Early years sector: learning from case reviews

Summary of key issues and learning for improved practice in the early years sector

November 2021

Introduction

This briefing is based on case reviews published since 2017 which review early years sector involvement in child protection cases. It summarises and highlights the learning contained in published reports.

Published case reviews highlight that practitioners don't always have the right training to recognise and respond to child protection concerns. Organisations might not have appropriate safeguarding and child protection policies and procedures in place, so practitioners don't know what to do if they do have concerns.

Learning from these case reviews emphasises the need for all staff to have appropriate child protection training and for organisations to have robust policies and procedures that staff understand and follow.

About this briefing

The early years sector comprises of organisations or individuals who care for children aged 0-5. This includes nurseries, pre-schools, children's centres and registered childminders.

Some of the children in these reviews were older than 5 when the incident/s being reviewed happened. However, early years sector involvement was examined as part of the case review.

The children in these case reviews were aged between 3-months and 12-years-old.

Reasons case reviews were commissioned

Reasons case reviews were commissioned include:

- child death or serious injury as a result of suspected abuse and neglect
- neglect
- physical abuse
- child sexual abuse.

Key issues

Recognising and responding to concerns

Some practitioners weren't able to recognise or identify indicators of child abuse, which meant that appropriate action to protect children wasn't taken. In one situation, a manager dismissed concerns about a child having blue lips because the child was 'very small and feels the cold'. The child was later found to have been experiencing neglect and physical abuse.

Some members of staff were aware of concerns about children, but these weren't shared with nominated child protection leads. This was sometimes because the organisation did not have a formal process for recording and responding to concerns.

Sometimes practitioners recognised that a child's parents and carers needed support but didn't consider the impact this would have on their ability to provide safe and loving care for their child or children. This meant the focus was on the adults, with support or services arranged for parents and carers, but children's services weren't informed.

Professional curiosity and understanding the child's lived experience

In some situations, practitioners missed opportunities to find out more about a child's home environment because they were not curious about the child's lived experience outside the setting.

For example, practitioners didn't always seek further information from children, parents or carers when children had bruises or injuries. This meant that possible child protection concerns weren't always recorded or responded to and practitioners weren't able to identify patterns of behaviour that might cause a concern.

Training and supervision

Not all settings provided comprehensive safeguarding and child protection training. This meant that practitioners weren't equipped to recognise concerns and/or respond appropriately with a child-centred approach.

Practitioners didn't always have an understanding of safeguarding and child protection arrangements, such as legal orders or special guardianship orders, and so didn't understand the significance of roles different adults played in a child's life or the dynamics of a family. This meant that practitioners didn't know who had responsibility for a child or understand that a child might have been experiencing a situation that made them more vulnerable or put them at risk.

Practitioners weren't always given opportunities to have regular meetings or discussions with more experienced supervisors or managers. This meant they were less able to raise concerns about children's welfare and get advice about how to proceed. As such, concerns were sometimes overlooked or not followed up.

Similarly, practitioners didn't always have time to reflect together about individual families. This reduced the opportunity to share and explore concerns, recognise patterns of behaviour and build an overall picture of a child's lived experience.

Sharing information with other agencies

In some reviews, early years settings hadn't received relevant information from other agencies working with the child or family. Settings didn't always follow this up or actively seek information about the child's history. This led to practitioners being unaware of previous concerns or vulnerabilities and less able to recognise continuing patterns of behaviour or signs that a child or family needed extra support.

Similarly, staff in early years settings didn't always share information about child protection concerns with other agencies, such as children's services and social workers working with the child, or schools and other early years settings if the child was moving on. This meant that other practitioners working with families didn't have the full picture and their ability to take appropriate protective action was reduced.

In some instances, early years settings had shared concerns with other agencies but other agencies seemed to be taking no action. However, the staff in early years setting didn't follow local escalation procedures to challenge this or raise further concerns. This meant that children and families didn't receive timely safeguarding intervention and/or support.

Learning for improved practice

Recognising and responding to concerns

Early years settings should ensure that there are robust safeguarding and child protection policies and procedures in place and that staff understand and are able to follow them.

Settings should implement a formal system for recording child protection concerns and ensure that all staff know how to use it.

Safeguarding and child protection procedures should include information about how and when to follow up on actions with other agencies, following local escalation processes.

Practitioners should have appropriate training to be able to recognise concerns and know how to record them, who to share them with and how to share them.

Practitioners should also be trained to understand and recognise how challenges being faced by parents might impact on their ability to care for their child and be able to take appropriate action.

Professional curiosity and understanding the child's lived experience

Practitioners should work to build up a picture of a child's lived experience and show curiosity about their life outside of the setting, such as their home environment and family relationships.

If practitioners recognise injuries or bruises that happened outside the setting, they should ask the child open questions, and speak to parents and carers to find out what happened. Any concerns should be shared with the nominated safeguarding lead and/or local authority.

Training and supervision

All staff working in an early years setting should have regular and ongoing safeguarding and child protection training to ensure they know how to recognise and respond to concerns about children and families and escalate these when necessary.

Practitioners should be given opportunities to reflect on any concerns about children and families with colleagues and agree how to respond to these in the child's best interests.

Managers should have sufficient oversight of practice and should engage in reflective supervision with practitioners, including making sure that practitioners are recognising and responding appropriately to any safeguarding and child protection concerns.

Sharing information with other agencies

Nominated child protection leads should know which local agencies they need to share child protection information with and be able to follow local escalation procedures if they feel other agencies aren't taking appropriate action.

Nominated child protection leads should follow up with other agencies if they have not received relevant safeguarding and child protection information about a child.

Early years settings should develop and implement procedures for sharing information with schools and other settings when children move on.

References

A list of the case reviews analysed for this briefing is available on the **NSPCC Library Catalogue**.

The national case review repository makes it easier to access and share learning from published case reviews at local, regional and national level. You can access the repository via the Library.

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