1 Background and Concerns

Child 3 aged two and Child 4 aged six were removed from their parents care in February 2020 due to domestic violence. The final incident of domestic violence saw father perpetrating violence toward mother, who then stabbed him with a knife. The children became subject to an Interim Care Order and were placed with their maternal Aunt and Uncle. In September 2020 Child 3's nursery reported injuries to Child 3. Children's Social Care enquiries highlighted further injuries that had not been picked up by nursery staff during the absence of the Nursery manager. It was indicated that injuries may have been caused to Child 3 by a young cousin with Aunt and Uncle failing to protect.

2 Purpose of the Review?

The purpose of a Line of Sight review is to identify learning for the multi-agency partnership which will strengthen the safeguarding system. Beyond individual cases reviews they also provide a window into wider systems (ways of working/ processes) which may need to be changed. In this case it was felt that there was an opportunity for learning and practice improvements in several areas.

3 Key Lines of Enquiry

- To what extent practitioners used professional curiosity to explore injuries.
- How training and supervision impacted on decision making.
- To what extent the voice of the child was heard, listened to and acted upon.
- Impact of Covid-19 on practice.

4 Key Practice Episodes

Expected good practice

- Within CSC the case was stepped up when the risks were understood
- The school had clear evidence of the voice of the child.
- There was good information sharing in the health records.
- The police evidenced timely information sharing.

Areas for improvement

- Voice of the child is lacking in all agencies except school.
- Lack of face to face visits to the children by CSC during covid, over reliance on CLA reviews.
- No agency having sight of the children long periods time
- The assessment of the carers may not have been as robust as it should have been due to them being family members.
- Lack of professional curiosity/ challenge by nursery.
- Practitioners viewed injuries as individual occurrences rather than undertaking a holistic assessment.
- Injuries were not recorded consistently in the nursery and safeguarding procedures were not followed
- Lack of supervision and training within the nursery.

5 Learning

- Assurance is needed in respect of the level quality of safeguarding training undertaken by local nurseries
- The SCP required assurance in respect of agencies covid contingency plans
- Professionals need to employ professional curiosity and challenge in respect of the explanations given for childhood injuries
- Agencies need to gain the voice of the child in relation to the child's lived experience and act upon the outcome of this.

6 Progress/Impact

An action plan has been developed which includes:

- Exploration of the safeguarding training trainee nursery nurses undergo whilst in college and the ongoing safeguarding training and safeguarding supervision within nurseries
- Recommendations to the SCP/SAB regarding oversight of covid/business contingency plans
- Practice guidance/practice workshop to be developed in relation to responding to childhood injuries
- Wider work to be planned in relation to supporting agencies to understand the meaning of "voice of the child" and how to assess the child's lived experience

7 Further information

- Threshold of Need
- Referral Process
- SCP Training
- SCP Policies & Procedures
- Line of Sight process