NSPCC Repository – December 2023

In December 2023 six case reviews were published to the NSPCC Repository featuring a number of issues including neglect, suicide, and parental mental ill health
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Local child safeguarding practice review: The siblings

Covers an 18-month period of a parent suffering complex and enduring mental health problems including intrusive thoughts about harming their own children.

Learning themes include: mitigating the risks of harm to children where parents have mental health difficulties; the impact of the parent's mental health difficulties on the children; ensuring that children with disabilities and differing communication styles are supported and heard; young carers and help-seeking behaviour; and stability in practical living arrangements and attachment relationships.

Recommendations for the local children's safeguarding partnership include: update the guidance 'Children at Risk where a Parent has a Mental Health Problem: Inter Agency Safeguarding and Child Protection Procedure' to include the needs of children specifically and what help and support they might need, including children with disabilities and the requirement for a young carers assessment and factors to consider; update practice expectations to take account of the needs for children with disabilities, making clear that children with disabilities will have many professionals and family members who are experts on a child's preferred communication style; make clear the circumstances in which child and family assessments will be shared with agencies who will be supporting children who are subject to Child in Need plans; update the guidance regarding Child in Need meetings to consider timetabling requirements so that all those agencies working with a family can attend and make clear that the decision to end a Child in Need plan should not be made without a clear step-down process.

Other resources Read practice review (PDF)

2. Child safeguarding practice review: Chloe

Death of a 17-year-old girl, Chloe, by suicide when in a state of mental crisis.

Findings include: the need for resources to be available to support families in a child's early years; language used by professionals to describe help seeking behaviour can infer judgement or nuanced negative undertones; the importance of family, friends and kinship for children who are looked after; the importance of a sense of self for children who are looked after.

Recommendations for the partnership include: consider how to build a child's sense of identity using existing processes; assess progress made following the vulnerable adolescent thematic review, with a particular focus on how trauma-informed practices are being enacted in services provided, and are supporting the multi-agency workforce; guided by the national reviews, embed

relevant learning in mental health and wellbeing services for survivors of CSA; ensure the therapeutic work a child needs is detailed in a child's care plan; criminal compensation should be pursued for all children who have been the victim of sexual abuse; identify opportunities to provide support to carers in the local area and for this scaffold of care to be detailed in a child's care plan; consider how to reduce false transition points within agencies (including the private and voluntary sector) to maximise opportunities for practitioners to build consistent relationships with children; promote the briefing by the NSPCC on findings from young people who complete suicide, in particular the advice that suicide threats should be routinely assessed for motivation and level of intent.

Other resources Read practice review (PDF)

3. Child safeguarding practice review: MDS20 and PDS20

Serious neglect of two young people from two separate families.

Learning themes include: disguised compliance and professional curiosity; escalating concerns at an earlier stage; the welfare of pupils who become long term absent from school; identifying potential neglect of young people and assessing the abilities of parents to respond appropriately; safeguarding pupils who are the subject of applications to be electively home educated; the voice of the child and action taken following repeated concerns from a parent followed by cancelled appointments; ensuring the safety of children whilst they are on CAMHS waiting lists; parental mental health and its impact on their ability to address the neglect of the young person.

Recommendations to the Partnership include: ensure that all child protection training reminds practitioners that procedures and guidance apply to all children irrespective of age; include the risks related to prolonged periods in bed into existing child protection training; consider how practitioners/managers can be supported to reframe the concept of service users "failure to engage" to that of how can practitioners work persistently and creatively to engage children and their carers?; work with schools to identify training packages/requirements for attendance workers and seek to strengthen the arrangements for assessing the welfare of children not in school; seek assurance that all agencies understand the routes to an Early Help Assessment and that such assessments are completed where required; seek assurance that all practitioners are familiar with, and use where appropriate, the Graded Care Profile along with other tools that can be used when undertaking assessments.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Family CC

Significant neglect of a large sibling group by their parents.

Learning themes include: working with parents who are highly resistant/hostile to agency approaches or display disguised compliance; safeguarding children who are electively home educated in the context of neglectful parenting; relevance of neglect/abuse of animals when assessing risks to children; relevance of family history when screening for service delivery; and role of voluntary sector agencies in providing support to vulnerable families.

Recommendations include: review processes for professionals working with resistant parents with sufficient focus on understanding the relevance of family history and the lived experience of the child; request that health agencies consider the issue of fabricated illness in this context and require health professionals to not rely solely on evidence reported by parents; adapt child social care audit processes so that any child protection plan that ends after three months is audited by a senior manager; develop the neglect policy and training for professionals to consider the needs of children who are electively home educated, with any concerns triggering an assessment of parenting skills; request all agencies review their recording systems to ensure that workers screening referrals or starting assessments can review the wider family history and any previous agency involvement; consider how to better involve voluntary sector agencies in the multi-agency safeguarding processes; and consider whether multi-agency safeguarding assessments have sufficient focus on fathers and other significant males.

Other resources Read practice review (PDF)

5. Child safeguarding practice review report: Children N and O

Fatal stabbing of a 16-year-old-boy by a 17-year-old boy in November 2020. Child N and Child O knew each other through peers but had no contact until a few days before the murder.

Learning themes include: agency responses to both boys criminal activity; the complexity of working with vulnerable children with links to gangs, who have police, social work and youth offending service (YOS) involvement, especially when a child is in care and moves placements between local authorities; the importance of education as a protective factor for children; and the importance of practitioners having strong relationships with young people as a significant factor in reducing offending behaviour and improving outcomes in general.

Recommendations for the Partnerships include: supporting the development of arrangements which will result in detailed operational multi-agency, multi-disciplinary risk management pathways for individual children most vulnerable to being involved in violent incidents due to their involvement in gangs, including children moving areas for their own protection; supporting the development of more alternative educational and training options for children who have disengaged or been excluded from school; reinforce with practitioners the importance of young people having strong and enduring relationships and recognising the impact on young people when practitioners change; ensure risk assessment checks are completed for every potential change of address prior to accommodation being confirmed; improve information sharing arrangements between the Criminal Justice Liaison and Diversion (CJLD) service and the YOS; and improve the availability of placements for children at risk in the community.

Other resources Read practice review (PDF)

6. Child safeguarding practice review: Hazel and Lilly

Death of a 16-year-old girl in 2021. Hazel took her own life. Hazel and her sister Lilly received multi-agency services in response to concerns about maternal care in childhood and in response to emerging mental ill health in adolescence.

Learning themes include: understanding and responding to the risk of suicide as a safeguarding concern; safeguarding children across multi-agency boundaries; schools knowing children and understanding risks; caring for traumatised children; the importance of family networks; paying attention to the language used when recording what children say; and the impact of the coronavirus pandemic.

Recommendations for local safeguarding children partnerships involved in the case include: seek representation from services to understand how the risk of suicide and the impact of related factors are understood, and what service changes are in place that prompt a timely safeguarding response to children in real time; consider how a trauma-informed culture across the multi-agency partnership is being implemented, including how parents/carers of children are supported to understand the impact of trauma on the child and family; evaluate how wider family and kin-networks feature in safeguarding activity, including involvement in safety planning; consider what changes may be needed to enable the sharing of a child's story across services to minimise re-traumatisation, and how nominated trusted adults might be supported to understand a child's lived experiences; and make representations to the relevant national qualifying authorities, raising the importance of training and support for practitioners in understanding and responding to adolescent mental ill health and wellbeing, and the impact of secondary trauma.

Other resources Read practice review (PDF)