NSPCC Repository – December 2021

In December 2021 eight case reviews were published to the NSPCC Repository featuring a number of issues including adolescent boys, violence, child neglect, and contextual safeguarding

1. Child safeguarding practice review: overview report: Ava, Luca, Harper, and Chloe

Chronic neglect of four siblings over several years. In 2019, two of the siblings aged 1.5-years-old and 2.5-years-old were reported to have been injected with heroin, which was confirmed by a child protection medical examination.

Learning focuses on the following themes: understanding the lived experiences of each child and impact of the behaviour and lifestyle of the parents and carers; responding to neglect; processes around child protection, public law outline (PLO) and placements; adult services' work with parents and incorporating a Think Family approach; multi-agency working and communication; and desensitisation and professional culture.

Recommendations include: examine the current position relating to neglect in the local area; ensure that that PLO processes are being conducted in a timely way and any delays and risks are addressed immediately; ensure a partnership approach in supporting families involved in PLO proceedings and related matters; provide training to the multi-agency workforce on working with families significantly affected by substance misuse; promote the use of the resolving professional disagreements protocol and the role of the child protection conference chair as a point of reference for any professional who is concerned about the progress of a child protection plan; provide opportunities within training for professionals to focus on desensitisation and the impact this may have on the children and families receiving support.

Other resources Read practice review (PDF)

2. Serious case review: overview report: Child LT

Injuries to a 3-month-old infant in June 2018 consistent with having been severely shaken and from impact with a hard surface. Father was arrested and criminal investigation is ongoing.

Learning focuses on: the extent to which practitioners considered the impact of father's mental health issues on his parenting capacity; mother's disclosure of domestic violence and abuse and the professional response to this; the effectiveness of interpreter services; the lived experiences of Child LT and sibling.

Recommendations include: ensure that risk assessments address the impact of parental mental ill health on children; promote awareness of the ways in which parental mental ill health can result in abuse or neglect of children and the key issues for practitioners to consider when assessing the risks to children; ensure that hospital staff fully explore a patient's presentation after suspected self-harm, make referrals for hospital mental health assessments and consider any safeguarding issues; promote the Think Family

approach; consider advising the National Child Safeguarding Practice Review Panel of the interpretation challenges highlighted by this case; promote the need for practitioners to provide advice on coping with crying babies to parents when using interpreters.

Other resources Read overview report

3. Serious case review: Child W: review report (full overview report)

Death of an 8-week-old infant girl in September 2018. The post-mortem revealed non-accidental head injuries and fractures. Father was subsequently convicted of murder and mother was convicted of allowing death.

Learning includes: predisposing risks and vulnerabilities need to be considered when deciding if a pre-birth assessment is required; the need to support children in care and care leavers who become parents as a part of corporate parenting; consider the additional support a family may require following an early birth and when a baby is in a neonatal unit; information should be sought from other local authority areas if a family have moved and it is believed there is historic safeguarding information; partner agencies should be asked to check what historic safeguarding information they hold on family members, and there should be proactive information sharing when concerns emerge.

Recommendations include: the safeguarding partnership alerts the Department of Health and the Home Office to the need to review national guidelines so that CT scans and full skeletal surveys are carried out immediately on infants and young children who have died from unexpected or unexplained causes, and where there are siblings who may need to be safeguarded; the safeguarding partnership and partner agencies explore how they can use multi-agency programmes to promote the safe handling of babies.

Other resources Read full overview (PDF)

4. Learning review 'Leo': overview summary

Murder of a 17-year-old boy from multiple stab wounds believed to have been inflicted by a several other young people. Leo had special educational needs (SEN) as a result of his severe difficulties with speech and language.

Learning and recommendations are combined and include: ensure that professionals have access to good training on the signs, symptoms and impact of speech, language and communication disorders, prioritising staff working with children at risk of offending; ask that agencies take all reasonable steps to identify and engage the fathers of children and young people with whom they are having contact; the Youth Offending Service should ensure that being charged with a violent offence triggers a multi-disciplinary assessment of need and risk.

Other resources Read learning report (PDF)

5. Serious case review: 'Baby S' (full overview report)

Death of a 5-month-old infant girl in April 2016 due to injuries caused by shaking. Mother stood trial in 2019 and was found not guilty of manslaughter.

Learning includes: a more 'enquiring' approach to the familial circumstances might have highlighted a variety of additional needs and better-informed agency responses; professional curiosity is required and justified in all, not just troubling, situations.

Recommendations include: GP practices should capture in records which adult presents a child and ensure that immunisations or other medical interventions have fully informed consent, from a parent or person with parental responsibility; NHS Trusts should remind staff that effective record keeping requires evaluated observations of a child's familial circumstances, behaviours of its members and any additional support needs.

Other resources Read full overview (PDF)

6. Serious youth violence: thematic serious case review

Review of the services provided for three teenage boys following a serious knife crime in 2018 in which one of the boys was seriously injured. Considers what led to the boys' involvement in serious youth offending and ways in which professional interventions may have safeguarded them more effectively.

Recommendations include: ensure that primary schools are able to identify children who show severe behavioural difficulties, respond to their needs and make an appropriate referral for additional early help services; ensure that early help interventions are family-focused and take a full account of the child's history; ensure that secondary school transfer arrangements identify any child who has shown severe behaviour problems in primary school; ensure that policies, procedures and practice reflect the best current thinking about contextual safeguarding risks; and ensure that agencies and partnerships actively engage with black and minority ethnic communities over the prevention and reduction of serious youth violence.

Other resources Read review (PDF)

7. Suicide in children and young people: thematic analysis 2014-2018

Thematic review of adolescent suicides, analysing five reports relating to the suspected suicides of young people between May 2014 and June 2018.

Learning includes: the interface between different specialist health services and other organisations is a vital, but vulnerable, line of demarcation and may be decisive in determining effective service response; suicidal ideations and suicidal plans may not be a reliable indicator of intent to commit suicide, therefore a comprehensive assessment is required; consideration should be given to a 'trigger event phase' that may capture deterioration in presentation; consideration should be given to how to support family survivors of suicide.

Recommendations include: GPs and school teaching staff should be an integral part of the inter-professional holding network and receive training commensurate with this role; professionals need to have greater awareness of young people's use of online activity and social media; professionals need to respond with a comprehensive and immediate psychosocial assessment of the young person and their engagement in a therapeutic relationship; ensure that there is timely and proportionate access to mental health services with emphasis on direct positive engagement, comprehensive assessment and necessary treatments; listening to and learning from young people and their families must be used in creating preventative suicide strategies.

Other resources Read thematic analysis (PDF)

8. Child practice review report (final): re: Child D

Death of a 6-week-old infant in April 2014. Both parents received prison sentences for offences of child cruelty and causing or allowing the death of Child D.

No specific learning was identified.

Recommendations include: ensure that midwifery, health visiting and early help assessment records include a standard section that prompts practitioners to ask questions about whether either parent/carer has any other children and if so the level of contact held with their children.

Other resources Read child practice review (PDF)