

Summary of case review choices.	
Case 1 - Child P	
Publisher	Calderdale Safeguarding Children Partnership (2024)
Abstract	Significant injuries to a 3-month-old infant boy in April 2018 whilst in the care of his parents. Child P's mother had longstanding mental health problems, with the family receiving support from a range of agencies since her first pregnancy. Learning considers: the impact of parental mental health; the effectiveness of early intervention co-ordination and planning; child-focussed practice; and the role of the father and other adults in the home. Recommendations include: remind partner agencies of the need to consider the potential impact of the birth of a subsequent child to a family about which there are prior concerns and to ensure that support needs are acted upon promptly; emphasise the importance of fully assessing the risks that parental mental health could present to children in the household, ensuring that single and multi-agency policy, systems and training supports the assessment of such risks, and obtain assurance that adult mental health services always give priority to the child's needs when considering risk; obtain assurance that the provision of early help is timely, addresses all needs and is managed robustly to avoid drift; examine the issue of how the lead agency/practitioner for early help is decided upon and, where necessary, reviewed; remind agencies of 'hidden male' research findings with a particular focus on raising awareness in adult services; seek assurance that the perinatal mental health pathway includes sufficient focus on parenting capacity and that knowledge of the pathway is promoted by the local NHS foundation trust; and the local NHS foundation trust to update guidance to practitioners on the safety of breastfeeding whilst the mother is taking medication.

Key Words	Antenatal care, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Bonding behaviour, Breast feeding, Child protection, Early intervention, England, Family support services, Fathers, Feeding behaviour, General practitioners, Health visitors, Home visiting, Hospitals, Infants, Injuries, Maternal depression, Mental health services, Midwives, Nurseries, Obsessive-compulsive personality disorder, Official inquiries, Parenting capacity, Parents with a mental health problem, Personality disorders, Postnatal care, Pregnancy, Prescription drugs, Psychiatrists, Psychoses, Risk assessment, Siblings, Sleeping behaviour, Suicide Search for catalogue records containing all of these Keywords
Case 2 - Child L	
Publisher	Cheshire East Safeguarding Children's Partnership (2024)
Abstract	Disclosure of sexual abuse of a 13-year-old girl in 2022 by a known sexual offender. At the time of the incident, Child L was subject to an Interim Supervision Order and a Child Protection Plan and had previously made three allegations of rape and sexual assault outside of the home. Learning themes include: appreciating the child's lived experience and the cumulative impact of adversity, harm, and trauma; listening to children and young people who make disclosures of abuse with intent to take action; ensuring systems and practice are domestic abuse aware and trauma-informed; recognising the safety that school can provide for children experiencing intra and extra-familial harm; increased awareness of the signs of child sexual exploitation and processes to access specialist guidance and support; developing a whole family response to support understanding of risk where there are complex adult issues. Recommendations to the Partnership include: consider how it can strengthen practitioner skills that enable the child's voice and experiences to be listened to and responded to verbally or non-verbally, including child

	observations and understanding of behaviours that may reflect harm and distress; work undertaken with regard to the role of education in providing a key protective factor should include learning about the importance of relational practice, trusted adults, and advocacy; clear leadership and challenge should be provided about victim-blaming language; and seek assurance that when services are commissioned/decommissioned, a relational approach is taken with regard to children and families to be mindful of the importance of continuity of relationships from the child's perspective
Key Words	Adverse childhood experiences, Behaviour, Child protection services, Child sexual abuse, Child sexual abuse identification, Child sexual exploitation, Children at risk, Children in violent families, Children missing education, Crime, Delinquency, Domestic abuse, Drug misuse, England, Extrafamilial child sexual abuse, Official inquiries, Physical abuse, Police, Rape, Children who go missing, Schools, Self harm, Substance misuse, Trauma, Trauma-informed practice, Voice of the child
Case 3 - Jez and Siblings	
Publisher	Cheshire East Safeguarding Children's Partnership (2024)
Abstract	Death of a 17-year-old boy in December 2022 from a drug overdose. Jez was autistic and known to services due to experiences of domestic abuse, mental health issues, substance misuse and self-harm. There were allegations against Jez's stepfather of domestic abuse and sexual abuse. Learning includes: response to concerns about child sexual abuse and the impact a lack of a robust response can have on children's lives; support for children and families when they experience domestic abuse; responding to allegations of physical abuse; support to mothers with care and support needs; and professional response to deteriorating mental health, self-harm, and substance misuse in the context of a trauma informed approach.

	Recommendations to the partnership include: set up a task and finish group to improve the multi-agency response to child sexual abuse; consider how to strengthen practitioner skills that enable the child's voice and experiences to be listened to whether there is a verbal or non-verbal disclosure; ensure that all partner agencies have awareness of self-harm NICE guidance and the key principles of safety planning, managing risk and suicide prevention; and implement a domestic abuse-informed response within child safeguarding responses.
Key Words	Abuse allegations, Abusive men, Adolescent boys, Autism Spectrum Disorder, Child mental health services, Child protection, Child sexual abuse, Children in violent families, Children with a mental health problem, Children's services, Domestic abuse, Drug misuse, England, Interagency cooperation, Official inquiries, Physical punishment, Physically abused children, Postnatal depression, Self harm, Siblings, Step-parents, Substance misuse, Suicide, Trauma, Trauma-informed practice
Case 4 - Eva	
Publisher	Croydon Safeguarding Children Partnership (2024)
Abstract	Non-accidental injuries to a 4-month-old girl in June 2023. Baby Eva was taken to hospital by both parents, with a pain in her right arm. Examination revealed a spiral fracture and further examination revealed multiple fractures, including rib fractures of varying ages. Both parents were subsequently arrested and remain under investigation, with Baby Eva's mother later alleging domestic abuse by the father. Learning themes include: assessment of the impact of previous learning; the impact of systems on the quality and response to information sharing; responding to information about fathers and other children. Recommendations to the Partnership include: ensure partner agencies review and enhance their systems and practices to facilitate effective information sharing, particularly concerning fathers or male partners; share the

	findings of this review with the out of area hospital where Eva's mother attended antenatally and gave birth, to enable them to consider what action they need to take in response to the identified factors that impacted upon safeguarding; seek assurance that the "normalisation" of parental/carers aggression is not happening routinely and there are appropriate systems in place to support professionals who may be at risk of vicarious trauma; and consider whether there is a need for the Integrated Care Board to undertake an assessment to gain assurance across the borough that GP practices are applying a system of coding that facilitates the immediate identification and sharing of safeguarding concerns for different health practitioners working within the practice, staff who may work in multiple practices, and for when patients transfer surgeries.
Key Words	Abusive fathers, Abusive men, Adverse childhood experiences, Aggressive behaviour, Antenatal care, Child protection, Child protection registers, England, Ethnicity, Domestic abuse, Fathers, Foster care, General practitioners, Health visitors, Hospitals, Information sharing, London Safeguarding Children Board, Parent-professional relationships, Parental behaviour, Physical abuse, Physically abused infants, Police
Case 5 – Child X	
Publisher	Gloucestershire Safeguarding Children Partnership (2024)
Abstract	Sexual abuse of a 15-year-old girl in care with complex emotional and behavioural needs. Child X was the subject of a Deprivation of Liberty order and was cared for in an unregistered placement. Child X became pregnant in this setting, which was thought to be the result of grooming and sexual abuse by a male carer. Learning themes include: crisis placements; the child's voice, culture and identity; commissioning of placements and care packages for children with complex needs; quality assurance arrangements for placements and care packages including the quality and competence of professionals commissioned to look after children with complex needs; and managing allegations against staff working with children.

	Recommendations to the Partnership include: the Safeguarding Children Partnership Executive should have oversight of all children placed in unregistered settings and ensure that there is good quality governance and accountability; the children in care nursing service must be involved when a child is placed out of authority to support careful and consistent health and care planning; all agencies must develop a robust and informed approach to assessing and meeting children's cultural, race and identity needs; all agencies must ensure that there is an understanding of racism and bias that can lead to the adultification of some children where their vulnerability and support needs are not understood; and awareness should be raised of the Local Authority designated Officer (LADO) role and ensure that partners understand their responsibility in contacting the LADO when there are concerns that an adult may cause a child harm through abuse or professional neglect.
Key Words	Adverse childhood experiences, Black children, Child protection, Child sexual abuse, Children in care, Children in need, England, Ethnicity, Grooming, Institutional child abuse, Official inquiries, Placement, Placement breakdown, Pregnancy, Professional negligence, Racism, Reporting laws, Residential child care, Secure accommodation, Self harm, Sexually abused adolescents, Sexually abusive people, Special educational needs, additional needs and disabilities, Temporary accommodation, Trauma-informed practice, Voice of the child