

THEMES

THE IMPACT OF ETHNICITY, IDENTITY AND LANGUAGE

HEALTH VISITOR INVOLVEMENT

SUPPORT FOR THE SIBLING

THE VOICE OF THE CHILD

MULTI-DISCIPLINARY ASSESSMENT / DIAGNOSIS OF CHILD MALTREATMENT, AND PROFESSIONAL CHALLENGE

COMMUNICATION BETWEEN AND WITHIN AGENCIES

CARE OF THE CHILDREN IN HOSPITAL AS A PLACE OF SAFETY.

PROFESSIONAL CURIOSITY, UNDUE OPTIMISM / FALSE REASSURANCE

RECOMMENDATIONS

The Board should seek assurance that hospital staff working out of hours and those in Emergency Departments are familiar with the process of making contact with Children's Social Care, and what does and what does not constitute a referral, following existing guidance.

The Board should seek assurance that medical practices are aware of the need to ensure the notification to Child Health services of families with young children living in their area, particularly Health Visiting, and promote awareness of Universal Services which could provide support.

The Board should seek assurance that member agencies have procedures which emphasise the need to ensure follow up appointments in the safeguarding context. GPs should follow LSCB procedures in relation to making referrals to Children's Social Care and the Police, and ensure that missed appointments where there are safeguarding concerns are followed up and escalated as appropriate.



SERIOUS CASE REVIEWS

Child J

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. These processes should be transparent, with findings of reviews shared publicly.

<http://www.cambridgeshire.gov.uk/lscb/reviews>

SERIOUS CASE REVIEW: Child J.

A Serious Case Review was conducted in respect of Child J who was 4 years old at the time of the serious incident prompting this review. She was the younger child of a family of two children; there was also a six year old male sibling. The family had recently arrived in the UK having previously lived in another EU country. She was presented at hospital in August 2013, suffering from bruising to the arms and trunk, a bite mark and evidence of significant trauma in the genital area. Following the incident, Child J and her sibling were taken into care. Child J is currently the subject of a supervision order and in the care of her mother. Her stepfather was convicted of the offence of sexual assault, and has been sentenced to 17 years imprisonment.

CHILD J

This is a tragic case of a very serious sexual assault on a four-year-old girl. There is no clear evidence that it could have been prevented, although with hindsight it is likely that deliberate harm was a factor in the mid July presentations to hospital, which would have justified some challenge and an assessment of potential risks. There were no evi-

dent systemic failures within the multiagency safeguarding process.

There was one potential opportunity in mid July 2013 to identify the risks to the subject but these were missed. There were other occasions when professionals could have been more curious as noted below:

The lack of follow-up by the GP and the practice nurse to involve Primary Care (Health Visiting). This may have been a missed opportunity for the Health Visitor to get to know the family well, which may have enabled the mother to express any concerns she had about the child.

Medical professionals not talking directly to the child due to a perceived (and incorrect) language barrier. This review has identified the need for all professional Agencies to identify the language spoken by families, including children, as part of the service uptake process. Lack of direct communication at the surgery, at UCC, and the hospital were other missed opportunities to engage directly, and potentially understand the family situation better

Lack of pro-active curiosity is understandable in the context of busy professionals working in services under pressure to achieve tasks and activities within prescribed timescales. Routine tasks are undertaken and targets met in this

way, but skilled and trained professionals should be encourage keep their minds open to exploring the unusual and seeking to understand uncertainty, particularly in the context of their duty to safeguard children. This would be in addition to following required procedures, and can help to clarify the thinking and evidence which inform important professional decisions.

There were also some professional practice issues which potentially impact on safeguarding, and may have put the child at additional risk.

These include:

A reluctance to challenge other professionals, particularly within the medical profession. This is understandable in the context of status differentials within the medical profession, and between the medical profession and other Agencies. A preferred culture would be one of respectful discussion between junior and senior professionals, where it is seen as part of the learning experience to seek clarification, and the reasons for the professional judgements of more senior staff.

The importance of the *Cambridgeshire LSCB's Escalation Policy – Resolution of Professional Disagreements in Safeguarding Work* should be emphasised.

The prevalent means of communication within and between Agencies is written, through notes, email

or fax. Some of the Agency report authors have identified the benefits of more direct verbal communication, in person or by phone which can help clarify any areas of debate or uncertainty. A key message must be for professionals to talk to each other when uncertain about what they are seeing rather than relying on electronic communication.

The undue level of trust placed in the mother to take her child to medical appointments was potentially dangerous, and may have exposed the child to the risk of the mother not complying and potentially taking her out of the area. This practice was evident even when serious abuse could have been suspected. It appears likely that medical professionals did not recognise the potential safeguarding issues until the incident in August, but still did not take the necessary steps. In such circumstances it is necessary for all professionals to make arrangements to ensure that children do get to appointments, and that systems are set up to ensure that Agencies are quickly alerted in the event of this not happening.

There were also some key areas of good practice shown by all Agencies involved as documented in the report.