5 Safeguarding in FIVE

Serious Case Review Child B

1. Background

- Child B was known to Hackney Children & Families Service from birth and was supported by the Children with Disabilities (CWD) Service. Age 7, Child B was admitted to hospital for an amputation that could have been prevented with appropriate treatment. Child B was not brought to a number of medical appointments and there were concerns in the professional network about neglect.

2. Findings

- When Child B was not brought to appointments, this was not challenged by professionals. There was no exploration with the family about the practical support they might have needed. The family were under significant pressure.
- Children need to be seen, heard and helped. There was little evidence of Child B's voice during intervention.
- Engaging parents and carers to support disabled children is key, but this should not dilute professional challenge. Non-engagement by parents / carers can be a 'red flag'.
- It can be a challenge to hold the complete pictures of the family when supporting children with complex health needs. There is a need for clear systems and processes to support effective child focussed practice.
- Professionals need to 'Think Family' and 'Think Fathers'. There was an over-focus on Child B's mother and not enough thinking around the family dynamics or the role that Child B's father played.

3. Recommendations

- All local health services should have access to and use a 'Was Not Brought" policy.
- The Disabled Children's Service terms of reference and agenda structures for meetings should include an analysis of a child's attendance at appointments.
- Seek reassurance that recording systems in local organisations are able to identify repeating patterns of children not being brought to appointments.
- Review CHSCP and single-agency guidance for inclusion of risks associated with children not being brought to appointments and the importance of communication and hearing the voice of the child.

4. Reflections

- Do you recognise the features of this case in your own practice or that of your team / service? What implications does this have for your service or practice?
- What changes can you and your team make to improve practice in line with the findings and recommendations?
- How will you be able to tell these changes are having an impact on children, young people and their families?

5. Further Learning

- Read the full report on the CHSCP website HERE.
- View the upcoming programme of multi-agency safeguarding training HERE.
- Visit the Practice Guidance section of the CHSCP website (Working with Neglect; Safeguarding Children with Disabilities and Think Family).
- Watch a short video on 'Was Not Brought'
- Sign up to the Things You Should Know Briefing to keep up to date on safeguarding news and training.

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