

**Local Child Safeguarding Practice Review**

**‘Lost in Plain Sight’**

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

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**Table of Contents**

|  |  |  |
| --- | --- | --- |
| **1.** | **Context** | 3 |
| **2.** | **Rapid Review** | 3 |
| **3.**  | **Action Plan (January 2020)** | 3 |
| **4.**  | **Measuring Impact: Methodology** | 4 |
|  | **4.1 Chronology Exercise (December 2021)** | 4 |
|  | **4.2 Engagement with Family (February 2022)** | 5 |
|  | **4.3 Practice Event (February 2022)** | 9 |
| **5.**  | **Corroborative Evidence** | 14 |
| **6.** | **Conclusions and Recommendations** | 17 |
|  | **6.1 Evidence of positive impact** | 17 |
| **7.**  | **Acknowledgements** | 19 |
|  | **Appendix 1** | 20 |
|  | **Appendix 2** | 23 |

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1. **Context**

The subject of this case was a pre-school aged, white, British child who died in 2019. In the last week of their life, they attended their nurseries each day with their twin. Nursery staff noted new bruising each day to their face and head and raised this as a safeguarding concern. They were subsequently seen in hospital, but Mother stated they needed to leave as she had to collect their twin from nursery.

The day after the child was last seen at nursery there was an incident in the family home when they were in the care of Mother’s partner. The child sustained blunt-force trauma to their head, which Mother’s partner claimed had occurred as a result of a fall. The child died some days later in hospital. Mother’s (now ex) partner was convicted of their manslaughter.

1. **Rapid Review**

The Local Authority made a Serious Incident Notification as there was reason to suspect abuse and neglect may have been contributing factors in the child’s death. The child and their siblings were receiving services from multi-agency professionals at that time.

A Rapid Review meeting was convened in early 2020 and considered information provided by a range of Kent services that had knowledge or involvement with the child and their family. The group agreed that the case highlighted improvements needed to safeguard and promote the welfare of children and, as such, determined that a Local Child Safeguarding Practice Review (LCSPR) should be undertaken. The key, local multi-agency learning identified related to the quality of agency assessments; decisions made as a result of those assessments; and how professionals’ concerns were escalated. Following correspondence with the national Child Safeguarding Practice Review Panel it was agreed that an LCSPR was not required, and a more flexible approach would be undertaken to identify and act upon learning locally.

1. **Action Plan (January 2020)**

The learning points identified in the agency summary reports provided to the Rapid Review group were collated to inform an action plan following the Rapid Review meeting in early 2020. This plan and progress against actions can be seen in Appendix 1.

In relation to action 2 and with regard to the Practice Event discussed in section 7, though there were 2 professionals at the event representing Urgent Treatment Centres (Minor Injury Units), there were none representing Accident and Emergency departments. This undermined the ability of the Practice Event to measure likely impact against Action 2; however, statistical data was subsequently sought to track any potential impact with particular attention paid to this area.

1. **Measuring Impact: Methodology**

In November 2021, the Partnership devised an ‘impact methodology’ to retrospectively measure whether the implementation of the 2020 Action Plan had been successful. This methodology comprised of three aligned approaches designed to pinpoint and triangulate the effectiveness of changes brought about since the Action Plan was enacted: a chronology exercise; engagement with the child’s family; and a practice event for multi-agency professionals unrelated to the child’s case. The aim was to explore how frontline practitioners from across the Partnership, independent of this case, would currently respond to a similar set of circumstances and if this represented a positive improvement since the child’s death.

Further details of each component part of this methodology are set out below.

* 1. **Chronology Exercise (December 2021)**

A Chronology Exercise was undertaken in preparation for a Practice Event to avoid hindsight bias when sharing the case example with the group. Information received in Agency Summary Reports for the Rapid Review in early 2020 was extracted to create a multi-agency timeline of involvement from September 2008 to December 2019, which was colour coded to clearly identify which agency the information had come from. The Agency Summary Reports used in this exercise were provided by:

* Integrated Children’s Services
* Health - Primary Care
* Education Safeguarding
* East Kent Hospitals University Foundation Trust
* Kent Community Health NHS Foundation Trust
* Kent Police
* South East Coast Ambulance Service
* Early Years childcare provider

Not only did this exercise enable 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,’ it also allowed for the highlighting of information that it was not possible to discuss in detail at the Rapid Review, but which is likely to have been salient in terms of factors relevant to the child’s death. This has helped inform follow-up Action Plan 2 (December 2021). The further themes identified as part of this exercise have been summarised on page 3.

Adverse Childhood Experiences: As an adult, Mother disclosed to her GP she had been the victim of intra-familial sexual abuse between the ages of 3 and 16 years. At the age of 16, Mother is also recorded to have suffered a miscarriage. At this time, domestic abuse was noted between Mother and her partner by Health professionals. It is unclear from records if a trauma informed approach to supporting Mother was considered when she became a parent herself, recognising that her childhood experiences were likely to impact her parenting style and capability.

Pregnancies: Between the ages of 16 and 27, the chronology suggests that Mother had 4 miscarriages, a termination, 4 live births and was pregnant again. This is perhaps significant in the context of Mother’s childhood experiences and reports of domestic abuse in her relationships, especially when we consider the impact on her mental health and parenting capability. The records available to us did not suggest this was something considered at the time.[[1]](#footnote-1)

Trigger events/times: The chronology highlighted a significant shift in support dynamics for Mother and the children within a short space of time - approximately 6 months prior to the child’s death. The changes in the family’s life at this time included the Mother and Father to the child separating, frequent practical support from Paternal Grandmother reducing, the family being stepped down from Child in Need status to Early Help which meant a change in worker, Mother commencing a new relationship, and Mother’s new partner moving into the family home. On reflection of the information available, a key learning point is that 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.

Other agencies: The chronology referenced additional agencies whose information had not been either/or individually requested or received previously. These agencies were:

* Portage
* Probation
* Specialist Early Years provider
* Childminder
* Housing
* A local counselling service
* The primary school of the older siblings
* School Nursing Service
* Educational Psychology Service (albeit they had only received referrals in respect of an application for Education Health Care Plans for the child and their twin).

The initial Rapid Review decision was to proceed with an LCSPR, a decision which was revisited following liaison with the National Panel.[[2]](#footnote-2) In instances such as this, it is worth considering if the Rapid Review Group wishes to reconvene to decide if summary requests should be sent to additional agencies cited in the initial summaries received, to best inform appropriate next steps and explore any additional learning themes.

Domestic Abuse support: A noticeable ‘missing’ element to the list of agencies who provided support to the family according to the Rapid Review summaries, was in relation to domestic abuse. Domestic abuse was cited at various points in the chronology and was clearly a ‘known’ element of risk. However, there was no indication that either parent had worked with supportive organisations to address this given in the summaries provided. It may be argued that if professionals failed to address this issue directly, they may have been complicit in Mother’s self-confessed ‘normalisation’ of violence and aggressive behaviour in the home (see next section), which also links back to the impact of Mother’s adverse childhood experiences. Alternatively, it may be the case that the agency summaries provided for Rapid Review did not adequately reflect work completed in this area.[[3]](#footnote-3)

|  |
| --- |
| **Learning Points** |
| **1.** | 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. |
| **2.** | In instances where the CSPRP has suggested an LCSPR is not necessary, the Rapid Review Group should consider if summary requests should be sent to additional agencies cited in the initial summaries received, to best inform appropriate next steps and explore any additional learning themes.  |

* 1. **Engagement with Family (February 2022)**

The Kent Safeguarding Children Multi-Agency Partnership is committed to including families in reviews wherever possible. Their insight into how professionals engaged with and supported them is invaluable when considering what needs to change to improve the safeguarding of children.

In 2021 the criminal proceedings in relation to the child’s death were concluded which offered a window of opportunity to engage her family in the review with open and honest conversation prior to the Practice Event.

Three immediate family members were advised that this Review would be taking place and were invited to contribute to the learning with their views. A range of options were explored to undertake this liaison successfully with individuals’ diverse needs in mind. Text messaging, emails, telephone conversations and a virtual meeting were employed. Face-to-face meetings were offered but declined. All three members responded and engaged to various degrees. We are incredibly grateful for the insight this has offered us.

Mother’s views

Mother stated that her primary support need was in relation to domestic abuse. She said that due to her abusive childhood, a certain level of abuse was normal to her. When the abuse was at a level that was distressing, she did not know how she could escape the situation, especially with young children. She stated that on reflection, she wishes a professional had signposted her to relevant support and talked her through the options she had.[[4]](#footnote-4)

Mother recognised that she had needed practical support. This included keeping on top of maintaining a safe and clean home environment which she found a challenge due to working full time. She felt judged by professionals for working full-time, but equally felt she would have been judged for not working. Mother shared that working to provide for her family was something she was very proud of and was important to her sense of identity. Mother also needed practical support getting the children to medical appointments. This was because she does not drive and could not take the child and their twin in a taxi due to their behaviour. She said that without proper car seats they would climb around, kick, bite and punch to the point they were unsafe to have in a car. As a result, there were many missed health appointments which she felt blamed for with, she felt, little support forthcoming from professionals to find a reachable solution.

Mother identified one Social Worker in particular (V) to have been incredibly supportive. Mother felt that V helped her to find solutions and was not judgemental. V supported Mother to get the child and their twin to a medical assessment which she found very helpful. Mother said she was proud of the progress she made working with V, which led to the family’s case stepping down to Early Help. However, Mother said she did not have the same rapport with her Early Help worker who could be hard to contact due to annual leave and she felt that “no one was watching out for us anymore.” (Please see Trigger events/times in the previous section and Paternal Grandmother’s comments further down.)

Mother felt that she had done the appropriate thing by using ‘Claire’s Law’ before her new partner moved into the home. She was also aware he had an enhanced Disclosure and Barring Service (DBS) check from work. She felt that “on paper, he looked perfect.” On reflection she felt that with no significant information shared via her Claire’s Law application (as there was none to be shared), she was lulled into a “false sense of security.” When it came to the child presenting with bruising, Mother said it did not even enter her mind that it could have been caused by her partner.

Importantly, Mother suggested that at no point did a professional raise with her the possibility that her child’s injuries could have been caused by abuse. She recognised that had they done so she would have been defensive, but it would have forced her to at least question the possibility. “There were only four people that looked after them. Nursery wouldn’t have done anything to them. Her nan would never hurt them. I knew I hadn’t done anything…so who does that leave? I would have had to at least think about it.”

Grandmother’s Views

Paternal Grandmother described a high level of personal involvement with the initial multi-agency support plans, with actions assigned to her by Children’s Social Care and meeting minutes routinely copied to her. She would sometimes be present at the family home for visits made by professionals.

Paternal Grandmother confirmed that she offered practical support to the family by looking after the oldest two children 2-3 times per week and the twins on alternate weekends. However, when Father and Mother separated, Mother withdrew consent for Paternal Grandmother to be included in future meetings with professionals or to have information shared with her. She was also removed as the emergency contact for the children’s school and nursery. From this point, her practical care of the children reduced significantly along with her ability to maintain oversight of their safety.

Paternal Grandmother shared her view that when Father was no longer in the family home, professionals automatically perceived that the risk to the children had reduced without considering the wider context and other risk factors. She also commented that she could only recall one professional over the years who had made ‘an effort’ to build a relationship with Father to understand his views and role in the family. She explained that Father was able to engage, though due to his Autistic Spectrum Condition needs, professionals required a more creative approach to how they did this. In correspondence with Father he echoed this, indicating he felt ‘unheard.’

Key messages for professionals

The family were asked for the key messages they would like shared with professionals to improve their ability to safeguard children. They were:

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 to too many people, than not enough.
4. 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?’
5. Can information you are getting from one person be corroborated with anyone else?
6. Be prepared to believe that the worst can and does happen.
	1. **Practice Event (February 2022)**

The aim of the Practice Event was to measure the impact of changes in practice since 2019, to understand whether current working practice would lead to a different outcome for a child in similar set of circumstances to this child. To achieve this, a practice event was held in February 2022, with attendance sought from some of the key services that were involved with the child’s family, but importantly **with workers from across Kent who were independent of the child’s case**.

The event was structured around two exercises. The first saw attendees split into four groups (with equal multi-agency distribution) and provided with a case example based on information relating to the child in the lead up to their death. Each group was also given different additional information relating to one of four themes extracted from the Rapid Review summaries. These were:

* Missed appointments
* Parents’ support needs
* Behaviour and needs of siblings
* The child’s developmental needs and behaviour.

The groups were asked to consider and analyse the information, in order to identify:

* What are they worried about?
* What are the strengths?
* What further information do they require?
* What action is needed?

The second exercise saw the groups tasked with identifying what policies and procedures they are aware of that would be relevant to the case they had discussed and ascertaining any barriers that may exist to them being used in practice now. The aim of this exercise was to enable the KSCMP to better understand why, when adequate policies are in place, they may not always be acted upon appropriately in reality – with the child’s case being used as an example scenario.

Attendance

The event was advertised through KSCMP communication channels, as well as to targeted services, with spaces capped at 24. In total 52 professionals of varying levels of seniority – from frontline practitioners to managers - registered their interest to attend. The spread of multi-agency representation of the requests can be seen on the following page:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agency/Service** | **No. registered** |  | **Agency/Service** | **No. registered** |
| KCHFT Health Visiting | 10 |  | KCC Children’s Social Work | 7 |
| KCHFT Urgent Treatment Centre | 2 |  | KCC Early Help | 9 |
| KCHFT Other | 1 |  | KCC Disabled Children’s Service | 7 |
| Other Health Trusts | 2 |  | KCC Portage Service | 3 |
| Kent Police | 5 |  | KCC Other | 5 |
| Early Years Setting | 1 |  |  |  |

Of the 24 places allocated, 22 professionals attended the event. The representation of attendees is shown below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agency/Service** | **No. attended** |  | **Agency/Service** | **No. attended** |
| KCHFT Health Visiting | 4 |  | KCC Children’s Social Work | 3 |
| KCHFT Urgent Treatment Centre | 2 |  | KCC Early Help | 1 |
| Other Health Trusts | 2 |  | KCC Disabled Children’s Service | 4 |
| Kent Police | 3 |  | KCC Portage Service | 3 |

Early Years settings and Accident and Emergency were two of the key services it was hoped would be represented at the event, however this proved not to be possible. Despite efforts by the KSCMP Business Team only one Early Years setting registered to attend and had to cancel the morning of the event due to urgent matters. One A&E clinician expressed interest in attending but did not respond to further registration emails to attend the event.

The KSCMP would like to express its thanks to all the professionals who attended and engaged in the event. All attendees approached the exercises openly and engaged in healthy discussion, particularly around identifying barriers to practice. Feedback from the event to date has been positive, and the format will be considered for future events.

Exercise One – response to concerns

This exercise allowed for an understanding of how practitioners would currently respond to a child presenting with this child’s circumstances, and how practice may have changed since 2019. It was noteworthy that there was consensus amongst all groups that **a Child Protection referral was required**, with a view to **a multi-agency strategy meeting being convened**, alongside a **CP medical and s47 enquiry**, based upon the child presenting with a significant injury – in this example, a black eye. Professionals questioned the explanation offered that it had been caused through self-injurious head-banging behaviour. Importantly **professionals showed a healthy scepticism and understanding for the need to corroborate whether the injury was likely to be incurred through such behaviour**, whether this behaviour had been reported by anyone other than her Mother and to **consider the possibility of physical abuse.** **There was no evidence of professionals assuming that the injury was due to the child’s reported disability**, which was felt to have been a disguising factor in the response to this child’s injuries. Further, professionals indicated that even if the injury had been sustained through self-injurious behaviour, then **consideration should have been given as to how well supervised the child had been at the time** and whether this was behaviour which increased due to stress. Professionals also discussed what the lived experience of the child must have been like in the lead up to the injury. Professionals further discussed the important considerations they would evaluate in various settings, including **considering calling the Front Door for immediate advice**, or **contacting police to consider whether the child required immediate protection**.

The lived experience of the child in the scenario, particularly noting that they were non-verbal, was also highlighted by practitioners as a key consideration. Practitioners commented that the wider concerns appeared to suggest that **the basic needs of the children were not being adequately met**, and **the importance of understanding what life is like for children who cannot verbalise their experiences**. It was also highlighted that there is a need to **consider the individual needs** and experiences of each child, not considering them just as one single sibling entity. This was particularly relevant, given it was noted from Rapid Review records that this child and their twin were often referred to as ‘the twins’ with entries sometimes appearing on only one of their records, but applying equally to them both. Issues and concerns specific to the older siblings were also considered by the professionals in their discussions.

Importantly **professionals considered all the information they were provided with in a cumulative manner**, analysing concerns around home conditions; poor supervision; parental mental health and past trauma; parenting capability; and poor engagement. This led the groups to conclude **that a multi-agency discussion was of most importance**, highlighting that different services each held pieces of information about the family, which when considered holistically painted a clear picture of children who were failing in their environment and required professional intervention.

**In considering their actions, the groups went beyond simply recognising the need for a Child Protection referral and multi-agency discussion and thought about the actions that should be generated as a result**. They identified a clear need to be more fully informed and involved with the fathers of the children, and the new partner in the home. Professionals also recognised the mention of additional support provided by paternal Grandmother and wanted clarification about whether this was continuing following the relationship breakdown; they also discussed the importance of understanding whether this support was positive or carried inherent risks. Professionals recognised the need to fully understand the environments the children were being cared for in, suggesting that this additional support might be acting as a ‘lifeline’ for Mother, who could be overwhelmed with four young children with behavioural challenges. However, consideration also needs to be given to the potential risks or protective factors posed by adults who are unknown to services or whose circumstances are not fully understood within that home environment. It was further highlighted that as Mother worked fulltime, childcare arrangements for the children needed to be better understood.

To add to this, the groups discussed that whilst it was important that focus was maintained on the needs of the children, there was a need for an open conversation with Mother about what support she needed and what would make a difference to her to enable her to meet the needs of her children. **It was noted that Mother had a history of abuse as a child herself, which could mean traumatic childhood experiences may have been normalised and therefore difficult for her to recognise and act on**. Professionals also considered the need for corroboration of Mother’s reported mental health diagnosis, with colleagues highlighting that some diagnoses can only be made by secondary mental health services, so confirmation should be sought through those agencies, as the GP may record what is self-reported by the patient.

Significant discussions were held around the pattern of missed appointments. When summarised it is clear that there were an enormous number of missed or cancelled appointments for the child and their siblings, but professionals discussed whether this was disguised by the fact that they were split across multiple children, and perhaps Mother had engaged in just enough appointments to avoid triggering ‘was not brought’ policies to be enacted.

**Whilst it is clearly not possible to predict how the outcome for this child may have been different, this exercise provided a number of indicators which strongly suggest, should a similar scenario arise at the current time, there would be a different professional response which would likely lead to recognition of the possibility of abuse prior to a fatal injury occurring**.[[5]](#footnote-5)

It is recognised that whilst facilitators were careful to not include information that was not knowable to professionals at the time of the incident, hindsight bias may still have been a factor in the responses during the practice event, given attendees were aware the event was developed in response to a practice review. It was clear, however, that during the discussions all the groups came to the same consensus about what action was required, and highlighted most, if not all, of the key issues which were identified by the KSCMP in reviewing the agency reports regarding this case.

Exercise two – Potential barriers to practice

The groups identified a range of policies and procedures which could support them in the scenario outlined, including the **Non-Accidental Injury pathway, Was Not Brought policies, Kent Support Levels Guidance and Thresholds, and the Kent Escalation and Professional Challenge policy**. It was highlighted that each individual agency has a range of policies which would be of relevance and used in the scenario, often regarding the same topic, but each professional would only have sight of their own services’, with no knowledge about the specifics of policies other professionals may be following.

The groups then considered what barriers may exist in reality which could impact on practice now, preventing policies from being followed as per design, or which could prevent the actions they outlined in the first exercise from being achieved. These potential barriers fell under eight broader themes and were discussed generally by all relevant professionals (rather than being specific to an individual organisation). Please note: these barriers are **not in direct relation to this child’s case, of which this group of professionals had no prior knowledge**. This learning is being considered more broadly by the Partnership, and not specifically via recommendations resulting from this child’s case:

**Knowledge of policy –** Whilst professionals acknowledged the range of policies available to them, they also highlighted they cannot know the detail of *all* of these and may not always have the time to read them all thoroughly. For example, practitioners indicated they would look for relevant policies to guide them on specific issues, but where practitioners do not know they exist, or do not recognise trigger points, then these may not be read through at the time they are needed. Whilst the Kent Escalation and Professional Challenge Policy was noted by one group, a majority of attendees indicated that they were unfamiliar with it, and it was also discussed that even when professionals are aware of it, there may be a lack of confidence or willingness to use the policy.

**Engaging with families –** Where risks do not meet statutory thresholds, or where referrals require parental consent, non-consent and non-engagement of families is often a challenge. This can lead to a pattern of referrals deemed suitable for non-statutory intervention, and closure as a result of non-consent, with no improvement seen for the children. It was also highlighted that some parents are aware of non-attendance policies and may seek to avoid engaging with professionals by deliberately not attending or responding (for example, where there is a policy of 3 non-attendances leading to closure).

**Capacity –** Capacity issues within services can lead to delays in referrals for safeguarding concerns being submitted. There was also a discussion specifically regarding police capacity to support joint visits to non-engaging families, where there is not a statutory requirement for children to be seen. Similarly capacity challenges can mean that enhanced follow-up in non-attendance circumstances is not possible.

**Focus on adults –** Practitioners identified that where parents or adults within the family have recognised vulnerabilities or specific issues, focus can be shifted onto parental problems, rather than being maintained on the impact on and experiences of children. It was also highlighted that where practitioners sympathise with challenges being experienced by parents, whilst well intentioned to provide them support and ‘leeway’, this can lead to children being left in harmful situations for longer periods of time.

**Difficult conversations –** Whilst professional curiosity has been a topic of significant training and guidance over recent years, it was identified that practitioners sometimes remain uncomfortable asking difficult questions of parents. Sometimes this is because the agency is seeking to safeguard future working relationships (for example, school settings), and so seek other agencies to ask those questions. It was also highlighted that practitioners often take on a degree of personal responsibility for the wellbeing of the individuals and families that they work with, which can increase reluctance to jeopardise working relationships. It was suggested that there may be circumstances where professionals avoid making a necessary referral, out of concern that this might cause disengagement and therefore increase the risk to the individual.

**Working with non-verbal children or children with SEN –** It was highlighted that there is training available to services working with children who have SEN needs, including those who are non-verbal, but this is not more broadly available to multi-agency professionals not in those specific services. A number of resources and tools which can aid engagement were shared during the event, but it was felt that broader awareness and training may be useful to assist professionals in engaging with and hearing the lived experience of the child.

**Front Door triage and engagement –** A significant discussion was held amongst attendees regarding the Front Door triage and responses to referring professionals. It was acknowledged that not all professionals necessarily understand the social care threshold and what powers social care have, sometimes having unrealistic expectations of what can be achieved. Similarly it was noted that professionals are sometimes surprised by the assessment made by triage in terms of support level, both due to lack of understanding of the support levels, but also through lack of appreciation that Front Door may have access to further information when making triage assessments.

It was suggested that time limited services such as Minor Injury Units could include a consent prompt within their forms, so this is sought at the time of the interaction to support appropriate onward referrals as necessary.

During the practice event, professionals commented that if they were to ask Front Door for details of the Social Worker allocated to a child/family via telephone, they may be advised that due to data protection this cannot be shared and it cannot be confirmed if a family are open to Social Care. If however they were to email the Front Door and request for an allocated worker to make contact with them, this often does illicit a response from a Social Worker. It is important to note this is a GDPR matter and that an email from a recognised professional address can be quickly responded to, whereas a phone call from an individual purporting to be a professional cannot. There is no issue with the names of social workers being shared with professionals if the Front Door can confirm who they are, however, the practice event would indicate that some professionals, particularly in healthcare roles, are unaware that this is an easily navigated GDPR matter which with better understanding might expedite their queries and professional information sharing.

**Safeguarding is everyone’s responsibility** - A final point was noted and agreed amongst the professionals in attendance, regarding the recognition of safeguarding as being everyone’s responsibility. It was highlighted that particular services often have safeguarding concerns reported to them by other professionals, with the request that they submit a relevant referral, not recognising that all agencies have the responsibility to submit safeguarding referrals where they hold concerns. It was suggested that there should be a coordinated campaign to highlight safeguarding as every agency’s responsibility.

1. **Corroborative Evidence**

To establish if learning gleaned from the Practice Event was reflective of wider practice, additional statistical data was sought to assess whether, if faced with a similar set of circumstances again, there is a greater likelihood that professionals today would be more likely to respond to these safeguarding needs in a more timely and effective manner, to better ensure the safety and wellbeing of children in Kent.

*“It was positive that there was consensus amongst all groups that* ***a Child Protection referral was required.”***



Comparable statistics[[6]](#footnote-6) indicate there was an increase in referrals to Kent’s Front Door Service between 2019 and 2021 in relation to abuse or neglect of children in the 0-4 age group. This supports the hypothesis more professionals are making safeguarding referrals and there is therefore likely to be a better recognition of potential abuse or neglect ‘across the piste’.[[7]](#footnote-7) To add to this, a ‘drill down’ into which agencies have made referrals over this period shows that Health has made increased numbers of referrals into Kent’s ‘Front Door’ over this time – in particular, we have seen a notable increase in referrals from Accident and Emergency departments. This is significant, since this child was seen by multiple health professionals during the timeframe considered at Rapid Review and a safeguarding referral was not made by medical professionals at A&E when they were presented with bruising prior to the serious incident in 2019. This increase would suggest professionals are now demonstrating an enhanced level of professional curiosity when presented with children in the 0-4 age group who may have been neglected or harmed.[[8]](#footnote-8)





Also of relevance to this child’s case, is that referrals during this period increased from Paediatric and Midwifery services, both of which were involved with this child’s family. These professionals would have a level of safeguarding oversight for children in a similar position today. It is expected that the decline in referrals from GP’s, Health Visitors, School Nursing and Speech and Language services during this specific timeframe are likely to be due to the impact of the coronavirus pandemic on face-to-face service delivery, and that these referral numbers are likely to increase over the coming year (see action 10, Action Plan 2, Appendix 2).

1. **Conclusions and Recommendations**

In early 2020, it was recognised that the circumstances surrounding this child’s sad death were likely to offer the multi-agency network important learning relevant to child safeguarding. In recognition that learning was likely to positively impact safeguarding practice and reduce the likelihood of a similar incident occurring in the future, the Rapid Review Group agreed an action plan. Following implementation of that action plan, in December 2021 the Kent Safeguarding Children Multi-Agency Partnership Business Team developed a methodology to measure its impact. In doing so, a thorough chronology based on summary reports was complied, the child’s family were invited to share their views and experiences, and a case study was developed to share with a multi-agency group of professionals unrelated to the case to test whether changes in practice had led to observable systemic improvement in the time since elapsed.

**6.1 Evidence of positive impact**

As demonstrated in the Practice Event section of this report, it is likely that if faced with a similar set of circumstances, professionals from within the multi-agency network would:

* Refer to Kent’s Front Door service
* Convene a multi-agency strategy meeting
* Request a CP medical
* Query how the presenting injuries could be explained by headbanging behaviour
* Corroborate alleged behaviours with the wider professional network
* Consider the possibility of physical abuse
* Query the level of supervision offered if injuries of that nature were being sustained by any means
* Consider if environmental factors were increasing stress, leading to reported behaviours
* Consider safeguarding implications for the sibling group
* Consider presenting information in the context of the family’s history as opposed to the here and now, and analyse risks in the context of each other
* Include fathers/step-fathers in assessment, along with the wider family network
* Corroborate parents’ reported diagnoses
* Be mindful of a trauma informed approach to practice
* Refer to relevant policies and guidance

**As such, it is likely that the factors identified as obscuring this child and their siblings from the sight of professionals and contributing to a tragic outcome, would have a lesser impact as a result of Action Plan 1 and changes to practice since this child’s death. Indeed, no subsequent cases of serious incidents caused by harm or neglect involving children sharing similar characteristics to this child have transpired since their death.**

Additional learning points

Through the work outlined in this report, a number of 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:

* How the lived experience and voice of children can be heard and understood, when the child is non-verbal?
* When a child with a disability is presenting with injuries reported to be self-inflicted, there is a need for further consideration and enquiry. It is important to consider whether injuries are being caused in the manner reported, but also 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

From the information gathered in this review, it is suggested that consideration be given to the following to further improve safeguarding practice:

* 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.
1. **Acknowledgments**

The Kent Safeguarding Children Multi-Agency Partnership would like to acknowledge family input into this review. It was clear that their pain at revisiting such a terrible set of circumstances and immense loss, was overridden by their desire to reduce the likelihood of something similar happening to another child. With this in mind, they were keen to share their experiences with us and requested we highlight their key messages to safeguarding professionals. For that we are extremely grateful.

We would also like to acknowledge the role in this review of professionals who engaged in the Practitioner Event in February 2022. Despite the restrictions that delivery via MS Teams as opposed to in person could have presented, everyone committed to open and reflective conversation that has enabled us to draw out salient learning themes and inform ongoing recommendations and actions.

**Appendix 1 – Action Plan 1**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No. | Action | Expected outcome(s) | Target date | Progress |
| 1. | Each Early Help and Children’s Social Work Service Manager will undertake a review of the last 30 step down cases to review decisions, plans and interventions and professional curiosity within the Early Help service. | * Understand whether information protocols are fully embedded in this unit and across Early Help when staff are working with families below the Statutory level of intervention.
* Understand if ‘What If’ scenarios which do not in of themselves trigger a safeguarding concern, fully explained and discussed at the point of step down.
* Depending on outcome a further action to be considered to deliver practice guidance and further training.
 | March 2020 | *An exercise was completed in March 2020 where 240 step downs across KCC were audited (20 per district).**The learning from the audit was used to implement the Early Help framework and update the strategy in May 2020.* *Early Help Module continues to implement updates. Supervision forms are now on EHM and are monitoring stepdown performance. Within Child Outcome Analysis (COA) where practice is observed in each district, the step-down process and step across requests are observed, as well as Strats from the Front Door.****COMPLETE*** |
| 2. | East Kent Hospital University Foundation Trust will review assessment of physical facial/head injuries in children where a disability or developmental delay is given as explanation. | * Understand whether practitioners are demonstrating the ability to ‘think the unthinkable’ for disabled children.
 | March 2020 | *The ED and Safeguarding team have discussed at length ‘thinking the unthinkable’ in relation to children with disability /developmental delay. This is discussed on an individual basis when children attend when there are concerns around any mismatch of mechanism and injuries/behaviours seen. For any child who attends with a head injury, the teams follow clinical guidance set down by NICE and follow the EKHUFT safeguarding policy. The Kent and Medway procedures for bruising in non-mobile babies is available to staff on our intranet and has been discussed in ‘peer review’ bi-monthly education meetings for Paediatricians where individual cases are reviewed and discussed. Practice following this case with other similar scenarios has demonstrated that change has been embedded.****COMPLETE*** |
| 3. | East Kent Hospital University Foundation Trust will undertake an audit of notes of children attending health appointments against the ‘was not brought’ policy.  | * Ensure appropriate safeguarding actions have been undertaken by practitioners across services where children attend.
 | March 2020 | *‘Guideline’ changed into a ‘policy’ and endorsed June 2021 so it was a must do. This delayed the audit. We are currently in the process of working with our clinical audit team to devise the new audit tool and re-do the audit again spring 2022****ONGOING*** |
| 4. | Kent and Medway CCG will re-visit escalation procedures within GP training and development. | * Ensure escalation procedure is understood, and GPs are able to use the procedure when there are concerns about a lack of response.
 | March 2020 | *Escalation was discussed as part of GP training events in 2021. GP’s are encouraged to escalate any issues and to ask the Named GP for Safeguarding for support.* ***COMPLETE*** |
| 5. | KCC to inform all pre-school and early years settings in Kent of the status of TEP consultation and advice service and their duties to refer any safeguarding concerns to the Front Door regardless of the involvement of any other agency. | * Ensure early years settings are fully conversant with the referral process and their responsibilities outside of the consultation service offered by TEP.
 | February 2020 | *TEP have revisited with Early Years settings the differences between their education safeguarding advisory service and Front Door referrals or requests for consultations. Evidence suggests that a significant number of early years settings are now requesting Front Door consultations.* ***COMPLETE*** |
| 6. | KCC to review the form and function of the Education Safeguarding Service within TEP which it currently funds. | * Understand whether the right level of professional curiosity and advice is provided to settings, enabling them to take the appropriate action in referring concerns to the Local Authority.
 | *March 2020*  | *This was delayed due to the coronavirus pandemic but is now an active review.* ***ONGOING*** |
| 7. | SECAMB will revisit the referral pathway for safeguarding as well as potential criminal matters if cases where the explanation of injuries does not fit the presenting facts. | * Ensure that consideration is given to whether a crime may have been committed, and appropriate safeguarding referrals are made in a timely fashion to Kent Police and the Local Authority.
 | March 2020 | *SECAMB have confirmed frontline staff are routinely trained in the referral pathway for safeguarding, including where the explanation of injuries does not fit the presenting facts. However, it should be noted that SECAMB’s priority is always to treat medical need first, which may appear to lead to a delay in the referral pathway being commenced.* ***COMPLETE*** |

**Appendix 2 – Action Plan 2 (December 2021)**

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| --- | --- | --- | --- | --- |
| No. | Action | Expected outcome | Target date  | Progress |
| 1. | This child to be included into the KSCMP thematic review into responses to safeguarding concerns for disabled children. | * Understand whether disabled children’s safeguarding needs are being overlooked due to additional needs.
* Ensure that agencies are able to ‘think the unthinkable’ for disabled children.
 | April 2022 **onwards** |  *KSCMP Learning and Improvement Group (LIG) will be established in April 2022 and will be responsible for this piece of work.* ***ONGOING*** |
| 2. | KSCMP to hold a practitioner event focusing on understanding how practice has changed, and how concerns and areas of learning would be responded to now. Attendees to include: Early Help, EKHUFT, CCG & Early Years. | * Understand how practitioner has changed since 2019 when the events occurred.
* Identify areas of learning that still require further resources.
 | February 2022 | *Event held on 8th February 2022, summary and impact evidence included into summary report.* ***COMPLETE*** |
| 3. | KSCMP to develop a learning briefing from this case. | * Identify key areas of learning from the review.
 | March 2022 | *Drafted and ready for publishing alongside overview report and/or executive summary****COMPLETE*** |
| 4. | KSCMP to develop a webinar on learning from this case and the practitioner event. | * Disseminate keys areas of learning to multi-agency audience.
 | July 2022 |  |
| 5. | KSCMP to produce a written report outlining the activity undertaken, key learning identified, changes in practice, and outstanding learning to be supported. | * Disseminate key areas of learning to multi-agency audience.
* Publish review on website.
 | April 2022 | ***COMPLETE*** |
| 6. | Seek assurance and update around progress against Action 2 in 2020 plan | * Understand whether practitioners are demonstrating the ability to ‘think the unthinkable’ for disabled children
 | April 2022 | ***COMPLETE*** |
| 7. | Seek an update regarding Actions 5 & 6 in the 2020 plan. | * Understand whether Early Years settings are aware of and following the routes to raise safeguarding concerns
 | April 2022 | ***COMPLETE*** |
| 8. | KSCMP to seek assurance that agencies have made policies and procedures easily accessible to staff, including signposting to multi-agency policies and procedures.  | * Ensure staff have access to all relevant policies and procedures.
 | July 2022 |  |
| 9. | Undertake survey and dip-testing activities across partner agencies to understand where there is knowledge of relevant policies & procedures. Undertake awareness raising activities of the multi-agency policies and amendments, including through signposting and training. | * Understand multi-agency professional awareness of policies and procedures, including barriers to accessing/application.
* Delivery of resources to highlight multi-agency policy provision.
 | July 2022 | From March 2022 a new section has been added to the KSCMP newsletter which highlights recently amended local policies and procedures, as well as summarising key national policy updates. |
| 10. | Review statistics for Front Door referrals initiated by Health practitioners for the year 2022.  | * Test the hypothesis that returning to face-to-face service delivery will lead to increased referrals to Kent’s Front Door Service for children aged 0-4 for concerns of abuse or neglect by GP’s, Health Visitors, School Nursing and Speech and Language services. Does the data indicate gaps and/or a new action to disseminate learning/improve training?
 | January 2023 |  |

1. Available records included multi-agency summary documents provided for the purpose of the Rapid Review and were not an exhaustive/in-depth overview of all agency input in terms of assessment, planning and delivery of support. [↑](#footnote-ref-1)
2. Following more recent guidance from the National Panel regarding flexible methodologies this overview report is now being badged as a Local Child Safeguarding Practice Review. [↑](#footnote-ref-2)
3. Summary report training is an identified action in the March 2022 Practice Review Project (Part 2). [↑](#footnote-ref-3)
4. It is worthy of note that information subsequently received indicates that mother had in fact been referred to an Independent Domestic Violence Advisor during the timeframe under review. [↑](#footnote-ref-4)
5. No subsequent cases of serious incidents caused by harm or neglect involving children sharing similar characteristics to this child have been notified to the KSCMP since their death. [↑](#footnote-ref-5)
6. KCC changed the way referrals received into the Front Door service were coded during this timeframe. The data we have analysed shares the most similar risk correlates. [↑](#footnote-ref-6)
7. However, it is recognised this is not a definitive indication. This does not show, for instance, whether the number of children at risk has increased, who those referrals came from, or if the roles of those referrers would likely be relevant to a child in similar set of circumstances to this child. [↑](#footnote-ref-7)
8. However, we are unable to demonstrate the specific relevance of identifying abuse or neglect in disabled children as A&E admissions are not coded in a way that would indicate if a child is disabled, so that group’s subsequent care plans and onward referrals are harder to track. [↑](#footnote-ref-8)