

**5. Speaking Directly with Children**

There were missed opportunities to speak with Toby when safeguarding concerns were raised when he was younger. Children should always be interviewed, ideally alone, when there is an allegation of abuse. Children should be spoken to directly to seek their views about their circumstances and this information should be included in all assessments.

**6. Out of Hours Referrals**

The Rapid Review identified that some agencies made safeguarding referrals in writing to the MASH inbox on the night of the incident, however as this was in the evening outside of working hours (Mon – Fri 9-5pm), the referrals should have been made by phone to the Emergency Duty Team. Instructions on referrals to MASH out of hours have since been clarified so that it is clear that referrals to the Emergency Duty Team can only be made by phone.

**7. Further Reading & Resources**

[Solvent abuse facts & research | Re-Solv Solvent Abuse Charity](https://www.re-solv.org/solvent-abuse-facts-and-research/)

[Honest information about drugs | FRANK (talktofrank.com)](https://www.talktofrank.com/)

[Support we offer | Young People (turning-point.co.uk)](https://www.turning-point.co.uk/support-we-offer/young-people)

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**3. Butane Gas**

The Rapid Review identified a potential concern that organisations running excursions for children/young people may encourage them to acquire and carry their own Butane gas, which is a substance where sales are restricted for under 18 year olds. When inhaled, users describe initially feeling a ‘drunk-like intoxication’ and ‘euphoria.’ However, it has serious adverse effects on an individual’s health. Tolerance can develop quickly, meaning that more of the substance is required to gain the same effect. Following this Rapid Review, the National Child Safeguarding Practice Review Panel has written to organisations that run organised activities for children, asking them to review their policy on use of butane gas for camping excursions. Any organisations that host activities for children should also consider their guidance in relation to access to butane gas.

**2. Background – Toby**

Toby is a teenager who ingested a significant amount butane gas when at home, which caused him to go into cardiac arrest. He had obtained butane gas for an organised trip and said that he had started to inhale small amounts at the suggestion of a friend. While Toby survived this incident, a Rapid Review was undertaken due to historical safeguarding concerns in relation to Toby and his family, and to identify learning in how professional agencies worked together and with Toby and his family.

**4. Understanding a family’s situation and offering support**

The Rapid Review identified that, although safeguarding concerns were raised a number of years ago when Toby was younger, there was a need to strengthen Child and Family Assessment practice as assessments did not provide a clear understanding of the family’s circumstances or the day to day reality for Toby and his siblings.

There was also a need to improve practitioner’s understanding of the cumulative effects of parental acrimony and alienation, how to identify safeguarding concerns in these situations, and appropriate support to offer families to minimised the risk of harm to children.

Furthermore, where a parent is using substances, practitioners should be curious to understand the level of substance use and whether it presents a risk to or impacts on parenting, and to offer support if the parent wishes to reduce or stop using cannabis.

**1. Rapid Reviews**

A Rapid Review is completed by the Local Safeguarding Children Partnership when a child suffers serious harm or dies, and abuse or neglect is known or suspected. The purpose of the Rapid Review is to identify learning among agencies involved with the family, so that improvements can be made to avoid these incidents happening again. At the conclusion of a Rapid Review, the Safeguarding Partners make a decision on whether the criteria are met to commission a Child Safeguarding Practice Review (Working Together to Safeguard Children 2018).

The sections below explain the learning identified in the rapid review for “Toby.” Although the Safeguarding Partners decided that this case did not meet the criteria for a Child Safeguarding Practice Review, professionals should take this learning into account in their daily practice.

