid review, which appropriately considers implications for contextual safeguarding. More information about the child's early life and scrutinising what was/could have been done to divert from the pathway to further suffering may have been beneficial. It is useful for all rapid reviews to appropriately consider early life and family history when looking at cases of exploitation. Additionally, the rapid review does not include any upfront details of the child's gender, age, ethnicity, or any disability, nor of the wider family. It is essential to include this information.

Professionals present: [List of names and agencies removed]

Facts: Documentation available for case discussion

In [date] CHILD D was allegedly raped by her ex-boyfriend, referred to here as CHILD E.

At the time of the incident CHILD D was reportedly separated from her boyfriend. CHILD E had been the perpetrator of a domestic abuse incident against CHILD D in [date]. She was referred to MARAC as a high-risk Domestic Abuse victim in [date] and a Children's Independent Domestic Violence Advocate (ChiDVA) was allocated to work with her. As a result of the Domestic Abuse incident CHILD E, who was subject to court Bail conditions that were meant to prevent him from having contact with CHILD D. CHILD E had been assessed as posing a high risk of serious harm by the National Probation Service.

CHILD D was first known to be in a relationship with CHILD E in [date]. It was initially believed that services only became aware of that relationship being violent or volatile when the Domestic Abuse incident occurred in [date] and at that point CHILD D had been made the subject of a child protection plan and was referred to [name], [location's] Domestic Abuse Service. However wider concerns about CHILD D's vulnerability and risk in relation to child sexual exploitation and criminal exploitation had previously been raised and although it was not established at the time whether CHILD E was a potential perpetrator or victim of those crimes (he was named as being present when that activity was taking place).

Safeguarding concerns were raised by school in [date] and as those emerged and escalated, [location] Families Together and Edge of Care Service were allocated to support CHILD D and her family. Along with school, those services became worried that CHILD D was being sexually exploited as she had disclosed that she was having unprotected sex with different older males and drinking alcohol. There had also been a missing from home episode where she had stayed out all night and subsequently disclosed having sex with an older male in his 20s and transporting drugs.

Following a further missing from home episode in [date] a charity completed a missing from home interview. They shared that CHILD D had disclosed that she was carrying drugs and weapons for gang members and that she was being paid. She also reported having had a number of sexual relations which had been unprotected, one of the males was CHILD E.

This information is significant because it indicates that CHILD D is linked to CHILD E not just in terms of sexual activity but possibly via a CSE and CCE model. This additional information shows that agencies knew that CHILD E potentially presented a serious risk of harm to CHILD D in [date] a year earlier than the Domestic Abuse incident.

Panel Comment: This is a concise and clear outline of the circumstances of and background to the incident. The final paragraph provides a helpful consideration of the relevance of the contextual information.

About the child

CHILD D had previously been subject to a child protection plan in [location] in [date] under the category of neglect and emotional abuse. CHILD D went to live with her grandmother in [location] but continued to have contact with her mother. Her relationship with her grandmother has become strained as CHILD D's grandmother found it increasingly difficult to manage her behaviour and protect her from harm. Both her mother and grandmother had said that they could no longer have CHILD D in their care and had requested that she be placed in a residential placement.

CHILD D has said to services that she hasn't had any positive experience of a healthy relationship and believed violence to be acceptable. During discussions with services. CHILD D had recognised some of the risks relating to her relationships and behaviours but has always felt that she could manage those risks.

CHILD D has engaged well with services and talked quite openly about her behaviour to the ChiDVA and pastoral staff in school for example. CHILD D's ChiDVA has noted that she has exhibited signs of PTSD and that these were evident prior to the sexual assault in [date]. She has currently declined support from Mental Health services.

CHILD D has shown some resilience in completing her [exams] in [date] and applying for college. CHILD D enrolled with a course which aims to prepare students for progression to a main college course the year after. She continues to attend the gym and has been talking to and seeing close friends.

Immediate thoughts

CHILD D was placed on a child protection plan from [date] to [date] when the case was stepped down. She then went back on to a child protection plan in [date] following the Domestic Abuse incident. Rapid review members queried the rationale for stepping the case down when the risks around CSE and CCE were still prevalent and questioned whether that was a multi-agency decision.

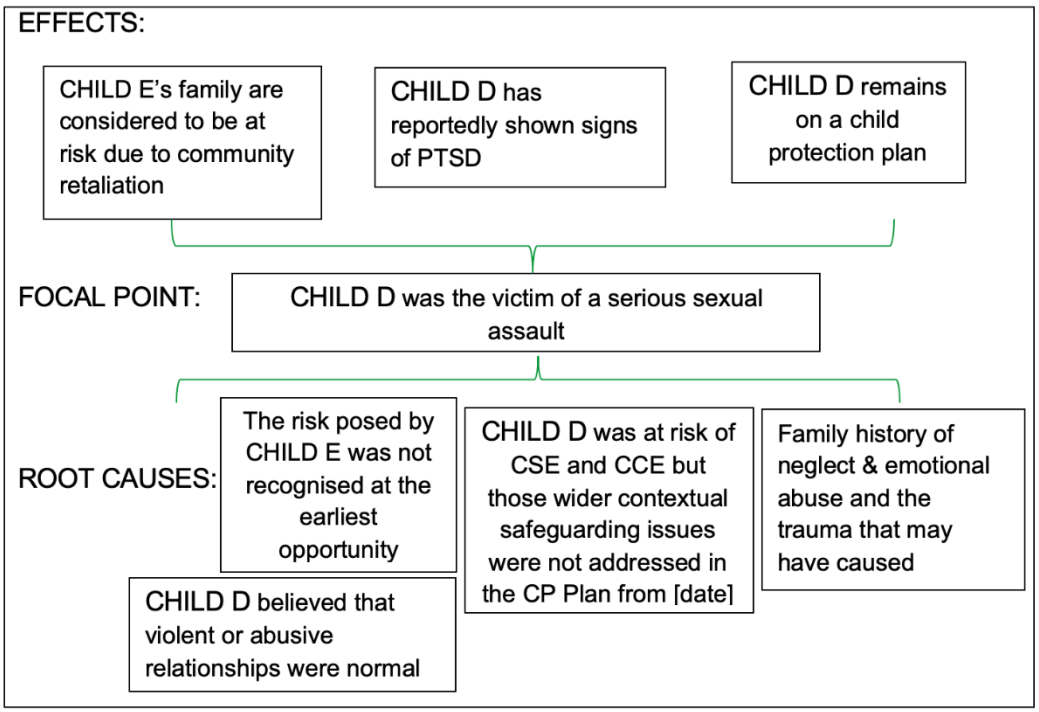
CHILD D's risk of exploitation seemed to become secondary to the risk of domestic abuse from [date] onwards. The wider contextual safeguarding risks to CHILD D were not the focus of the child protection plan.

Police checks were not requested by any agency from Police on CHILD E until [date]. Rapid review members felt they should have been done sooner: when CHILD E was first mentioned as being present while CHILD D was involved in suspected CSE and CCE in [date], or when CHILD D was known to be in a relationship with CHILD E in [date].

Rapid review members believed that there was too much reliance on CHILD D's grandmother to protect her and keep her safe. Professionals could see that was not the case from the missing from home episodes and from what CHILD D's grandmother was saying herself.

Panel Comment: The section above provides a brief but pertinent recognition of some of the key areas of concern arising from the case. The use of an analysis tree helpfully summarises some of these key issues and sets the context for the deeper exploration.

Analysis tree



What are we worried about?

Rapid review members were concerned that some of our service interventions only sought to address the presenting behaviour, the symptoms, and not the root cause of that behaviour. In this case there was a plan to deliver a CSE resource [name of resource] to CHILD D but actually she had experienced ACEs from a young age. Members believed that her full history had not been assessed, analysed and understood. To support this [local area] need to develop a trauma informed approach across its multi-agency safeguarding practice.

That approach needs to be reflected in [location] thresholds guidance so that the application of thresholds, and allocation of service resources, is based on the entire historic risk of harm and not just the current presenting risk of harm. For CHILD D the school referral to the MASH expressed concern about sexual activity with older males and was allocated to early help. However, CHILD D had already suffered historic neglect and emotional abuse as a young child and services could have predicted, based on attachment theory, that there would be underlying attachment issues impacting on her family and intimate relationships. Rapid review members therefore believed that an Initial Child Protection Conference and a referral to the Complex Safeguarding Team could both have been requested sooner. There was concern that our safeguarding response to complex safeguarding issues is not triggered early enough or in the way that it can be for other forms of abuse or neglect. This was considered to be partly due to professionals' knowledge and understanding of the service response to complex safeguarding.

Services in [local area] are designed and delivered using a 'Team around the family' approach. Rapid review members recognised that a family approach is evidence based and often successful but felt that an alternative model was needed for teenagers especially in relation to tackling exploitation and wider contextual safeguarding concerns that arise from outside the family home. This needs to be a multi-agency response via the complex safeguarding team which addresses the full range of needs for the person at risk of harm as well as taking a proactive response to mapping (using a legal basis) that young persons' peer group, so that other victims or perpetrators might be identified, and activities enabled within a wider community context are identified so that a relevant community safety or public health response can be enacted. Rapid review panel members acknowledged that [local area] moved from a CSE model to a complex safeguarding model in 2020/21 and therefore the partnerships response to exploitation would now be different. There needs to be a wider workforce understanding of the multi-agency response to exploitation and further development of a contextual safeguarding model.

Rapid review members noted that child protection conferences were not all attended by Police and although Health were represented CHILD D's health needs were not fully recognised and responded to. For example, at a conference it was reported that there were no outstanding health needs but CHILD D was having unprotected sex with different older males, was drinking alcohol, had problems with her vision and vitamin and iron deficiencies. This case highlights again the importance of multi-agency attendance and sharing of information at child protection conferences so that the holistic needs of the child can be met, so that external risk factors (in this case CHILD E and also the risk of exploitation from others) can be addressed and so that decisions to step cases down are based on all aspects of that young persons' life.

Child protection and criminal justice processes could have considered the risk CHILD E posed in [date] and that might have led to an earlier statutory intervention to safeguard

Child D and to a different service response to support CHILD E who at that time was being supported by the Youth Justice Service. It could potentially have identified CHILD E as a victim of exploitation himself. At the time of the Domestic Abuse incident in [date] CHILD E was subject to Conditional Bail for the Common Assault offence and was not to have any contact with CHILD D. CHILD E breached his conditional bail conditions and was known to present a high risk of serious harm. Although this couldn't have been evidenced in court, rapid review members questioned whether services could have done more in these circumstances to protect CHILD D.

The Out of Hours Service response was restricted due to limited resources. At the time that CHILD D was missing from home and deemed to be at risk of harm the service could not undertake home visits. Good practice would have seen Children's Services provide further support at the time that CHILD D had been located.

What worked well?

There was lots of evidence of good practice in relation to this case. The school offered a good level of support and their safeguarding concerns were referred in to the MASH in a timely way. Although the case was initially allocated to [location] Families Together the case was escalated. Relevant referrals were made throughout including to the Complex Safeguarding Team, MARAC and to [name]. A number of professionals from different services were able to develop a good relationship and rapport with CHILD D. Further support in relation to CHILD D's mental health was offered but declined. Services did recognise the risk of CSE and CCE and worked with CHILD D to try to protect her. However, this could have been offered at an earlier stage and there was insufficient work done to address the external risk factors linked to the CSE and CCE or to identify and address the risk posed by CHILD E.

Panel Comment: The above sections provide a helpful analysis of what worked well and of where there is scope for learning from the case.

What needs to happen?

The rapid review panel members agreed unanimously that the criteria for a Local Child Safeguarding Practice Review was met. Panel members agreed that the rape was a serious incident and that CHILD D had suffered serious harm. This was set apart from other cases of serious harm because of CHILD D's vulnerability and level of risk to child sexual exploitation, criminal exploitation and domestic abuse.

Rapid review members were satisfied that via the collation of a combined chronology, single agency practice summaries and during the course of two rapid review meetings they had explored and identified relevant learning. In addition, they were mindful that some of the learning identified, in relation to the need for a trauma informed approach and contextual safeguarding model, is similar to other reviews it has conducted including [name] and [name]. There is also national learning and recommendations identified by the National Child Safeguarding Practice Review Panel in their report "It was hard to escape" published in 2020 and a number of reviews relating both sexual and criminal exploitation already undertaken in the region. **For that reason they agreed that it was not necessary to undertake a Local Child Safeguarding Practice Review because it would not identify any additional learning.**

The rapid review members agreed that there is a small window of opportunity to support CHILD D whilst she is still under 18 and on a child protection plan. Services needs to address the trauma that she has suffered and help her to develop her internal controls so that she can protect herself and have healthy relationships in the future. Other professionals need to support Children's Social Care to deliver this including Health and [location] Care. It was suggested that the ChiDVA helps support this as somebody that CHILD D already has a good relationship with.

Panel Comment: The rationale for the decision not to undertake an LCSPR is clearly set out. This is accompanied by a clear action plan below to take forward the learning already identified. The rapid review helpfully considers learning from other reviews, including the national review on criminal exploitation.

Action

- Arrange tripartite supervision between CSC, Health and [location] Care. This will need to include relevant practitioners and team managers. It will be facilitated by the Head of Child Protection and Child in Need Services who will ensure a trauma informed focus.

- Establish a Local Steering Group to support the [region] Trauma Responsive and ACE Framework Implementation Plan proposed by the [region] in [date]. This states in its Executive Summary that "A paradigm shift is needed across [location] to ensure a coordinated population approach to reduce children and families exposure to adverse childhood experiences (ACEs) and, to prevent or mitigate the consequences of trauma and ACEs by becoming a Trauma and ACE responsive city-region."

- Undertake a complex safeguarding needs assessment and develop a plan to address any identified needs or gaps in current service provision. As part of this the Complex Safeguarding Strategic Group should;
    - Complete the Contextual Safeguarding Network's self-assessment tool in relation to contextual safeguarding and determine the feasibility of implementing such an approach.
    - Undertake desktop research regarding the link between contextual safeguarding and CCE and determine whether our existing complex safeguarding offer is sufficient in regards to these issues.
    - Review the effectiveness of the current complex safeguarding offer, including the Achieving Change Together model, and whether it is providing an early and holistic response to CSE and CCE.
    - Provide assurance that the 'Local Learning Points' listed in Chapter 16 of the National Panel's report 'It was hard to escape' have been progressed or that there is a plan in place to do so.
    - Complete consultation with the children's workforce regarding their knowledge, understanding and application of practice relating to [location's] complex safeguarding offer.

- To create a working party to explore how safeguarding partners can utilise existing child protection processes to protect vulnerable young people from individuals that pose a serious risk of harm when they repeatedly breach their bail conditions.

- Children's Services to provide assurance regarding the sufficiency of its resource and response in the Out of Hours Service.

Panel Comment: This is a focused rapid review, which considers implications for contextual safeguarding and mentions the public health approach to reduce the probability of children being at risk of serious violence. More information about the child's early life and scrutinising what was/could have been done to divert from the pathway to further suffering may have been beneficial in identifying relevant learning from the case.

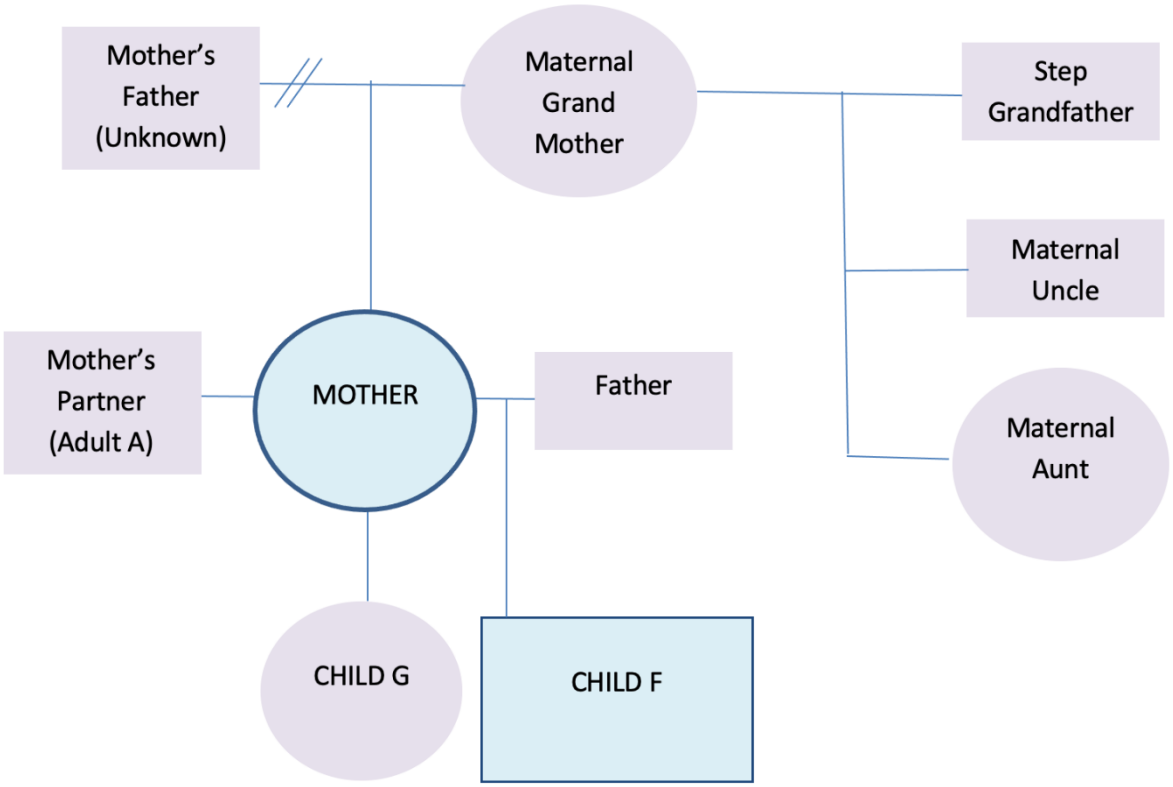
Example 5: Non-accidental injury

The following rapid review concerns a 4-month-old baby who presented at hospital with injuries that were identified as non-accidental. This review involves a case with several individuals known to a range of agencies throughout their lives and complicated family relationships. The Panel agreed with the decision not to initiate a local child safeguarding practice review (LCSPR) into this case. Overall, the Panel thought it clearly identified relevant learning in the service delivery and agreed with the steps being taken to address all learning, noting that that there now needs to be a comprehensive action plan to address issues identified and to be monitored by the partnership.

1. **Family background**

Anonymised name	Gender	Relationship	Ethnicity
CHILD F	Male	Subject of the notification and aged 4 months at time of incident. Half-brother to CHILD G.	White British
CHILD G	Female	Half-sister to CHILD F aged 19 months at the time of incident.	White British
Mother	Male	Mother of all the children, aged 20.	White British
Father	Male	Father to CHILD F, aged 18.	White British
Adult A	Male	Mother's partner, aged 21.	White British
Adult B	Male	Father to CHILD G.	White British
MGM	Female	Maternal Grandmother to CHILD F and H.	White British
SGF	Male	Step Grandfather to CHILD F and H. Stepfather to Mother. Father to MA and MU.	White British
MA	Female	Maternal Aunt to CHILD F and H, half sibling to Mother. Aged 16 at time of incident.	White British
MU	Male	Maternal Uncle to Child A and B, half sibling to Mother. Aged 18 at time of incident.	White British

Genogram



Panel Comment: This is a complex rapid review so the table and genogram setting out the family relationships is very helpful. It would also be useful to record the dates of birth of each family member and any disabilities in the table above.

2. Rapid review process

A serious incident notification was made to the Child Safeguarding Practice Review Panel on [date], which initiated a rapid review. The rapid review requested information on all extended family members and Mother's Partner (Adult A), because they were all known to be living in the household at the time of the incident. Information was received from the following agencies, and this was collated into a multi-agency chronology: [list of agencies removed].

3. Incident

The following rapid review sets out the circumstances leading up to CHILD F's attendance at Hospital in [location] with injuries that were identified as non-accidental, the mechanism of injury not consistent with injury and cause for safeguarding concern on [date].

On [date], Mother presented her son CHILD F (4 months old), at Hospital on advice from the GP. She had noticed he had a sore and swollen leg which concerned her. Medical examination and X-ray identified a fracture of the tibia just above the ankle joint on the right leg. There was also a fracture of the lower part of the femur, on the right leg which

had callus, and this was suspected to be an old fracture. The skeletal survey revealed a further distal tibia fracture (above ankle joint) on CHILD F's left leg, with the final medical report identifying three fractures: two on the right leg, one new and one likely 10-14 days old and one fracture on left leg, all indicative of non-accidental injury.

No plausible explanation was provided by Mother other than to say that half-sibling CHILD G (19 months) "can be rough" with CHILD F. A later explanation of a fall from a swing has been provided by the Maternal Aunt who is 16 years old, but she was uncertain when this happened. CHILD G's Child Protection Medical did not identify any injuries or health concerns, police investigation is ongoing, and Mother has been arrested for GBH and neglect with bail conditions in place. The other adults in the household, including Adult A, are also under investigation as part of the S47 enquiries underway

4. Summary of case and key events

This review involves a case with several individuals and complicated family relationships. The genogram above outlines the family make up and relationships. CHILD F lived with his mother, half siblings, maternal grandmother, maternal step grandfather and maternal aunt and uncle. CHILD F and CHILD G are half siblings.

- Adult A (mother's partner). Adult A is resident in a neighbouring Local Authority and was recorded to have a learning difficulty, a history of intervention from children's social care and reported to be a potential perpetrator of physical and sexual offences.

- Father of CHILD F is a care experienced young person, having been in foster care since he was 13 years old, with a history of exposure to domestic abuse. He had been known to police since he was a young teenager with a history of offences including violence, drugs, weapon, and sexual offences. He had been issued multiple Child Abduction Warning Notices in relation to the risk he may pose to children.

- Adult B (father of CHILD G). Mother was thought to be estranged from CHILD G's father whom she had disclosed was emotionally abusive and controlling.

- Step Grandfather. Information provided to the rapid review panel indicated SGF had a previous history of violent and sexual offences, and this had been previously assessed as part of previous social care activity.

Mother was 19 when she had CHILD G and was recruited to Family Nurse Partnership (FNP) whilst pregnant. She did not engage with FNP and was transferred to the care of the Health Visitor prior to the birth.

Mother and her half siblings had been subject to significant involvement from social care during their childhoods. Mother, Maternal Aunt and Maternal Uncle were subject to a Child Protection Plans from [dates] for neglect due to concerns about inappropriate sexualised behaviour by Maternal Uncle, who had learning disabilities, towards Maternal Aunt and parent's ability to maintain boundaries. Maternal Aunt and Maternal Uncle continued to be subject to a period of child in need, which ended in [date]. Mother was also known to police for concerns around risks of child sexual exploitation as a child.

In [date], a MASH referral was made from a neighbouring authority following recovery of a 15-year-old Looked After Child being found at Mother's house. He had been reported missing. The outcome of the referral was a Single Assessment. CHILD G was only 5 weeks old at the time. Mother said she had met the 15-year-old child online and had allowed him to come to her home without knowing him. Social care records showed that this was the second occasion that a similar situation had occurred as historically, the family also had another inappropriate male stay in the family home, who took pictures of another family member, aged 16 years old, in the bath. This family member is not included in this review.

The Single Assessment focussed on CHILD G, Maternal Aunt and Maternal Uncle, and concluded that there were no concerns for CHILD G. She was seen to be clean, and observations of warmth between Mother and CHILD G were noted. Recommendations for CHILD G were for a step down to Support Service with an allocated Family Key Worker for a period of support (this is a level of service sitting below CiN). Mother received support from a Family Key Worker [for 2 months] where work was undertaken around safe and healthy relationships and parenting support. The Family Key Worker raised concerns about the amount of stimulation CHILD G was receiving and a referral was made to the Community Nursery Nurse who was unsuccessful in engaging with Mother. Mother's siblings aged 14 and 16 at the time were supported under Child in Need Plans.

During the period of support from the Family Key Worker, the ambulance service attended the family home to attend to CHILD G who was said to be screaming uncontrollably. The paramedics attending noted concerns about the home environment and CHILD G being in an old, soiled nappy with bad nappy rash. Both Mother and Maternal Grandmother refused to change CHILD G's nappy. It was also noted that there were lots of people in the property apparently in breach of covid rules in place at the time. The paramedics recorded that Mother was young and not coping. The ambulance service raised a concern with MASH the following day and the Family Key Worker followed up with an unannounced visit that day where CHILD G was seen, and the family showed her the nappy cream they had just bought. There are no records to show whether incident was considered in relation to Mother's attachment or parenting capacity to meet the needs of CHILD G but information about this incident was shared with the Health Visitor who agreed to make contact with Mother.

In [date], the police undertook a welfare check following a pram, baby clothes and CHILD G's Red Book being discovered in undergrowth. Officers attended the home address and spoke to Mother who said that the items had been stolen but she did not want them back. Officers noted that they had no concerns for CHILD G but noted that Mother's demeanour suggested they had been fly-tipped. They completed a PPD1 that was shared with the social work team as it was noted that the family were open to social care.

In [date], Father's Social Worker contacted the safeguarding team. Father had been seen on his own with a baby in a supermarket. It was established that Father's girlfriend was Mother and that the baby was CHILD G. On the same day information was shared between Social Worker and Family Key Worker that mother had stayed overnight at Father's flat with CHILD G. Father was not permitted to have overnight guests in his supported living and in doing so was putting his placement at risk. When spoken to by the Family Key Worker, Mother denied leaving CHILD G alone or being in a relationship with anyone.

In [date], support from the Family Key Worker ended. The case was stepped down to Early Help with a referral being made to the children's centre and health visitor visiting at the 9-month point. Recent non-engagement from Mother was noted but no additional concerns were raised. Referrals were made to the children's centre, and it was noted that the Health Visitor was involved. Between [date], after an initial call and home visit, there followed a period of unsuccessful attempts by the children's centre Outreach Worker to contact Mother, often because Mother's phone number and email address were not working or had been changed. Conversations between the Outreach Worker and Family Key Worker noted that Mother's siblings were open to social care with a Social Worker going into the house. This provided a level of reassurance that all the children in the family were being supported.

Mother contacted the Birthing Centre in [date] to inform them that she had a positive pregnancy test that indicated she was 3-5 weeks pregnant. On attendance at her antenatal booking appointment, she said that she was unsure who the father was and did not give any names or details of prospective fathers but suggested it might be father of CHILD G. Mother was assigned to the local team for women who are vulnerable or require additional support through pregnancy. The midwifery team noted concerns around her young age, past history of children's social care involvement as a child and concerns that she was no longer involved with the father of the baby.

In [date], a MASH referral was made by the Assistant Practitioner from the Learning Disability Team who had completed a home visit as support for Maternal Uncle (who was still subject to a CiN Plan). Concerns were raised about the home environment, described as unclean with debris on the walls, flooring and surfaces. During the visit Mother was heard calling CHILD G a slur and swearing in front of her when the phone rang. Concerns were noted about the 'chaotic atmosphere' in the family home. The outcome of the referral was that there was no role for social care. A Social Worker was already visiting the home and no concerns had been observed by her regarding the care of CHILD G and interaction between mother and baby.

Following the decision that there was no role for social care, the Health Visitor contacted MASH to raise a number of concerns: non-engagement with the children's centre; previous history relating to the missing child being located at the family home, Mother staying overnight at supported accommodation with CHILD G; Mother being pregnant again and the language she was observed to use in front of CHILD G. Concerns were also raised that mother was considering moving into a flat with her new partner. The outcome of the contact was advice that the Health Visitor should make a visit and see what support should be put in place for Mother. The chronology indicates that the outreach worker and Health Visitor discussed their disappointment that social care had not taken the case up, but this was not escalated by either agency for reconsideration.

In [date], the Health Visitor completed a home visit for CHILD G's 9-month assessment. CHILD G was noted to be clean and appropriately dressed; she was crawling and pulling herself to stand. The Health Visitor observed her to be very 'responsive and a happy smiley girl'. Mother reported that she was happy about her pregnancy and confirmed who the father was, although he did not want any contact. The Health Visitor recorded that she believed the extended family contributed to the care of CHILD G and would be concerned if Mother and CHILD G lived alone. Although this case was deemed to be Universal Plus, additional support with a Health Visitor seeing the family every six to eight weeks, there is

no further Health Visitor contact with the family until [date – 6 months later] for CHILD F's new birth visit. This was due to the Health Visitor being off sick and the allocation of the case to an alternative Health Visitor not being made.

Mother attended a routine antenatal appointment at 28 weeks gestation. As standard practice, further enquiries about domestic abuse and mental health were made with mother reporting no issues. Mother disclosed that she had a new partner and that they had been together for about 7 months. Mother said that he did not have any children and she was not sure where the relationship was going. No surname for the partner was documented and there was no enquiry about partner's alcohol or drug use.

On the [date], CHILD F was born in at the Hospital. Mother and baby were visited at home two days after the birth, which is understood to be standard practice, and were noted to be well with no concerns. It was also noted that Mother had support from Maternal Grandmother which was seen as positive. Another home visit by the midwife team four days after birth again did not document any concerns for mother or baby.

Following the initial home visits after CHILD F's birth, the Health Visitor struggled to contact Mother and she did not attend a planned postnatal appointment on day eleven. This resulted in a home visit by Health Visitor on [date], the same day the midwife also attempted a home visit. No access was gained to the home by either professional as Maternal Grandmother said that the family had COVID-19 and both CHILD G and CHILD F were staying with a family friend. A further home visit was arranged by the Health Visitor for the [date] but was again cancelled as Maternal Grandmother had COVID-19. The visit took place the following day where CHILD F was observed to alone in the living room, not strapped into a baby bouncer. Concerns were noted about Maternal Grandmother raising her hand to the family dog and shouting at CHILD G. The Health Visitor discussed housing with Mother due to the number of people living in the home and the concerns she had regarding Maternal Grandmother raising her hand and shouting. Maternal Grandmother was apologetic and explained that she would never smack a child.

In [date], a MASH referral was made by Father's Personal Assistant in respect to him being the father of CHILD F and the risks he might pose. The outcome of the referral was a Single Assessment in regard to any contact arrangements Mother intended to put in place between CHILD F and his father. Mother and Maternal Grandmother were clear any contact between CHILD F and his father would be supervised and that Father would not be registered as the father, thereby not giving him any parental responsibility. The assessment concluded that Mother was making good decisions in terms of any contact CHILD F would have with his father and this was seen as protective.

During the Single Assessment, Adult A (mother's partner) was seen in the home and Mother confirmed that they had been in a relationship for 7 months and that the relationship was positive and supportive. No assessment of Adult A was made as part of the Single Assessment.

On [date], Mother contacted NHS 111 as CHILD F was vomiting, not sleeping in his usual routine and had been crying for several days. A home visit by a Nurse Practitioner diagnosed colic. It was noted that CHILD F was not registered at a GP surgery. The allocated Health Visitor took absence from work due to ill health on the [date] and the case remained on her waiting list at Universal Plus service provision and was not allocated to

another Health Visitor. Other agencies were not aware of her absence and that visiting by the Health Visitor was not happening.

On [date], Maternal Step Grandfather contacted NHS 111 to say a child was crying in pain and constipated; they had vomited and had been continually crying for over an hour. Four attempts to contact Mother by a Doctor and Nurse Practitioner resulted in them assuming that the child was 'settled', and the case was closed. This case did not follow the "Failure to Make Contact Policy" correctly. There was a very small amount of time between the last two calls and no dynamic risk assessment documented before closing this case down.

On [date], CHILD F booked into the Emergency Department at Hospital with an injury to his right leg. Hospital contacted Social Care Out of hours service at 01:35 on [subsequent date]. It was agreed the hospital would provide full supervision of Mother and CHILD F until a strategy discussion could be held in the morning. CHILD G was not considered in terms of safety planning and remained in the care of extended family, including Adult A, at the family home. The strategy discussion took place at 11:30am on [date] when the criminal investigation commenced. CHILD G was collected from the family home that afternoon. There were no medical concerns for CHILD G however paediatrician noted a lack of 'stranger danger'. CHILD F is expected to make a full recovery.

CHILD F and CHILD G have been placed with Local Authority foster carers under S20 whilst care proceedings are issued. An application for Interim Care Orders has been made. Mother has been arrested for GBH and neglect with bail conditions in place. Interviews of other potential suspects within the household are being undertaken including Maternal Grandmother, Step Grandfather, Maternal Aunt, Maternal Uncle and Adult A.

Panel Comment: This is a good summary of a very complex case. The Panel thought it was very detailed and could have been further truncated so it reads less like a chronology of events, focussing more on the key practice episodes. However, the table below works well to draw out the key events in regards to agency involvement.

Key events:

DATES (removed)	
	Single assessment in respect of CHILD G, Maternal Aunt and Maternal Uncle following referral received from a neighbouring authority following recovery of a 15-year-old Looked After Child being found at the family's house.
	Outcome of single assessment is a period of Family Key Worker support for CHILD G. Maternal Aunt and Maternal Uncle stay supported at CIN.
	Case closed to Family Key Worker service.
	Period of support for Mother from Children's Centre Outreach Service. Case closed due to non-engagement.

	Antenatal booking appointment.
	MASH contact, concerns raised about home conditions and Mother swearing in front of CHILD G by Assistant Practitioner from Learning Disability Team.
	MASH referral from Health Visitor regarding failed contact and ongoing concerns.
	CHILD F born
	No access to home by agencies due to family having COVID-19 and missed appointments with midwifery team.
	MASH referral by Father's Personal Assistant due to concerns about risk posed by him if he has contact with CHILD F.
	Period of Single Assessment.
	CHILD F booked into Emergency Department following identification of suspected non-accidental injuries.
	Strategy discussion held following safeguarding referral made by the hospital.

5. **Analysis of practice**

The summary above highlights a complex family make up, with a range of vulnerabilities. The case highlights a number of practice themes from the Child Safeguarding Practice Review Panel Annual Report (2020) related to 'stubborn and perennial issues' in child protection, including: understanding what the child's daily life is like; working with families where the engagement is reluctant and sporadic; and critical thinking and challenge.

These are also reflected in the recently published Review of Child Protection in England Report. These practice issues provide a helpful framework through which to consider the practice in this case, whilst being mindful that as yet it is not clear who caused the injuries to CHILD F.

Understanding what the child's daily life is like - It is known that the complexity of situations in vulnerable families can lead to a particular focus on parental needs. This can often get in the way of professionals identifying and understanding risks posed to children. Much of the assessment and direct work in this case was focused on Mother, or risks posed by Father, and there is little evidence of the voice of CHILD G or CHILD F in any agency records seen as part of the Rapid Review. There does not appear to have been any exploration or assessment of attachment between Mother and CHILD G or CHILD F and what this might mean in terms of parenting. There are references to observations of positive interactions however these are contrasted with examples where Mother is heard to swear at CHILD G. There was no analysis of the overall attachment to weigh up why such different observations were being seen. What is clear is that both children were likely to have been receiving care from multiple adults both inside and outside of the home. There are references to a 'chaotic' household with several adults in the property. At no

point does there seem to be full consideration of what this might mean for CHILD G or CHILD F.

Critical thinking and challenge - Critical thinking skills are central to effective safeguarding practice. There was an accepted narrative that Maternal Grandmother was a protective factor although her own children had been subject to Child Protection and Child in Need Plans. Whilst assessments considered Mother's own childhood and experiences of being parented, it did not explicitly analyse this when considering her relative strengths and areas of need within her own parenting.

This case evidenced a lot of activity and agency contact throughout the period of review. There were examples of timely and appropriate information sharing: for example, Ambulance Service contacting the Family Support Worker after they had attended the family home; Father's PA sharing information and raising concerns once it was known that he was CHILD F's Father – this resulted in a further single assessment. There were also examples of referrals to MASH being followed up to find out the outcome. The Rapid Review Panel discussed the lack of any multiagency process and whether there should have been one in place, for example an early support assessment (ESA). It was concluded that an ESA was not appropriate as there were few agencies involved and Mother was not likely to have engaged with this process. However, it was felt that some of the multiagency work was disjointed, and as a result understanding of the vulnerabilities and potential risks was not as comprehensive as it could have been.

Working with families where their engagement is reluctant and sporadic – There were patterns of missed appointments, cancelled home visits, and offers of support not taken up. There are several references to Mother's phone numbers being out of service/changed. However, the level of non-engagement appears to be accepted by all agencies despite Mother's known vulnerabilities, acknowledging that there were no grounds to compel Mother to work with agencies. Mother chose not to work with agencies and there were no grounds to escalate. Whether sufficient effort was made to support engagement is a question we can ask with hindsight, particularly in relation to the exploration of underlying issues giving rise to reluctant or sporadic engagement, but we have no evidence in relation to whether this would have changed the outcome for CHILD F.

Impact of COVID19 - It is important to acknowledge that the period of this review is during the COVID-19 pandemic. Although the impact of COVID19 is not immediately obvious in this case, aside from the no access visits following CHILD F's birth, the rapid review panel sought to understand, whether the circumstances of the pandemic affected the family and the response of professionals.

Discussion focused primarily on professional curiosity, critical thinking, and importance of reflective practice. National and local feedback from practitioners suggest that cases have become more complex following the pandemic. Local demand modelling suggests that this is likely to be as a result of exacerbated family stressors, increased mental health issues, financial pressures and heightened vulnerabilities associated with abuse. It is taking more time for workers to address these multiple risk factors and build relationships with families. All agencies speak of service pressures created by staff sickness absences, exhaustion, a high number of vacancies and difficulties in filling them.

Whilst the importance of case discussion and reflective practice was widely acknowledged by the rapid review panel, it was felt that professionals are often 'firefighting' with little time or 'head space' to be professionally curious, think critically and challenge. COVID-19 has added to the challenges of the recruitment and retention of experienced health and social care staff. Although these challenges existed before the pandemic, they have been made worse by more staff leaving roles in the last two years adding to service pressures.

Invisible Men - Learning has been identified nationally about the necessity for meaningful involvement with and assessment of fathers by professionals working with children, in particular under 1s. There have been many published case reviews where fathers or the partners of mothers are responsible for the death or harm of babies, highlighted in the Child Safeguarding Practice Review Panel report, The Myth of Invisible Men, published in 2021. In this case, there were known risks associated to CHILD F's Father related to domestic abuse, cannabis use and unpredictability and there was evidence of effective information sharing to communicate concerns amongst agencies about him. CHILD F's contact with Father was discussed as part of a Single Assessment and mother was seen to be making good decision about CHILD F's welfare.

It is not clear from the records if any professional fully grasped the relationships Mother had with different men; men who themselves had vulnerabilities including a background of abusive or neglectful parenting. Adult A, Mother's new partner, was not invisible; his details were shared with midwives, and he was seen in the family home, although not spoken to or assessed by the social worker during the single assessment. However, it was accepted that this was a 'supportive and caring' relationship without sufficient assessment of him. Given Mother's history of relationship patterns and the concerns around boundaries when she herself was a child more consideration should have been given to assessing Mother's partner. In contrast the potential risks from Father were well understood and raised immediately once it was known that he was the father of CHILD F. This was good practice.

Panel Comment: This analysis is very good, highlighting the key learning points and failings as well as instances of good practice. The use of the Panel's Annual Report 2020 and national review is very helpful as it structures the analysis around important themes. Although the Panel did not require partnerships to consider the extent to which COVID-19 featured when this rapid review was submitted, it usefully picks up COVID-19 as a barrier to visits and the impact of recruitment and retention of staff.

Recommendation

The rapid review panel considered this information against the criteria for a Child Safeguarding Practice Review, as set out in Working Together 2018 and agreed that there was evidence of physical abuse causing significant injuries to CHILD F.

Much of the learning from this case is not new and reflects some of the themes in the national reports as has already been set out. The safeguarding partnership has already identified the need to prioritise the response to babies under 1yrs old and the understanding of the particular risks they face, as a result of both local and national learning. Safeguarding under 1s is a priority for the safeguarding partnership and a Safeguarding Under 1s Steering Group is now in place to drive an improved system wide response for this vulnerable group.

A local child safeguarding practice review currently being undertaken by the partnership has provided a further focus on under 1s and recommends that the partnership and all its constituent parts should: *"actively adopt a more differentiated and nuanced approach to the development of core safeguarding practice and policies to reflect the particular vulnerabilities of unborn babies and those under 1yrs. This differentiated approach should be applied throughout the safeguarding process to reflect the risks and dangers experienced by under 1yrs as the most vulnerable of all children in the community."* This case reinforces this.

The rapid review identified the key practice issues in the case. Work has already been undertaken by agencies to address specific practice issues raised as set out below.

- Children's social care have implemented actions in relation to the delayed strategy meeting and safety planning for CHILD G: they immediately briefed all Out of Hours staff in relation to calling the Duty Manager in cases where NAI is suspected, safety planning for all siblings and timely strategy discussions. Similarly, Police briefed staff in relation to ensuring no delays in strategy meetings and a daily morning management meeting has been re-established between Police and Children's Social Care.
- Health Visiting have reviewed the process for case allocation in the context of a member of staff going off sick.

Transformation work is taking place to implement a model of Family Help that will create multi-disciplinary teams working in communities. The aim of this work is to improve collaborative working and information sharing below the threshold of social care intervention. Such ways of working may have helped provide a shared understanding of vulnerabilities and risk in this case.

The following have also been identified as actions from this case:

- The Safeguarding Partnership needs to assure itself that it has sufficient line of sight to Health Visiting Service through its quality assurance mechanisms. In addition, it will request:
    - an update on current levels of recruitment and retention and its impact on service delivery
    - update on review of all Universal Plus cases
    - assurance in relation to risk management safeguards put in place when a member of staff goes off sick and comprehensive handover
- Single agencies areas for improvement as identified will be followed up by the Partnership Practice Review Panel.
- A rapid review summary will be sent to all agencies involved to quickly share learning from this case. Although this case meets the criteria for a CSPR, the decision by the local rapid review panel is not to commission a local CSPR as work to address much of the learning and actions are already being undertaken within the work of the partnership and a further review would not add to the learning already identified.

6. Themes of potential national interest:

- The findings in this case mirror the findings already set out in the CSPR Panel Reports, The Myth of Invisible Men and CSPR Panel Annual Report 2020
- The impact of the COVID-19 pandemic on additional layers of complexity for safeguarding practice and wider ongoing service pressures, including recruitment and retention of staff.

[List of rapid review panel members, report author and senior endorsement removed].

Panel Comment: This rapid review culminates in clear actions for the partnership and individual agencies, demonstrating that an LCSPR is not needed due to the learning already being implemented and acted upon.