NSPCC Repository – April 2022

In April 2022 eight case reviews were published to the NSPCC Repository featuring a number of issues including infant deaths, children's rights, racism, child neglect, and murder

1. Serious Case Review overview report: Sarah

Death of an 8-day-old baby in Summer 2017 following head trauma caused by shaking.

Learning includes: maternity services should ensure written records reflect the needs of mother and baby; support plans should be clearly documented to ensure links with early help teams; when significant support is in place for a family it is good practice to hold a professionals' meeting before that support network is closed; maternity services must ensure that there is a full transfer of information in cases where a pregnant mother moves from one area to another; where appointments are missed there should be an effective follow up mechanism; health visitors should follow standard operating procedures when a patient is transferred from one area to another; when a pregnant patient fails to attend appointments, it is critical that these failures are correctly recorded and that a follow up is carried out according to procedures; the need for professionals to have a robust discharge plan for mothers to provide protection and support, including who is responsible; professionals in health and social care need to better understand structures and processes to improve information sharing and joint working.

Recommends that the local children's safeguarding assurance partnership should ensure that the learning points raised are subject to a SMART action plan.

Other resources Read full overview (PDF)

2. Local Child Safeguarding Practice Review: Child Q

Child Q, a girl of secondary school age, was strip searched by female police officers from the Metropolitan Police Service in 2020. The search, which involved the exposure of Child Q's intimate body parts, took place on school premises without an appropriate adult present and with the knowledge that Child Q was menstruating.

Learning includes: the decision to strip search Child Q was insufficiently attuned to her best interests or right to privacy; all practitioners need to be mindful of their duties to uphold the best interests of children; school staff had an insufficient focus on the safeguarding needs of Child Q when responding to concerns about suspected drug use; the application of the law and policy governing the strip searching of children can be variable and open to interpretation; the absence of any specific requirement to seek parental consent when strip searching children undermines the principles of parental responsibility and partnership working with parents to safeguard children; adultification bias is believed to have a significance to the experience of Child Q; racism (whether deliberate or not) was likely to have been an influencing factor in the decision to undertake a strip search.

Makes 14 recommendations to improve practice, including: the Department for Education should review and revise its guidance on Searching, Screening and Confiscation (2018) to include more explicit reference to safeguarding and to amend its use of inappropriate language; police guidance governing the policy on strip searching children should clearly define the need to focus on the safeguarding needs of children; where any suspicion of harm arises by way of concerns for potential or actual substance misuse, practitioners should contact children's social care to make a referral or seek further advice.

Other resources Read practice review (PDF)

3. Child Safeguarding Practice Review: Ben

Death of a 2-year-1-month-old boy in in October 2019. Ben died from significant non-accidental injuries; his mother and her partner were charged with murder and causing or allowing the death of a child.

Learning includes: the need to consider a multi-disciplinary response when assessing head injuries, especially in young children; the importance of informing referring agencies when a referral is not accepted, and why; the need to understand how parenting education is provided for new and inexperienced parents; considering 'was not brought' (to medical appointments) as a possible indicator of neglect of young children; keeping the child in mind and the child's experience central; the challenges of seeking to engage vulnerable parents who choose not to engage; assessing the risk of domestic abuse and supporting women who have experienced domestic abuse; tracking known violent adults and identifying them when there are concerns about children with whom they are in contact.

Recommendations include: consider routine progression to a child and family assessment for any child with an injury when requested by health professionals; inter-agency dialogue about next steps when a child requires in-patient observation or a skeletal survey following a serious unexplained injury; review the guidance to GP practices on linking parent and child records and childcare alerts to ensure that the child's vulnerability is noted on the parent's record; review the routine enquiry policy for midwives and health visitors.

Other resources Read practice review (PDF)

4. Learning Review Report: William

Serious neglect of a 12-year-old boy identified at admission to hospital in April 2020.

Learning includes: need to develop clear treatment pathways for specialist services; need for patient information for a family which details what the parental or carer expectations are to support the child's treatment; need for managerial oversight and supervision in complex cases, especially where there are concerns regarding parental engagement and compliance with advice and treatment; past information about a child and their parents

or carers should inform the child's future health care; have honest and clear conversations with parents about their role in supporting health needs and what will happen if those needs are not met; be 'professionally curious' about information provided by parents and how that impacts upon the care provided; professionals supplying referral information or agency reports for meetings need to be explicit when there are safeguarding concerns about a child; importance of seeking specialist support to ensure medical tests are completed in a timely manner; have robust conversations with other agencies to ensure they understand the significance of a child not having important medical tests completed.

Makes no specific recommendations.

Other resources Read learning review (PDF)

5. Serious Case Review: Child P

Death of a 5-week-old infant in 2019 due to severe, widespread and irreversible brain injury. Child P was admitted to hospital in an unresponsive state and died three days later. Both parents were arrested and subject to criminal investigations. Mother was subsequently convicted of manslaughter.

Identifies learning for all agencies around the following themes: information sharing and assessment of risk; professional over optimism and professional curiosity; and substance misuse. Identifies learning for individual agencies: the missed appointment policy should be reviewed to add guidance around recognising disguised or unhelpful compliance (midwifery and neonatal services); limited information was known about the father, and no consideration was given to him being an unidentified adult in that household (health visiting). Identifies areas of good practice.

Recommendations include: request health partner agencies to review and develop guidance on the use of vulnerable families meetings to share information and assess risk; promote awareness and undertake training on the themes of professional over optimism and professional curiosity; request that health agencies review their missed appointments policies to ensure this is identified as a potential risk factor, alongside apparent compliance; consider developing best practice guidance and training for universal services on responding to potential risk issues of substance misuse by parents.

Other resources Read full overview (PDF)

6. Serious Case Review: Child N

Death of a 13-week-old child due to injuries consistent with trauma. In all there were 41 separate injuries including fractures to her ribs and spine. Child N's mother and her partner were convicted of offences relating to her death and are serving prison sentences.

Learning includes: the importance of accessing and analysing historical information about families; the potential risks from the mother's new partner were not understood; the need for practitioners to comprehend fully the significance of bruising to non-mobile infants; transfers of case responsibility between teams, individuals and services were

problematic and would have benefitted from a more collaborative child centred approach; inconsistent understanding of the significance of faltering weight and growth measurements in babies; the over reliance on members of the extended family as a protective factor; and the failure to reassess when different information emerges.

Recommendations are made in the following areas: antenatal identification of need and risk; background family information; bruising policy; case transfer; poor weight gain, neglect and faltering growth; and assessment of extended family.

Other resources Read overview report

7. Child Safeguarding Practice Review: STORK: babies with injuries

Two cases of non-accidental head injuries and bruising of 14-week-old infants. A bruise was observed on Baby 1 two months prior to injuries; Baby 2 was in the care of their father at the time of the incident.

Learning includes: advice on safe sleeping and safe handling needs to be provided to both parents; professionals need to consider how they can meaningfully engage with fathers, including those who do not live with the child; awareness of the impact of having a new baby on fathers as well as mothers; if information about a new baby is not shared directly with a health visitor, it cannot be guaranteed with current systems that all important information will be known by them; even a small bruise on an infant needs to be recognised as a potential warning injury by professionals; family members should not have unsupervised contact with their child in hospital if a non-accidental injury may be the reason for attendance.

Recommendations to the safeguarding children partnership include: use learning from the next national child safeguarding practice review to explore what can be done to improve the involvement of fathers in work with families with new babies; undertake work to provide a better understanding of the role of fathers and the need to engage with fathers, and consider projects in other parts of the country; seek assurance from partner agencies regarding knowledge and use of the injuries in non-mobile babies policy.

Other resources Read practice review (PDF)

8. Child G

Attempted suicide by a 7-year-old child at the family home. Sixteen months prior to this event, Child G had disclosed that they had been sexually abused on two occasions by their stepfather. Learning includes: it is important to continue to communicate with children about their world; professionals need to be reflective in the context of what may be a change in the child's priorities rather than adhere exclusively to an adult assumption of what the child requires; consider a more judicious use of care planning forums when there is lack of clarity about what the options are in reducing risk within families; there should be more effective planning, assessment and recording at all stages of the achieve best evidence (ABE) process.

Recommendations include: for agencies to consider the importance of not making assumptions about the source of a child's distress in the absence of speaking to the child directly, and the clarity about a plan to work together concerning how the child's needs are met while awaiting specialist assessment; ensure that procedures for convening multi-agency meetings are followed, to allow for clearer planning and communication between agencies; ABE interviews should be carefully planned and appropriately documented, in line with expected good practice and guidance, and there should always be consideration as to whether a further strategy meeting is required following the ABE interview.

Other resources Read full overview (PDF)