



## **Child R**

### **Learning Review Briefing**

### **March 2019**

**Welcome** to this Learning Review practitioner briefing to help practitioners and their managers understand the key messages from this review.

#### **Who should read the review?**

Any practitioner and manager whose work brings them into contact with children, young people and their families. The messages are just as important for those working in adult services (where service users are parents or carers). The term 'children' includes children and young people up to 18 years of age.

#### **Why a Learning review?**

As per Working Together 2018, learning reviews are conducted regularly, not only on cases which meet statutory criteria for a Serious Case Review/Child Safeguarding Practice Review, but also on other cases in which potential learning is identified. They can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and ensure that learning is actively shared with relevant agencies.

#### **Background information**

Child R is a young person with very complex physical and learning disabilities and severe developmental delay. She is a vulnerable child with no expressive language and would be unable to make a disclosure and is not in a position to respond to questions. Child R is subject of a Child in Need plan and receives short breaks services from the voluntary sector. She attends a Special School and receives a number of medical services.

Since 2009, Child R had suffered a number of fractures and episodes of bruising. In the early part of 2018 there had been 2 incidents of bruising, which although had been investigated

in terms of child protection, did not follow the agreed processes for managing injuries/bruising to children.

There had been evidence of previous domestic abuse and substance misuse within the household. There are two other siblings within the family. Child R receives services from a number of agencies including GP and Hospital, CAMHS, Children's Social Care and voluntary sector.

#### **Overview of Learning**

The report identified the following key areas of practice where the learning from this review could help avoid a similar situation in the future.

#### **Response to bruising/injuries**

Child R is a young person with multiple complex needs. She is non-communicative and relies on others to advocate for her. Child R has experienced a number of injuries and episodes of bruising in the past and these were often attributed to poor manual handling or reported to be self-inflicted. There was a lack of "healthy scepticism" from professionals and explanations were not questioned on a number of occasions despite there being potential indicators of abusive injuries. It appeared that practitioners sometimes accepted explanations without question when bruising was noted in areas that in a non-disabled child would have been considered to be potentially abusive.

#### **Barriers to providing a child centred response to a child with disabilities**

Children with disabilities can equally be subject to abuse and neglect but are mostly unrepresented within child protection figures.

Factors that increase risk and lessen protection of disabled children include:

- Attitudes and assumptions that do not treat disabled children equally and have an impact on all aspects of their lives. There is a reluctance to believe that disabled children are abused and this can lead to a minimisation of the impact of abuse and mistakenly attribute indicators of abuse to a child's impairment.
- Barriers to the provision of support services that lead to the disabled child and their family being isolated.

- Impairment-related factors such as dependency on a number of carers for personal assistance, impaired capacity to resist/avoid abuse, communication impairments and an inability to understand what is happening or to seek help.
- Barriers to communication and seeking help where the child's opportunities for seeking help may be very limited.
- Barriers to the identification of concerns and an effective child protection response such as: lack of holistic child-focused assessments, reluctance to challenge parents/carers and professional colleagues, a skills gap and resource constraints.

### Professional curiosity

There was evidence of domestic abuse between Child R's parents with the mother being recorded as the perpetrator in a DART notification and police records. It is acknowledged that this was only following the breakdown of the relationship; however no professional questioned the possibility of previous domestic abuse within the relationship, particularly as mother reported long standing mental health issues and substance misuse which appears to have resolved following the breakdown of the relationship. Agencies worked closely with the family to support them in the care of Child R, however practitioners need to be mindful of the need for professional curiosity in all cases, particularly when there are injuries.

Whilst Child In Need meetings were held they did not include information from a senior paediatrician or police. Strategy meetings were not quorate and no single agency appeared to have a full picture of Child R's experiences or what life was like for her. Professionals did not appear to consider the historic and current concerns around maternal mental health issues, domestic abuse and substance misuse when assessing risk or challenging the parent's explanation for injuries or any lack of engagement.

### Supervision and management oversight

There was very little evidence of supervision and management oversight on the case. This may have been because agencies were not aware of the combined concerns and history and there was no evidence of comprehensive chronologies within some agency records. Supervision has been termed the 'cornerstone' of safe practice. Dudley

are currently implementing reflective supervision within the borough which is the regular collaborative reflection between a practitioner and supervisor that builds on the supervisee's use of their thoughts, feelings, and values. An important element in reflective supervision is enabling staff to question their practice, critically analyse and evaluate experiences, and debrief after challenging or stressful encounters. This will lead to a better understanding of the cognitive and emotional elements of practice and improve outcomes for children.

### Recommendations

1. To ensure that the children's workforce receive training around the added vulnerabilities of children with disabilities and complex needs.
2. To ensure that ALL staff involved in a case are invited to share information for Core Groups (and other multi agency meetings) to enable them to contribute to safe care planning and to review the offer and level of support being offered to the family.
3. To review and update the Practice Guidance: Safeguarding Children whose parents/carers have mental health issues, learning disability, emotional or psychological distress and substance misuse.
4. To improve the recognition of DVA related symptoms within primary care in order to offer early help and intervention and prevent any deterioration.

### What can the DSCB offer to support you in your work?



For both e-learning and face to face training use this link:

<http://safeguarding.dudley.gov.uk/child/work-with-children-young-people/training/>

Visit our website: <http://safeguarding.dudley.gov.uk>

For more information and access to the interagency child protection procedures.