NSPCC Repository May 2024

In May 2024 eight case reviews were published to the NSPCC Repository featuring a number of issues including family reunification, medical care neglect, child criminal exploitation, and physical abuse
Previous NSPCC Repositories and published Torbay case reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Serious case review: the importance of early panning and continuity of care for children with complex health needs (BSCB 2018-19/01)

Life changing injuries to a 3-year-old child in November 2017 whilst in the care of their parents. Evidence was found of old fractures and bleeding on the brain. After two years in hospital the child was discharged to parents. Mother was found guilty of child neglect in July 2020.

Learning points include: assessments of parenting capacity to fully consider the impact of the experiences of asylum seekers in their countries of origin and the potential for post-traumatic stress disorder and potential isolation in the UK; the need for professionals to understand national and local asylum seeking systems and processes, the role of the Home Office and contracted services, and local arrangements for support; the importance of early help to support first-time parents facing complex challenges and the need for comprehensive and holistic assessments; health professionals should consistently follow the 'was not brought' policy and inform social workers involved with the child concerned; the need for robust discharge planning for premature babies and children with complex needs; when children present with unexplained or suspicious injuries, professionals to exercise professional curiosity, healthy scepticism, respectful uncertainty, and work to avoid assumptions and the rule of optimism; following child protection procedures when a child is in hospital with a non-accidental injury; timely progress of plans to initiate care proceedings; and the importance of effective multi-agency communication between children's social care and hospital providers, including the appropriate level of supervised contact for parents with their child in hospital.

Recommendations are embedded in the learning points.

Other resources Read practice review (PDF)

2. Theo: local child safeguarding practice review

Death of a 10-month-old boy while in his parents' care. On examination, Theo was found to have multiple injuries. Evidence suggests his death was likely to have been the result of abuse.

Learning themes include: the quality of 'parenting assessments' and 'social work assessments'; recognising the difference between 'family arrangements' and being looked after; the effective use of pre-proceedings; concealed pregnancy; parental cannabis misuse; increasing the level of multi-agency work in care proceedings; reunifying children with their parents' during care

proceedings; working with families who appear to be avoiding contact with professionals; responding to issues of domestic violence and abuse; and workforce issues.

Recommendations to the Partnership include: undertake a multi-agency audit of recent parenting assessments to evaluate the quality of analysis and conclusions and the effectiveness of information-sharing and professional challenge; ask the local authority to provide evidence of its improved practice in distinguishing between 'family arrangements' and 'placements'; ask the local authority to provide evidence of the improved effectiveness of pre-proceedings work with children and parents; revise its procedures and guidance in respect of concealed pregnancy; encourage local public health commissioners of substance misuse services and the local authority to develop a working joint protocol in line with guidance; work with the local authority's legal service to develop and implement a practice model that will enable effective multi-agency work while children are subjects of care proceedings; complete a multi-agency audit of cases where children were reunified with parents in pre-proceedings or during care proceedings; seek a report from its Domestic Abuse Strategy Lead to verify that child safeguarding partners have arrangements in place to deliver an effective local response to domestic abuse.

Other resources Read practice review (PDF)

3. Local child safeguarding practice review: child 'Jay'

Removal of a child from his mother's care after an NSPCC referral in December 2021. A paediatric medical was undertaken and concluded Jay's injuries were non-accidental.

Learning themes include: cross borough practice; antenatal care and support from mental health services; risk assessment, intervention and multi-agency decision making; and agency responses to parents who struggle to engage.

Recommendations to the Partnership(s) include: write to NHS England to emphasise that written communication provided for patients on GP registration should be more explicit about whole family registration; when family members are registered at different GP practices safeguarding agencies need to ensure that they have the correct details for each family member; review the multi-agency training on parental mental ill health and ensure that staff working with parents have an appropriate level of skill and expertise to assess and intervene; promote awareness for safeguarding professionals on mental health assessment and interventions for parents of young babies; a mechanism should be established between the health visitor and GP, so that following multidisciplinary discussions, there is a shared understanding of actions, by when and by whom; decisions to close children's casefiles in safeguarding agencies should be communicated to all involved and if there is professional disagreement about that decision, agencies should use the existing escalation processes; review the use of their existing Escalation and Resolution Protocol and make sure all professionals are aware of its use; and ensure that all multi-agency safeguarding training explicitly reminds professionals of the crucial roles of birth fathers and carers in a child's life.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Child HN

Suspected diabetes mismanagement of an adolescent boy after he presented at hospital in a critical state in March 2023.

Learning themes include: management of type 1 diabetes; cross-border working together; understanding an adolescent's world; working effectively with families; and assessing medical neglect to inform levels of need and intervention when working with adolescents with chronic conditions.

Recommendations to the Partnership include: ask the National Panel to consider the benefits of producing national multi-agency guidance on the management of chronic health conditions in children; ensure that the roll-out of child neglect tools and training is updated and includes guidance on understanding and identifying what constitutes medical neglect; run a series of multi-agency practice learning briefings on direct work and voice of the child; address the quality of CIN Plans and communication with partner agencies, including ensuring minutes are circulated to all partner agencies and the family in a timely manner; in line with NICE Guidelines a task and finish group should find a solution to ensuring that children and young people with type 1 or type 2 diabetes are able to see a mental health professional who is skilled to understand their issues, including psychological barriers that children with diabetes can have; review the guidance for both regions around protecting children and families who move across local authority borders, ensuring that they are aligned and include guidance on information sharing when a family move into a refuge and are subject to a statutory plan, as well as information about cross-border transfer of children with chronic health conditions.

Other resources Read practice review (PDF)

5. Child safeguarding practice review: Child S1 summary report

Suicide of a 17-year-old girl in 2021. Child S1 was sexually exploited as a young teenager and was made subject to a care order in 2018. Child S1 spent two years in a therapeutic residence, before returning home to live with her mother.

Learning considers: the visible and hidden complexities of childhood trauma; awareness of foetal alcohol spectrum disorder (FASD); trauma-informed practice; appropriate professionals in attendance at multi-agency meetings; individual and collective interventions; risk assessment and risk of death through self-harming behaviours; children's plans; safety plans; chronology of significant impact events; and management of adolescent risk when threats to life have been identified.

Recommendations include: the partnership to request an early review of the local authority's 2020-24 suicide prevention strategy to specifically address risk in respect of adolescent children, including response to alcohol and substance misuse and emotional and mental health difficulties, and guidance around the timing and completion of risk assessments across health and social care; CAMHS to provide expert advice and guidance to multi-disciplinary teams when plans are being formulated to respond to adolescent suicide and self-harm; the partnership to seek assurance from children's health and social care services that they have systems in place to support robust managerial oversight of children's plans; and the partnership to ensure that practitioners working

with a child who has a neurodevelopmental condition, have access to information describing the impact of neurodevelopmental disorders and how this may shape their approach and intervention, making sure this is reflected in their assessments and care-planning.

Other resources Read summary report (PDF)

6. Learning review: Child F: executive summary

Non-accidental injuries to a 2-week-old-infant. During the mother's pregnancy, a range of services had been working with the parents and the unborn baby's name had been placed on the child protection register in 2022.

Learning includes: pre-birth support for vulnerable pregnancies including the Vulnerable Pregnancy Service should be reviewed and a clear pathway established; transfers between Duty and Child Protection Team, and Practice Teams should be more timely; Child Protection Plans should be more explicit and focus on the specific interventions to address identified risks; and decision-making at child protection case conferences should take account of risks, vulnerabilities and the likelihood of future significant harm. Makes suggestions for the Child Protection Committee to discuss including: setting up a working group to review practice in relation to earlier allocation of cases of unborn babies and pre-birth assessment completed by practice teams; identify specific actions within Child's Plans to include frequency and purpose of all contact with the family and clarity about the role of each professional involved including when interventions start and finish; the Quality Assurance subcommittee should observe child protection case conferences/planning and should also consider the role of reviewing officer; consider awareness raising about bail conditions and the need to confirm changes reported by the perpetrator; consider awareness raising the use of restricted access information and how it is taken into consideration when making decisions.

Other resources Read review online: publicprotectionwestlothian.org.uk/article/38072/For-professionals

7. Child practice review report: extended child practice review: re: C&VSB 042019

Death of a 16-year-old young person from suicide, who had difficulty in managing emotional regulation from a young age. The young person was receiving professional support due to adverse childhood experiences and developmental trauma experienced within the family unit.

Learning is embedded in the recommendations.

Recommendations include: a child or young person who is being considered as a child looked after and where placements are being sourced, should have a shared multi-agency chronology, the chronology should detail the risks and triggers for the child or young person and should be shared with agencies who will have direct involvement, to ensure they can plan and respond effectively; review the multi-agency arrangements for information sharing and planning for an effective transition of a child or young person into an out of county therapeutic placement, to ensure it is fit for purpose; agencies to be accountable for the transfer of services and care arrangements; no service should discharge their involvement until the receiving area has engaged

and there is a continuous service between local authority areas; ensure that a child, young person and their families are listened to and are able to fully engage in the care planning process; ensure the voice is captured at all stages of working with a family; and all agencies to receive training and fully understand the relevance of attachment theory, trauma, and adverse childhood experiences and for this to be evidenced as embedded into practice.

Other resources Read review online: www.cardiffandvalersb.co.uk/children/professionals-and-employers/child-practice-reviews/

8. Report from the multi-agency practitioner reflective learning eent held on 14th September 2022 following the rapid review of Child SD

Serious injury resulting in a permanent disability to a 17-year-old male in 2022. No suspects were identified after a thorough police investigation. At the time SD was under a Youth Rehabilitation Order for motoring offenses and had recently become a father.

Key learning themes include: real-time information sharing; coordination of support among multiple agencies; the challenge of engaging with families involved in criminal activity; transitions between services as youth turn 18; and the role of education in early prevention by detecting reduced school attendance and behavioural changes.

Recommendations to the Partnership include: reinstating read-only access to children's case files for Adult Social Care; ensuring visibility of involvement and interventions across agencies through the Early Help system; clarifying the Lead Professional's role in co-ordinating support across multiple agencies; establishing a 'learning offer' to increase understanding of 'adultification'; provide briefings on the impact of exploitation; ensure that education practitioners are trained in the use of GCP2; and subgroups should work together to evaluate the effectiveness of information sharing for exploited young people, including their National Referral Mechanism status.

Other resources Read practice review (PDF)