Executive Summary: Reflective Case Review

**‘Lost in Plain Sight’**

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

In November 2021, the Kent Safeguarding Children Multi-Agency Business Team devised an innovative approach to measuring the impact of learning and the implementation of action plan activities arising from incidents of serious harm to children. The approach needed to be flexible so that it could be replicated in future Local Child Safeguarding Practice Reviews (LCSPRs). It also had to provide us with a means of assessing whether the Partnership’s responsibility to improve front-line safeguarding practice is being effectively discharged.

The case selected to trial the new approach demonstrated particular themes of relevance to the local area such as insight into, and the opportunity to better understand, the lived experience of disabled children; childhood non-accidental injury; engagement with fathers and father figures; the impact of childhood trauma on parenting capability; and the appropriate escalation of professional concerns.

The impact methodology comprised of three aligned approaches designed to pinpoint and triangulate the effectiveness of changes brought about since this child’s Rapid Review Action Plan was enacted: a chronology exercise; engagement with the child’s family; and a practice event for multi-agency professionals. The aim was to explore how frontline practitioners from across the Partnership, independent of this case, would respond to a similar set of circumstances at the present time - and to gauge whether this represented a positive improvement since this child’s death in 2019.

*Chronology exercise:* this allowed for the creation of a case study example that did not give those at the Practice Event an unfair advantage in terms of what was ‘knowable’ at the time. It also allowed for the highlighting of information that was not discussed in detail at Rapid Review, but which is likely to have been salient in terms of factors relevant to this child’s death.

*Family engagement:* three immediate family members were advised that this Review would be taking place and were invited to contribute to the learning with their views. We are incredibly grateful for the insight this has offered us. Their key messages to professionals are.

1. Don’t let the fact a child is disabled or non-verbal be a reason why you don’t investigate more.
2. You cannot sign someone off from your service for something they *say* they are going to do. You have to *see* the evidence.
3. It is better to raise your concerns with too many people rather than not enough.
4. Don’t just ask questions. Ask the *right* questions. For example, health professionals asked the child’s 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?’
5. Can information you are getting from one person be corroborated by anyone else?
6. Be prepared to believe that the worst can and does happen.

*Practice event*: the aim of the Practice Event was to measure the impact of changes in practice since 2019, to allow us to understand whether current working practice would lead to a different outcome for a child in similar set of circumstances. Attendance was sought from key services that were involved with this child’s family, but also importantly,with workers from across Kent who were independent of their case.

The event was structured around two exercises. The first involved case example group work with additional information relating to missed appointments, the parents’ support needs, sibling needs and behaviours and child development. Professionals were tasked with identifying their concerns, strengths, additional information they would require and the action/s they would take. The second exercise explored the professionals’ knowledge of what policies and procedures they are aware of that would be relevant to the case they had discussed and to ascertain the barriers they felt may exist to them being employed in practice.

Evidence of positive impact: findings from the Practice Event would suggest that, faced with a similar set of circumstances, professionals from the across the multi-agency network would likely take the necessary steps to effectively safeguard a child in a similar position in the present day. Professionals were able to detail these steps, the policies, procedures and guidance they would follow and they independently identified the factors that appeared to have obscured this child from effective safeguarding practice at the time. It is worthy of note that no subsequent cases of serious incidents caused by harm or neglect involving children sharing similar characteristics have transpired since this child’s death.

A number of additional learning points have been identified that KSCMP and its partners should continue to be mindful of when working to reduce the risk of harm to children. These include:

* How the lived experience and voice of children can be heard and understood, particularly when the child is non-verbal.
* When a child with a disability is presenting with injuries reported to be self-inflicted, it is important to consider whether they 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.
* 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. Professionals should remain mindful there may be factors impacting a caregiver’s ability or willingness to give an accurate explanation for a child’s injuries. They must ask clarifying questions and corroborate responses.

Suggested improvements:

* The KSCMP Business Team will renew efforts to raise awareness of the Escalation and Professional Challenge policy amongst the multi-agency network. We would encourage each agency to be aware of the challenges some staff may face in keeping abreast of safeguarding policies and to undertake work to promote any relevant single and multi-agency training on this topic as well as to include easy-to-access information into their regular communication methods.
* Update forms used in Minor Injury Units to include consent to share information and referral to onward services.
* Seek assurance that safeguarding concerns within Accident and Emergency and Minor Injury Units are raised to professionals of appropriate seniority and expertise, and that parental explanation is explored and challenged where necessary to consider all likely causes.
* If a decision by Rapid Review Group to progress to LCSPR is subsequently reviewed, information should be sought from wider agencies involved in the case, to ensure next step decisions are made on the basis of the most up-to-date and comprehensive information available and to make sure learning is not missed.

Please contact kscmp@kent.gov.uk if you would like to request the full report.