

Learning Briefing - ‘Lost in Plain Sight’

***“Professionals need to be prepared to believe that the worst can and does happen.” (Family member)***

# In January 2020, Kent Safeguarding Multi-Agency Partnership undertook a Rapid Review following the death of a pre-school aged child, caused by non-accidental injury at the hands of their caregiver. At that time, a Rapid Review Action Plan was implemented across the Partnership with a view to improving safeguarding practice.

# In November 2021, the KSCMP Business Team devised a methodology by which they could measure the impact of the original Rapid Review Action Plan on frontline practice. A multi-agency team of practitioners unrelated to the case was convened and were presented with a case study informed by the original Rapid Review agency reports and the family themselves. Their comments regarding how they would act in response to the situation presented were used to benchmark progress against the January 2020 Rapid Review Action Plan. This enabled the KSCMP Business Team to measure what has worked and what still needs to be done to better safeguard children in Kent.

 **Factors obscuring this child from the sight of involved professionals:**

* Missed appointments – either by not being brought or professionals being refused entry to the home
* Support needs of the parents
* Individual child needs being lost within the sibling group needs and behaviours
* Disability and developmental needs

# **What this means for professionals:**

# Be familiar with your organisation’s ‘Was Not Brought’ or ‘Did Not Attend’ policy. Liaise with others in a family’s professional network to establish a pattern of attendance/non-attendance to identify potential risk.

* Consider the impact of parental need on parenting capability and lived experience of the child/children.

# Consider how you understand and accurately reflect the lived experience and perspectives of a child who is non-verbal. How is this captured in your case recording and assessments?

* When a child with a disability is presenting with injuries reported to be self-inflicted, consider whether injuries are being caused in the manner reported and whether the risk of harm through self-injurious behaviour is being adequately responded to. It is risk of harm that must be minimised, not just risk of harm by others.
* Adequate consideration must be given to the practical implications of significant changes to a child’s lived experience when planning for their ongoing care and support needs, particularly when considering ‘stepping-down’ the level of support as part of a formal process.
* Child abuse remains a difficult concept even for experienced professionals. It is against human nature to expect that a child is being harmed by someone responsible for their care and this sometimes prevents professionals from responding to the clear physical signs. Are you prepared to believe the worst can and does happen? Be mindful there may be factors impacting a caregiver’s ability or willingness to give an accurate explanation for a child’s injuries. Ask clarifying questions and corroborate responses.

**What will help?**

**KSCMP free e-learning -** [E-Learning - Kent Safeguarding Children Multi-Agency Partnership (kscmp.org.uk)](https://www.kscmp.org.uk/training/e-learning)

* Effective Communication with Children and Families
* Multi-Agency Working
* Physical Abuse
* Safeguarding Children with Disabilities
* Understanding Behaviour of Children and Young People
* Understanding Child Development

**Policy & Procedures -** [Kent and Medway safeguarding children procedures and strategies - Kent Safeguarding Children Multi-Agency Partnership (kscmp.org.uk)](https://www.kscmp.org.uk/procedures/kent-and-medway-safeguarding-procedures)

* Kent Escalation and Professional Challenge Policy
* Kent & Medway Actual or Suspected Bruising Procedures

**Guidance & Factsheets** - [https://www.kscmp.org.uk/training/factsheets](https://www.kscmp.org.uk/training/factsheet#s) and <https://www.kscmp.org.uk/guidance/kent-support-levels-guidance>

**Key messages to you from the family**

* Don’t let the fact a child is disabled or non-verbal be a reason why you don’t investigate more.
* You cannot sign someone off from your service for something they say they are going to do. You have to see the evidence.
* It is better to raise your concerns to too many people, than not enough.
* Don’t just ask questions. Ask the right questions. For example, health professionals asked nursery, ‘Do they have global developmental delay? Are they non-verbal?’ Rather than, ‘Is this pattern of bruising the same as usual? Has there been a change in their presentation over recent weeks?’
* Can information you are getting from one person be corroborated with anyone else?
* Be prepared to believe that the worst can and does happen.
* Kent Support Levels Guidance
* Family Context and Professional Curiosity