NSPCC Repository – May 2023

In May 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including parents with a mental health problem, and non-accidental injuries

1. Local child safeguarding practice review (LCSPR): Child A

A 16-year-old girl in local authority care detained under the Mental Health Act in November 2019, following an incident where she stated she intended to take her own life.

Learning includes: professional bias must be acknowledged and managed when working with a child who appears capable and articulate; supervision, including inter-disciplinary group supervision, is important for professionals working with highly complex families; when a child does not want to share allegations with the police or withdraws them, consideration should still be given as to whether a criminal investigation is required and whether there is a need to safeguard the child through other proceedings; professionals need to be clear about the law regarding child sexual exploitation, particularly relating to 16-17-year-olds; face to face meetings can help to ensure optimum information sharing when a child is living outside of their home area; it is important for a child who is placed in another area to keep as many key professional relationships as possible.

Recommendations include: ensure professionals in partner agencies have an awareness of mental health systems and understand how vulnerable children can access support; consider how professionals in partner agencies are supported to work with families who resist offers of support; use the direct words of Child A (including in the report) when training professionals and in supervision, to help provide an understanding of the impact of systems and practice on children who have mental health concerns and those at risk of exploitation.

Other resources Read practice review (PDF)

2. Serious case review in respect of Child K

Suspected non-accidental injury to a 4-month-old-infant in 2018.

Learning themes include: offering families early help; considering the nature of engagement and the refusal to engage with early help; understanding parental risk factors such as parental learning disability, domestic abuse, parental mental health, and parental drug use; considering new information regarding risk including anonymous concerns; environmental difficulties such as housing, homelessness and poverty; neglect and its impact upon child development; seeing patterns of neglect and understanding changes in families in relation to neglect; and communication and information sharing.

Recommendations include: consider how to enhance practice and processes to offer the right support to families in cases where early help is refused and unmet need results in repeated contacts being reported; ensure that practitioners respond to new information in the light of the possibility of cumulative harm to a child; revise and refresh the procedures, practice guidance and

training in identifying, assessing and making effective interventions where there is suspected parental learning disability or difficulty; ensure that practitioners understand the specifics of the parental risk factors as described in the local neglect strategy when working with any family; when responding to anonymous concerns to any agency, practice should be on a par with other contacts in terms of the scrutiny and weight given to the likelihood and impact of the risk identified by the anonymous referrer and should always be considered within the broader context of what is known about the family; and ensure that information sharing in safeguarding work is effective and serves to support the safety of children.

Other resources Read practice review (PDF)

3. Local child safeguarding practice review: Child B

Death of a 4-year-8-month-old boy in December 2020. His mother admitted to drowning him in the bath.

Learning includes: recognise that children in need and who no longer require a child protection plan can potentially have long-lasting vulnerabilities or risks of harm; inaccurate or imprecise language such as 'children doing well' may not support critical thinking and can give false assurances; the importance of recognising the interaction of mental health and other risk factors such as adverse childhood experiences of the parent; the importance of responding to changing risk and need; and the importance of adult orientated issues being assessed in their own right and for their impact on the child.

Recommendations include: revise guidance for assessments and reviews within the community mental health service; reinforce the Think Family approach to safeguarding and promote joint working across adult and children services; consider using an interpreter or alternative forms of communication when imparting complex medical information to a parent for whom English is a second language; information sharing when a child is given a diagnosis and a parent is known to adult mental health services; staff remain curious with regard to culture and family composition, and understand the cultural impact of diagnosis of children with additional needs; an established process for stepdown from a child in need plan to an early help plan; and the inclusion of important historical information when services make referrals to early years services or schools.

Other resources Read practice review (PDF)

4. Child safeguarding practice review: Child F

Death of Child F, aged 6-months-old, as a result of head, spinal and eye injuries in February 2021.

Learning includes: considering the emotional impact on the parents of an unexpected diagnosis of a serious health condition shortly after birth; the impact of additional costs when children are in hospital for prolonged periods and/or there are practical problems caring for siblings; the importance of midwives and health visitors knowing details of babies' health conditions so they can assess mothers' mental health; benefits of having the same interpreter for parents who need long term support; consider parents' cultural backgrounds and how they might affect their

understanding and response to their child's diagnosis; and the benefits of providing written information in parents' first language.

Recommendations include: develop training and briefing materials for practitioners about working with Black and Minority Ethnic people; ensure hospitals caring for local children have arrangements in place to improve practitioner awareness about practical and financial help for parents with children in hospital; seek assurance that arrangements are in place to improve practitioner awareness about assessment entitlement for children if they stay in one or more hospital settings for three or more consecutive months and for parents caring for disabled children; consider how best to improve information sharing between neonatal and paediatric intensive care services and midwifery and health visiting services; and ensure hospitals that provide neonatal care for babies have effective pathways to enable staff to break the news and provide prompt support for families whose babies are diagnosed with an unexpected health condition or disability.

Other resources Read practice review (PDF)

5. Multi-agency review of 'Lucy'

Lucy was a 20-month-old girl in May 2019 when she was attacked by the father's dog.

Learning includes: ensure professionals' have an adequate understanding of integrated offender management (IOM) and how individuals are managed under the framework; explore which opportunities for information sharing exist between IOM and non-participating agencies; ensure professionals are aware of the differences, and the potential differences in approach, between child protection plans and care orders where the child is placed at home and not with a foster family; and ensure multi-agency understanding of non-molestation and restraining orders, and the opportunities and consequences for professionals working with cases where they apply.

Recommendations include: there is a need for multi-agency awareness training around the role of IOM, and the effect of non-molestation and restraining orders; professionals from all agencies need a greater understanding of how some children can be subject to care orders but continue to live with a parent and the associated levels of risk; agencies need to review their IT systems to assess if the appropriate information is recorded or can be recorded for children on child protection plans and those on care orders but placed at home; and children's services should review their process for notifying and involving other agencies of children on care orders at home, to ensure that all relevant agencies are informed of the risks and plans in place and are sharing information adequately.

Other resources Read review (PDF)

6. Child E: serious case review (executive summary)

Non-accidental injuries to a ten-month-old in 2017.

Learning and recommendations include: a need to ensure that every child subject to a multi-agency plan has a safety plan in place that is commonly understood by professionals, relevant family members and the child where appropriate; ensure action is taken to enhance the

ownership of child in need plans amongst constituent agencies; support the development of critical thinking skills to enhance professional curiosity and analytical approaches to decision making; ensure gaps in understanding of sexual abuse and specialist services is addressed; request briefing from key organisations working primarily with babies how the issues of risk of abusive head trauma is being addressed and in particular, how consciousness is raised for professionals; and ensure that at all routine health contacts it will be evidenced that safe handling is discussed, and consistent and research-based information given to carers.

Other resources Read executive summary (PDF)