**Pitfall 5**

**Insufficient attention is paid to what children say, how they look and how they behave.**

Despite very significant emphasis on “seeing the child” in initial assessment, a volume of serious case reviews and public inquiries have clearly evidenced practitioner failings in this respect (Ayre, 1998; Rose and Barnes, 2008; Brandon et al, 2008; Brandon et al, 2009).

In 1998, Ayre noted a lack of child observational data in practitioners’ records and reports – a finding that has been reiterated in more recent work (Rose and Barnes, 2008). Aldgate et al (2006) noted how, for a number of reasons, children can be difficult to see, while recent research has shown that practitioners tend to see children in relation to their attachments and development, rather than attending to them as individuals (Thomas, 2010). This can cause practitioners to miss vital clues about wellbeing and safety, particularly in borderline cases.

Practitioners may lack communication skills or may feel awkward in asking to see children alone. However, it is imperative when making initial assessments that practitioners take time to see, speak to and observe children (Glaser, 2009). In order that they can be appropriately supported, staff need to be encouraged to inform their managers if they find themselves in situations where they do not feel confident in seeing and speaking to children.

As in the case of baby Peter Connelly, a small percentage of parents who severely and/or frequently abuse their children adopt a range of often plausible strategies to prevent the practitioner from seeing the child (Haringey Local Safeguarding Children Board, 2009; Munro, 2005b; Ferguson, 2009). Parents may take steps to conceal injuries. Practitioners must, therefore, be vigilant to this possibility and ensure that they recognise parental resistance to seeing the child. Practitioners should return to the family home, or seek permission to see a child in another venue, such as the child’s school. Where parents obstruct access, practitioners may need to make use of the provisions within the Children Act 1989, such as the Child Assessment Order, or police powers. Where staff feel that competing organisational priorities prevent them seeing children, they should alert their managers.

Moreover, seeing the child in the early stages of work must equate to more than just “ticking a box” and should constitute a detailed qualitative observation (Aldgate et al, 2006). Hart and Powell (2006) stated that a case file should give “a real sense of the day-to-day experiences” of the child. The practitioner should be able to picture what life is like for particular children in their families

The importance of seeing children physically moving, eg crawling or walking, has been recently discussed by Ferguson (2009), drawing attention to failings in the cases of Jasmine Beckford and repeated in the case of baby Peter Connelly.

Certain groups of children are particularly vulnerable; notably babies and young children, who are not able to speak out or seek help, children with physical or learning disabilities, and deaf children. These children are especially at risk when they are unable to communicate easily what is happening to them (or steps are not taken to facilitate communication) and are dependent on others for intimate care. When making an assessment of the needs of disabled children, including children who are deaf, it is critical that practitioners seek ways of communicating effectively with children and seek information from all possible sources.

Other relevant practitioners, including specialist teachers of disabled children, can be particularly well placed to offer information about a child's wellbeing or any deterioration in mood and behaviour (Morris, 2003). When families of a disabled child request help from services, studies suggest that practitioners can readily respond to the request for help, accepting the parent/carer’s description of the presenting problem. Notwithstanding the importance of meeting parents/carers' support needs, assessment should be holistic – to include sensitive analysis of risk factors – and should elicit views of the disabled child (Morris, 2003; Ofsted, 2009). Practitioners should seek specialist expertise where, for example, they lack knowledge of deaf culture and the necessary communication skills needed (Young et al, 2008).

As a serious case review in Birmingham (Barnett, 2006) indicated, there are also problems of seeing older children. The phenomenon of agency neglect of adolescents is now well documented (Hicks and Stein, 2010), with the needs of young people aged 11–17 easily overlooked by services. This is evidenced by the relatively lower number of older children subject to child protection plans. Yet very recent research has found that young people who have experienced troubled childhoods can experience an escalation of difficulties in adolescence due to increased propensity for risk-taking/acting out behaviour at this age (Rees et al, 2010).

At initial assessment, it is important that relevant expert assessment is sought where appropriate and any uneasiness about a child’s health, injury or other aspect of presentation is sensitively but appropriately probed. Specialist input at an early stage can make a significant contribution to the quality of the assessment and linked plan of intervention. It is also critical to ensure effective assessment of children where there are issues of language or assisted communication, drawing on appropriate expertise.

If staff experience that they are impeded from accessing expert assessments because funding is generally only available at the point of court proceedings, they must flag this problem with their managers. If, instead, staff simply stop requesting them, the danger is that the degree of unmet need remains hidden from senior management and not, therefore, addressed (Fish et al, 2008).

**Questions for practitioners:**

Have I been given appropriate access to all the children in the family?

If parents are cooperative, what type of cooperation was it? Was it, for example, ambivalent/hostile/confrontational?

What is the child’s account of his/her situation and needs?

Have I taken full account of the child’s additional communication needs; for example, in the case of children who are deaf or disabled? Have I sought appropriate specialist expertise to facilitate communication?

If the child uses a language other than English, or a method of alternative non-verbal communication, have I made every effort to enlist help in understanding him/her?

Did the interview with the child appear coached? What is the evidence to support or refute the child/young person’s account?

If I have not been able to see a child, is there a very good reason, and have I made arrangements to see him/her as soon as possible?

How should I follow up any uneasiness about the child(ren)’s health or wellbeing?

What do I know about this child? Do I know what they enjoy, like, dislike etc?

How is the child moving, eg when crawling or walking?

Have I consulted other relevant/specialist practitioners who have contact with the child, to draw on his/her observations of any significant changes in the child’s wellbeing or behaviour?

Would I draw this conclusion or make this decision if the child were not disabled?

Would I have taken any further protective action if this were not disabled?

**Questions for managers:**

Can I get a sense from practitioners’ verbal accounts and documents of how this child is living?

Am I sure that the social worker has actioned appropriate expert assessment – particularly in the case of children who are disabled or deaf?

Am I encouraging staff to improve their skills and confidence in seeing and speaking to children and young people with different needs and abilities?

Am I making sure that there are clear organisational messages about the priority of seeing and speaking to children and young people?

Have I asked staff if the balancing of competing demands and priorities currently feels manageable or whether they trade-off seeing and speaking to children in order to meet other priorities?

Does my department provide sufficient focus on observations and interaction with the child within the electronic record of the case?