

Programme: BSc Health and Social care

Module: Protecting and supporting families in health and care

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Good morning/Afternoon My name is Janna Akhter Student ID 2316153

Today I am presenting a case from my practice as a social worker involving concerns of medical neglect in relation to a child diagnosed with Type 1 diabetes. This case required careful threshold consideration, multi-agency collaboration, and application of safeguarding legislation.

Sections 17 and 47 of the Children Act of 1989 served as the main legal framework for my intervention. When there is a reasonable suspicion that a child is experiencing or will experience serious harm, Section 47 requires the local authority to investigate. However, Section 17 mandates that we protect and advance the welfare of children considered to be in need. The significance of coordinated multi-agency working throughout this case was further emphasised by the Children Act of 2004 and Working Together to Safeguard Children (2018).

After a severe episode of diabetic to acidosis that caused emergency medical care, the referral was made. Concerns were voiced by medical specialists about the parents' comprehension of diabetes management, skipped appointments, and irregular insulin delivery. This episode brought up safeguarding concerns over possible medical neglect, given the severity of DKA.

When a carer does not look for or follow up on necessary medical care, putting a kid at serious risk, this is known as medical neglect. The youngster was especially at risk because of their long-term medical condition, and inadequate care could have had fatal results.

I started a Single Assessment to find the degree of risk and whether the threshold for Section 47 inquiry was satisfied after a strategic discussion with medical experts. The child's everyday experiences, medication schedules, attendance at appointments, parental ability,

and the family's comprehension of the illness were the main topics of my evaluation. In my direct interaction with the family, I discovered that there was no proof of intentional injury, despite inconsistent diabetes management. In addition to being helpful, the parents acknowledged their nervousness about handling such a complicated medical situation. It became clear that routine and knowledge deficiencies, not deliberate negligence, were the cause.

I made sure the child's opinion was at the forefront of my evaluation. The youngster did not say that they felt unsafe at home, but they did show annoyance about hospital admissions. In my analysis, this was a crucial protective factor.

Following multi-agency information sharing and risk analysis, I concluded that although the child was vulnerable and there were clear risks, the threshold for significant harm under Section 47 was not met. Therefore, the case did not progress to a Child Protection Plan. Instead, I implemented a Child in Need plan under Section 17.

The Child in Need plan focused on strengthening parental capacity through structured support. This included specialist input from the diabetic nurse, improved education around insulin administration, clear daily routines, and regular professional monitoring. Multi-agency meetings ensured accountability and ongoing risk assessment.

Measurable progress was made over time. The parents showed increased knowledge and confidence in treating the disease, insulin administration became consistent, and appointment attendance stabilised. The likelihood of more DKA episodes decreased, and the child's health outcomes improved.

After giving this case some thought, I realised how crucial proportionate intervention is. Even though not all medical neglect cases qualify for child protection, they nonetheless need thorough evaluation and well-coordinated help. It also emphasised the significance of supporting the child's voice at the centre of decision-making, doing a clear threshold analysis, and supporting professional interest.

Outcome

Following continued multi-agency assistance, appointment attendance stabilised, parental understanding improved, and insulin administration became dependable. The child's health outcomes improved, and the chance of more DKA episodes declined.

I am aware that chronic health-related neglect requires ongoing monitoring since risk is constantly changing, even though there were less immediate safeguarding issues.

This case highlighted the complexity of medical negligence and the importance of distinguishing between unwillingness and incapacity. Horwath (2013) asserts that several stressors, as opposed to a single incidence of parental failure, are often the cause of neglect. I was able to support clear expectations and promote change by employing an authoritative but strengths-based strategy.

Brandon et al. (2020) draw attention to the way that covert compliance might mask persistent danger. Even while it was not obvious in this instance, keeping this possibility in mind heightened my professional curiosity.

Munro (2011) highlights professional expertise and criticises excessively bureaucratic safeguarding procedures. Instead of applying a threshold mechanically, this scenario called for intellectual reasoning. It helped me better grasp how dynamic risk management is an aspect of safeguarding, especially when chronic health concerns are involved.

Conclusion

The intricacy of protecting kids with long-term medical issues is illustrated by this example. Effective multi-agency cooperation, proportional decision-making, and crucial threshold analysis were necessary. I was able to carry out a protective yet supportive intervention under Section 17 by correctly implementing the law and using studies on cumulative injury and neglect.

In the end, this experience helped me better realise that safeguarding involves more than just responding to harm; it also entails reducing cumulative risk through child-centred, thoughtful, and analytical practice. All things considered, this case proves that safeguarding entails more than simply legal participation; it also involves empowering families, enhancing protective factors, and working together to effect sustainable change.

Reference

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2020) *Complexity and Challenge: A Triennial Analysis of Serious Case Reviews 2014–2017*. London: Department for Education.

Children Act 1989. London: HMSO.

Children Act 2004. London: HMSO.

Daniel, B., Taylor, J. and Scott, J. (2011) *Recognizing and Helping the Neglected Child: Evidence-Based Practice for Assessment and Intervention*. London: Jessica Kingsley Publishers.

Department for Education (2018) *Working Together to Safeguard Children*. London: HMSO.

Department of Health, Department for Education and Employment and Home Office (2000) *Framework for the Assessment of Children in Need and their Families*. London: The Stationery Office.

Horwath, J. (2013) *Child Neglect: Planning and Intervention*. Basingstoke: Palgrave Macmillan.

Munro, E. (2011) *The Munro Review of Child Protection: Final Report – A Child-Centred System*. London: Department for Education.