Review concerning a 3-year-old child
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7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a Learning Circle concerning an infant child after they attended hospital with injuries from a reported fall.

The areas the Learning Circle considered included the following:

1. Recognising accumulation of injuries over a period of time
2. Professional curiosity and challenge of parental accounts of injuries and children's behaviour at home
3. How non-accidental injury to ambulant children is considered
4. Maintaining a line of sight on children outside of statutory intervention

2 WHO WAS THE CHILD AND THEIR FAMILY?

Prior to the incident, the family came into contact periodically with a number of services since the eldest child was born. These contacts included several attendances at the Emergency Department concerning the child and their eldest sibling for illness and injury respectively. One of these incidents initiated contact with Children's Social Care, followed by another brief contact.

3 SUMMARY OF THE INCIDENT

The child attended hospital with injuries following a reported fall from a first-floor window. The child sustained two fractures to their skull and bruising to their lungs. There were further reports from somebody who knew the family as to concerns of the children at home. The nature of the concerns triggered an appropriate response from services to protect the children by being placed in foster care.

4 KEY POINTS AND ANALYSIS FROM THE REVIEW

- The child and their eldest sibling both attended the Emergency Department on four occasions each, respectively prior to the incident. There is a process in place for when a child attends the Emergency Department for three occasions within a year to trigger a review of records to determine what action is required to be taken. In the child and their siblings case this process was not initiated

- There was recognition there were limitations in questioning and a requirement for more curiosity as to how the child and their sibling sustained injuries in order to challenge parental accounts, which included siblings had inflicted an injury to another

- The child required two Child Protection Medicals, latterly for the incident concerned and another prior to this. On both occasions, all children were included in the medicals. All children have had Initial Health Assessments upon becoming Children In Care

- On reflection there was over-optimism from services and untested beliefs in what parents were attributing to causes of behaviour when previous concerns were raised. This included an anonymous referral made to Children's Social Care concerning children crying for long periods of time and shouting being heard towards children in the household. The case closed to Children's Social Care after a short time on the proviso parents would engage with Early Help. After initially consenting, at the point the support was due to commence consent was withdrawn. Records suggest there was no consideration by services to step back up to statutory services. Recent developments have taken place to strengthen the step up; step down process which now includes a joint visit and 3-month follow up review

- The child's eldest sibling was referred to the Speech and Language Team but after parents failed to 'opt in', the offer was closed. There was wider discussion as to the appropriateness of having an opt in process for children with additional safeguarding need. Reviewing this process is already underway with options being considered for an appointment to be sent as opposed to an opt in letter, which in turn would initiate the Was Not Brought Policy should a child then not be brought

- The family had the same Health Visitor throughout and records evidenced the strong relationship they had with the family which resulted in good engagement with all core contacts being provided and recordings of observations. There was good communication between the Health Visitor and Nursery to gain a view of the child's elder sibling outside of the family home

- The home environment assessment tool (HEAT) was not undertaken with the rationale father was upstairs with the children. This was not challenged as to why the HEAT could not be completed. Post the incident, the child's elder sibling showed police what is believed to be a 'naughty cupboard' which was a small boiler cupboard, where children were placed in by parents. No service was aware the cupboard was being used for these purposes and acknowledged whilst this needs factoring in to being part of curiosity, it is unlikely a HEAT would plausibly lead to looking in a boiler cupboard

- The case was not referred to the 0-19 Safeguarding Team for supervision and oversight which would have been appropriate to do so given the concerns

- The elder sibling's nursery setting demonstrated some excellent practice in the approaches and support provided to parents. This included allowing the child to attend nursery earlier on a morning, providing guidance on how to manage their behaviour at home, visiting the family home to enable the child's funding application to be completed so a place could be provided

- Service records indicated that the elder sibling's behaviour at home could be aggressive towards mother. Mother attributed this behaviour to the child having autism. There was limited evidence as to how services challenged this and considered what was driving these presentations to assess their lived experience at home in the context of parenting. In contrast, there were no concerns of the child's behaviour at nursery. Nursery's observations of the child were that they were a talkative and bright child who is developmentally and behaviourally consistent with their age

- Outside of the periods of contact with statutory services, there were limitations as to how those services who had ongoing involvement assessed the accumulative risk to children to escalate concerns. The 0-19 Service now have a cumulative risk assessment in place which once embedded should help strengthen the analysis and consideration of risk as part of routine enquiry. There was also opportunity to involve Wakefield District Housing in lines of enquiry when concerns were raised. Housing records suggest they were unaware of the contacts the family had with services

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WHAT WILL WE DO WITH THESE FINDINGS?

- The Learning Circle generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families

- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and families workforce

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NEXT STEPS

- The findings of the review has been approved by WSCP and work is underway in implementing the learning from the incident.

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RESOURCES

There are a range of national and local resources, guidance, and training in relation to safeguarding children on the WSCP website.

Wakefield Safeguarding Children Partnership