Key issues for the health sector in Oxfordshire case reviews

This short review is based on Oxfordshire case reviews, and themes in common with national case reviews, which have highlighted lessons for health professionals to improve safeguarding practice.

The report gives an overview of findings, learning points for health practitioners and actions taken for improving safeguarding practice.

Key issues for the health sector in Oxfordshire case reviews

In the case reviews examined, a child or children were seriously injured due to the following;

- Neglect
- Physical abuse/non-accidental injuries
- Malnourishment
- Possible fabricated and /or induced illness

Finding one
No one professional had a good understanding of the family context and dynamics and the implications for the child's wellbeing and safety.

The belief that the child's problems were linked to a condition diverted attention from the lived experience of the child and the parent's capacity to meet their needs.

Family dynamics and stresses were not always understood in relation to their impact on the child's wellbeing and safety. For example, practitioners were unaware of the lack of heating or hot water in one home environment and of past experiences of domestic abuse and threat of eviction in another.

It was not always recognised that risk levels could change and were not stable in relation to the impact of parental mental health and substance misuse on the safety and wellbeing of the child.

In one case the majority of professionals either did not know that the child was being home schooled and/or that this meant there was no requirement for home visits from any statutory agency. The professional community did not have a good understanding of the implications of elective home education including the lack of regulation and its limitations in safeguarding children.

Finding two
Management of children's health needs were fragmented with no one professional assuming responsibility for ensuring a coordinated approach.

In one case review, three services were involved in the management of the child's chronic constipation and there was evidence of confusion regarding the different role and function of each of these services.

Whilst there were examples of health practitioners developing comprehensive plans and referrals to address specific needs, the health care system did not adequately provide for one professional having responsibility for ensuring those plans were followed through.

Finding three
Lack of professional curiosity about self-reported information and focus on the voice of the child.

Effort and attention paid to the parent/carer led to the focus on the child often being lost.

Assessments in health organisations may be based mainly on self-reported information.

In one of the cases reviewed there were strong examples of practitioners being tenacious in following through their concerns.

Finding four
Having a whole family focus

There was a failure to 'Think Family' in cases examined.

For example, in one case there was a dominance of concerns about one sibling's needs, assessments were in respect of that sibling with no clear analysis of how the overall family circumstances impacted on the other child/children.

In two of the cases examined, no contact was made with father and his role within the family remained unclear.

Learning points for health practitioners

- Safeguarding should always be considered in cases where health concerns don't respond to treatment as expected.

- Thought should be given to whether there is additional information about family history available within health records for siblings, half siblings or parents that should be used to inform the assessment. This should include father's details.

- Children should be spoken to alone in relation to any allegation or physical signs of harm and Child Protection procedures should be followed.

- When a child is admitted to hospital out of hours with serious injuries that may be non-accidental, practitioners in social care, police and health organisations

should make sure that a strategy discussion takes place in order to plan next steps.

- There are challenges in managing serious injuries to children across local authority borders and practitioners need to be mindful of potential differences in custom and practice as well as being supported by effective protocols.

- Practitioners should consider convening a 'professionals only' meeting when interventions and planning have not led to effective outcomes for a child, there are concerns about drift or where adults are hostile, reluctant or failing to comply.

- Always follow up appointments where a child 'Was Not Brought', the new term for 'Did Not Attend'.

Themes in common with other serious case reviews where health is a key factor

- **Lack of professional curiosity, challenging parents and hearing the child's voice**
- **Not being brought to appointments**
- **Identifying and responding to neglect and abuse**
- **The importance of thinking carefully about the role of the father in the family system**
- **Formal child protection procedures not followed with sufficient rigour**

Actions taken in response to the findings

- The Elective Home Education Policy and Procedure, published in the OSCB online procedures manual, provides information on the legislation and guidance underpinning regulation of elective home education.

- NHS England is introducing a new read code for GP's that will signify on the child's record that they are being electively home educated

- All families electively home educating children are sent information regarding the support available to them from health professionals, particularly school health nurses. This includes information on the Health Child Programme, immunisations, vision screening, and contact details for all teams, see attached.

OCC Information Leaflet for Elective H

- The constipation and urinary continence pathway has been re-designed and all referrals go via a central hub

- An audit of strategy meetings for children in hospital was undertaken in Oxfordshire with a focus on the Hospital Team. Overall the findings of the audit were that procedures were being followed and the relevant professionals attended hospital strategy meetings in order to inform the safeguarding actions resulting from said meetings, fully: 73% of cases and partially: 27%.

- A multi-agency disabled children audit was undertaken and action was taken to ensure health practitioners keep a clear record of 'was not brought' episodes

- Guidance on Professionals Only Meetings published in the OSCB online procedures manual

- Oxford Health's annual safeguarding audit was undertaken and actions taken to include children's details on adult records, 'Think Family' when care planning, completing risk assessments and inviting practitioners to Care Programme Approach meetings. The audit highlighted the need for siblings to be considered more consistently where there are safeguarding concerns.