Health: learning from case reviews

Overview of risk factors and learning for improved practice for all professionals working in the health sector

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Health professionals are well placed to identify families who need early help. They have an overview of issues affecting individual family members which may impact on a child’s welfare.

They are also in a position to co-ordinate the work of different agencies supporting children and families.

Health professionals in paediatric and accident and emergency (A&E) teams have a vital role to play in spotting and responding to some of the most severe forms of child abuse and neglect.

Reasons case reviews were commissioned

This briefing is based on case reviews published since 2013 which have highlighted lessons for health professionals to improve safeguarding practice. In these case reviews children died or suffered serious harm in a number of different ways:

- non-accidental injuries
- physical neglect
- emotional neglect
- suicide
- child sexual exploitation.

Key issues for the health sector in case reviews

Seeing the bigger picture and having a family focus

Case reviews warn professionals against focusing exclusively on a child’s physical health needs. The impact of emotional stress on some medical conditions should be considered. Emotional stress could be a result of issues at home including domestic abuse or a parent’s drug or alcohol dependency.
When professionals work with a very large number of families with similarly complex needs, there is a risk that issues such as drug and alcohol misuse become ‘normal’. This can mean professionals are less alert to the dangers posed to children. Practitioners can also become accustomed to working in areas with high levels of street and drug-related violence. This ‘desensitises’ them to safeguarding risks in the wider community.

GPs, in particular, should be the ‘lynch pin’ in the network of services working with a family. They are best placed to get an overview of the issues facing a family and how these might impact on parents’ ability to care for their children. Case reviews found that some GPs were not recognising the ‘social aspects’ of a case and did not have a sense of problems accumulating within a family.

The case reviews uncovered a number of reasons for this difficulty in GPs seeing the bigger picture:

- a system of accountability for primary healthcare which focuses too much on measurable disease outcomes rather than on holistic health and wellbeing outcomes
- complex family structures: family members with different surnames and addresses and adults who frequently change partners
- a move towards larger practices with a number of full and part-time GPs and a range of services. This has affected continuity of care because individual patients are seeing a larger number of healthcare professionals.

**Challenging parents and hearing the child’s voice**

Although it is very rare, parents can sometimes be deceptive or manipulative when reporting children’s health problems. In some case reviews professionals were relying too much on parents’ reports and not examining the child or observing their behaviour. Repeat prescriptions were also issued by administrative staff over a long period without the doctor seeing the child. It is important to gather the views of children and other family members, particularly if one parent is dominant or assertive.

Case reviews also highlighted professionals’ reluctance to challenge parents’ views or probe for further information for fear of provoking a confrontation. When practitioners have to deal with parents who are hostile and aggressive they focus too much on the parents and not enough on the impact this behaviour will be having on their children.

**Following up missed appointments and linking incidents**

Children rely on their parents and carers to take them to medical appointments so missed appointments are always a cause for further action. Failure to attend medical
appointments is recognised as a child protection issue within statutory definitions of neglect. Missed appointments may also suggest that services are difficult for vulnerable families to access. Case reviews have noted a tendency to record missed appointments but no collation of information or questioning its significance. Reviews criticised the system of flagging non-attendance at medical appointments as DNA (Did Not Attend) which in some cases led to a withdrawal of services. The DNA category does not recognise the real issue which is children not being taken to appointments, a potential indicator of neglect.

Dealing with incidents in isolation is especially common in A&E where there is a high turnover of patients and a focus on the immediate issue. Considering previous hospital admissions as well as the child and family’s history and background can help professionals distinguish non-accidental injuries (NAI) from other medical conditions. It can also be vital in spotting patterns which indicate child neglect.

**Identifying and responding to child abuse**

Case reviews stress being aware of the significance of bruising on non-mobile babies and the importance of referring cases to children’s social care with full and accurate information. A lack of key medical diagnostic services can lead to failure to quickly identify and respond to significant injuries suffered by the child.

Some case reviews found that GP postnatal checks were a tick-box exercise with not enough analysis of potential indicators of child neglect such as slow weight gain. GPs need to be vigilant to safeguarding risks and refer these to health visitors to investigate further. Some reviews flagged the issue of not considering child protection and safeguarding issues when treating teenagers under the age of 18, particularly in A&E. There was also specific evidence of a lack of understanding of child sexual exploitation.

**Sharing information**

Most case reviews flag the issue of inadequate information sharing and ineffective work with colleagues and other agencies.

The knowledge held by an individual practitioner or agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern and risk. Practical barriers to information sharing include using different and incompatible IT or paper systems and diverse interpretation of policy, procedure and protocol.
Some case reviews criticised the system of assigning health visitors to a geographical area rather than a specific GP. This can result in little or no information being exchanged between health visitors and family GPs.

Information sharing is also compromised when the full range of health professionals working with a family fail to attend child protection conferences and core groups. Absent GPs, midwives and paediatricians are not able to give first-hand accounts of their involvement with families which can result in important nuances being lost, leaving other members of the group to interpret information.

**Working with professionals in social care and other agencies**

A number of reviews highlighted that health professionals were uncertain about what level of concern should prompt a referral and how to escalate concerns when a referral has been dealt with inadequately.

In some cases there was reluctance on the part of health professionals to challenge social workers on the presumption that they know best. There was also a tendency to not persist in flagging ‘niggling concerns’ because of the difficulties and complications of multi-agency work.

One case review highlighted the issue of out-of-hours doctors being unable to contact family GPs for guidance to inform safeguarding decisions. There was also no follow-up to reassure the out-of-hours doctor that the family GP had acted upon their referral.

**Workloads, targets, timescales and supervision**

Some case reviews flagged the issue of high levels of caseloads limiting the time professionals can spend with children and families undertaking thorough and reflective assessments. They are also under pressure to meet targets and work within stringent timescales. Such constraints result in superficial assessments and an incomplete analysis of the risks facing a vulnerable family who then miss out on vital support services.

Good supervision is essential in challenging practitioners to reflect critically on their judgements. Health professionals felt that due to the sheer volume of cases involved, their supervision had become too directive – checking that plans had been followed and targets and timescales met. This was at the expense of reflective, challenging supervision which was also supportive of the emotional demands of working with children and families.
Learning for improved practice

Having a family focus

- Find out each patient’s family details and their links to children. Record these and tell other agencies when this information is relevant to an assessment of need or provision of services.

- When working with mothers make regular enquiries about male partners who may have access to her children.

- When seeing parents and carers of children make routine enquiries about drug and alcohol use and domestic abuse.

- Always ask patients with mental health difficulties, learning difficulties or drug and alcohol misuse whether they have significant child care responsibilities. Consider their capacity to care for children safely. Record this information in medical notes and emphasise it in referrals and correspondence about patients.

- GPs who work with different members of the same family need to share information with each other on a regular basis.

- Explore how continuity of care can be improved by individual patients and members of the same family seeing fewer GPs and healthcare professionals.

- Develop documentation which prompts an assessment of the social history and background of the child and their family. Train staff in how to ask these questions. The use of genograms may be helpful.

- When treating a child who may have sustained non-accidental injuries, it’s important to make enquiries about any other children who may be at risk.

- Implement a system to alert hospital staff to children on child protection plans.

Listening to and seeing the child

- Do not automatically accept a parent’s or carer’s report without talking to the child and, if possible, other family members and close friends. If the child is very young observe and analyse their presentation and behaviour.

- When referring children, highlight anything that has only been reported by adults or has not been observed by professionals.
• Be alert to patterns in parents’ and children’s behaviour over time which may indicate the child is at risk of abuse or neglect.

• Do not administer repeat prescriptions to children without a GP regularly examining the child. Consider implementing an alert system to identify the over-prescription of drugs to a child.

• Be prepared to challenge parents and carers in order to gather as much information about a child’s wellbeing as necessary.

• Provide training for staff which models how to challenge parents and carers effectively and gives staff the confidence to inquire into potential abuse.

Responding to missed appointments

Always follow up a child’s missed appointments. Consider changing the non-attendance code from DNA (Did Not Attend) to WBA (Was Not Brought) which should prompt more positive intervention to safeguard the child and support their wellbeing. Watch Nottingham Local Safeguarding Children Board’s short animation "Rethinking ‘Did Not Attend’" on YouTube.

• Liaise with health, police and social care about arrangements for hospital discharge and the after-care of vulnerable children. Involve parents in these discussions.

Recognising child abuse

• Always be aware of the significance of bruising on non-mobile babies. Refer these cases to children’s social care with full and accurate information which includes a medical and social history, the child’s developmental stage and the explanation given by the parent.

• Look for signs of trauma in seriously ill babies when there is no clear cause of illness such as an infection.

• Take clinical photos as near to the time of injury as possible to record the greatest detail and include the photos in all formal child protection reports.

• Make all necessary diagnostic tools available to children whenever required, including during the evening and at weekends.

• During post-natal checks, remove a baby’s nappy before weighing. Plot the baby’s weight on the growth centile chart and analyse information and data gathered during the checks for potential safeguarding risks.
• Professionals should document they have read and understood the nature of safeguarding concerns about the child they are treating.

• Record discussions which take place during a medical supervision meeting where safeguarding concerns are identified.

• Use peer review to ensure medical staff are responding appropriately to safeguarding concerns.

Effective information sharing

• One case review highlighted the good practice of a regional health care partnership which introduced a single electronic patient recording system to which all professionals working with a patient could contribute.

• GPs should automatically share their records with health visitors as well as vice versa.

• If a GP cannot attend a child protection conference they should ensure that another member of the primary health care team attends and is able to represent the GPs’ views and experiences.

• Health commissioners should ensure primary health care teams have access to prison health records and court reports to identify adults who may pose a risk to children.

Working with other professionals

• Ensure there are policies and procedures for challenging professionals in other agencies who are not responding adequately to concerns about a child. Perseverance may be needed in such situations.

• When making referrals to children’s social services and other agencies, make sure that referrals are clear and concerns are spelt out. Remember other child protection professionals will not necessarily have an in-depth understanding of the medical issues.

• GPs have the best overview of all services involved with a child and their family. They are also best placed and have the professional authority to demand a coherent response from all agencies involved.

• Be prepared to communicate with out-of-hours GPs in order to provide them with the information they need to weigh up risks posed to a child.
• Follow up any recommendations made by an out-of-hours GP about a child quickly and inform them of outcomes.

Supervision and workloads

• Newly qualified health professionals need to discuss all their complex safeguarding cases during supervision.

• Experienced practitioners should bring 3 or 4 complex cases to supervision for in-depth discussion and analysis. Insight from these discussions should then be transferred to all cases with similar issues.

• Supervisors should encourage their staff to reflect on the emotional impact of managing complex cases.

• Health professionals should escalate failures in processes to managers so that action can be taken.

Contact the NSPCC’s Knowledge and Information Service with any questions about child protection or related topics:

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