CHILD SAFEGUARDING PRACTICE REVIEW

Child V

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Kingston and Richmond Safeguarding Children Partnership

Lead Reviewer & Report Author: Karen Perry

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1. INTRODUCTION AND PROCESS OF THE CHILD SAFEGUARDING PRACTICE REVIEW

1.1. This Child Safeguarding Practice Review (CSPR) is in respect of Child V who died in the summer of 2021. This is thought to be due to a chronic health condition. At the time of Child V's death there was also evidence of malnutrition. Both parents are currently subject to police investigation.

1.2. The review panel agreed a scope for this review to explore multi-agency involvement from July 2016 until mid 2021.

1.3. Kingston and Richmond Safeguarding Children Partnership (KRSCP) will ensure that learning is widely disseminated locally and will publish this report on the partnership and NSPCC websites. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning.

1.4. KRSCP agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted as they did at the time. Single agency reports were produced to explore issues identified in the Terms of Reference. Practitioners were involved in several ways; in the production of most of the agency reports, in two events led by the author, and providing comments on earlier drafts of this report. Family members were also offered the opportunity to speak to the lead reviewer. Both parents agreed to this, their views are described in Section 6.

2. MOST SIGNIFICANT LEARNING FROM THIS REVIEW

2.1. It is Important for all practitioners working with a child with a complex health condition to understand how the condition affects the child, and what optimum treatment at home looks like and any risks of mismanagement. Therefore, when a child has a complex health condition, especially if it is an unusual one, it can be helpful to have a briefing about the condition and its treatment and management at home from a specialist clinician in a setting which provides opportunities for practitioners to ask questions e.g. a professionals or core group meeting. Assessments and interventions should specifically consider whether there is an impact because of the parents' background, attitudes, or beliefs on the care a child receives, for sick children this would include their attitude to the health condition and the treatment for it. There are also potential benefits of agreeing which doctor should be the lead clinician for those children with complex health conditions who are particularly vulnerable. This would include children subject to child protection plans and any others where there are concerns about possible medical neglect.

2.2. Parents cancelling appointments, even when they are re-arranged, needs to be recognised as a form of "was not brought", which could constitute medical neglect. it is helpful to non-medical practitioners if GP reports to child protection conferences explicitly list the actual or potential impact for the child of non-attendance at health appointments and include the details of specialist health services involved with the child so this and other relevant information can be sought from them.

2.3. Research indicates that children, with disabilities or complex health conditions are more vulnerable to abuse. Signs of abuse and neglect may be masked by or misinterpreted as being due to those impairments of health (diagnostic overshadowing). Where children have complex health conditions it is useful to have a child protection medical or other form of health assessment, even when a medical is not otherwise deemed necessary, for example, because allegations of physical abuse are not recent.

2.4. Where families become known to Children's Services because of serious domestic violence, there is a risk that this colours the focus of the Child Protection measures with a reduced awareness/focus on the health and education aspects of children's needs. Especially for children with complex health needs, Child Protection and Children in Need plans need to be more detailed in their focus on health, including specific actions relating to each child's health rather than, for example, relying on a health visitor or school nurse to monitor it. Attendance at nursery is important to support children's development, this needs to be a focus of any child protection or CIN plan.

2.5. Whilst removal of the violent person may reduce the directly associated risks of domestic abuse, there is a need to recognise any positive contribution that that parent made to the functioning of the family and make sure the remaining parent or someone else is able to fulfil those positive roles.

3. DETAILS OF THE FAMILY AND CASE CONTEXT

3.1. Family members will be referred to by their family relationship to Child V e.g. Mother, Father, Sibling etc. Child V had two older siblings. The family are recorded as being of South Asian heritage. Both parents speak English. Father does not have a permanent right to remain in the UK. Members of the extended family have lived with the family with some members providing support with childcare throughout Child V's life, especially when Mother returned to employment.

3.2. Child V has been described by those who knew him as being friendly and chatty, after initial shyness and having a ready smile. He was a fan of dinosaurs, Superman, enjoyed drawing and jigsaw puzzles.

4. KEY EPISODES

Key Episode 1; from July 2016 to the end of 2018 (follow up of his health conditions during early childhood)

4.1. As well as the condition diagnosed in babyhood, prior to his birth in April 2017 Child V was diagnosed with a condition (referred to as Condition X in this report), that does not usually cause long term problems if it is diagnosed and treated promptly and followed up by secondary health care services.

4.2. Mother had taken up almost all the antenatal care appointments offered to her, and the midwifery service stayed involved longer than the standard 10 days, because of concerns about Child V's weight loss. They were discharged by the midwifery service on the 28th

day after birth as Child V has made a satisfactory weight gain and was under the care of the health visitor and the paediatrician for the health condition.

4.3. A health visitor made a new birth visit when Child V was 13 days old and liaised with the GP about his health condition. By June 2017, at the age of 2 months, the specialist hospital had diagnosed a medical condition, which would require surgery, followed by life-long management through diet and medication. The surgery was completed when Child V was aged 7 months.

4.4. In October 2018, about 12 months after the surgery, a paediatrician saw Child V again at the local hospital due to health problems. He was referred to the local hospital due to concerns about his weight gain and provided with high calorie milk formula. He was re-referred by the GP to the surgical team at the specialist hospital for follow up of Condition X.

Key Episode 2: from March 2019 (when concerns were expressed by the paediatirican about Child V's poor weight gain) until 1ST February 2020 when Mother made allegations of domestic abuse and physical abuse of the children

4.5. During this period Child V received treatment for Condition X as well as the other condition. In March 2019, Child V was seen again by a paediatrician at the local hospital with poor weight gain. The paediatrician issued several prescriptions and requested an urgent assessment from the specialist hospital. By May 2019 Child V's weight gain had improved, but he was still under weight for a child of his age and birth weight.

4.6. During April and May 2019 Child V was not taken to three appointments at the specialist hospital. The hospital notified the GP who saw Mother to emphasise the importance of following the treatment recommended and attending appointments. This, and a subsequent similar conversation in August 2019, had limited effectiveness.

Key Episode 3: from 1ST February 2020 when Mother made allegations of domestic abuse and physical abuse of the children until the cessation of the Child Protection Plan in April 2021

4.7. In January 2020 a family member reported to the police that Mother was suffering domestic abuse by Father. Mother reported a long history of domestic abuse and that Father had also assaulted the children. Father's bail conditions excluded him from the home. In February 2020 an Initial Child Protection Conference was held with the outcome that all the children were made subject to child protection plans, the category of physical abuse for Child V and emotional abuse for his older siblings.[1]

4.8. A Family Court Advisor (FCA) was appointed in mid-February 2020, when Father made an application for a Child Arrangement Order to have contact with his children. In April 2020 the FCA concluded the court would benefit from a report from a social worker. In July

[1] It is partnership policy that where there is domestic abuse the category for all children under 5 will be physical abuse due to research findings of their greater vulnerability to this when domestic abuse is present.

2020 Father attempted to withdraw the court application, this was not supported by the FCA duty officer, or agreed by the court, pending confirmation from the local authority that this would be safe for the children.

4.9. In March 2020 a health visitor saw Child V for the first time since his new birth visit. Prior to successful visits in September 2020, March, and April 2021, when Child V was weighed, Mother cancelled 3 appointments with the health visitor. In September 2020 Child V was also seen by a nurse at the GP surgery for immunisations.

4.10. In April 2020 Father was charged with four counts of assault on Mother and three further counts of assault in relation to the children. In June 2020 the case against Father was discontinued in court due to insufficient evidence for a successful prosecution.

4.11. In September 2020 Child V was admitted to nursery. Apart from enforced absence between January and March 2020 due to Covid restrictions, his attendance was characterised by blocks of good attendance and blocks of absence due to ill-health.

4.12. During this key episode all members of the core group and the Family Court Advisor were focused on the risk of domestic abuse. They shared information about concerns e.g. about the nature of the contact Father was having with the children, and concerns that he might be visiting the house or move back in. Practitioners at the Review Child Protection Conference in November 2020 agreed that the child protection plans should continue because of this. Both parents received specialist input regarding domestic abuse.

4.13. In March 2021 Mother presented at hospital for treatment for significant injuries. Her explanation for the injuries was accepted, so no referral was made to Children's Services.

Key Episode 4; From April 2021 when the Child Protection Plan was replaced with a Child in Need plan until the day Child V died in 2021

4.14. In mid-April 2021 practitioners believed that there was no longer a risk of significant harm from domestic abuse and so the child protection plans were discontinued, and the family was offered support via Child in Need (CIN) plans.[2]

4.15. In the few weeks between the ending of the child protection plan and Child V's death, he was seen four times, once virtually by the social worker, one home visit each by the health visitor, and social worker and one attendance at nursery. Nothing particularly unusual was noted by any of the practitioners, apart from nursery staff noting that he seemed more uncomfortable and quieter than usual. From mid May 2021 Mother was informing the nursery that Child V was too unwell to attend and that she intended to take him to the GP. She did not do so before he was found collapsed at home. Child V received treatment at

[2] A Child in Need (CIN) plan co-ordinates services provided under Section 17 Children Act 1989 services to support children to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development. Step down to CIN plans from a Child Protection plan is standard policy in the local area.

home for cardiac arrest from the ambulance crew and was transferred to the local hospital where CPR[3] was ceased due to no signs of life.

4.16. The local authority has made suitable arrangements to protect the siblings.

5. THEMATIC ANALYSIS

5.1. The learning from this review was identified from chronologies, single agency reports and at the practitioner event and from family members. The themes are:

- **Awareness and Management of Child V's health condition**
- **Response to medical neglect; Child V not being brought to medical appointments/accessing support offered**
- **Response to domestic abuse**
- **How agencies worked together to protect Child V and safeguard his welfare**

Theme: Awareness and Management of Child V's health condition

5.2. The medical condition that affected Child V is a medical condition which requires surgical management as an infant and long term follow up. Typically, symptoms are identified within a couple of weeks of birth, followed by procedures to confirm diagnosis, then surgery. Child V presented later with clinical symptoms. Later presentation and treatment of this condition causes additional symptoms. Certain procedures were required prior to surgery; these were not always done as consistently as necessary by Mother.

5.3. The impact of the disease after surgery is lifelong but variable; Child V exhibited the classic symptoms common to approximately 75% cases who would require regular use of medication sometimes daily (as for him). He also needed regular attendance at outpatient appointments to monitor his progress. His condition causes pain and, in severe cases/cases which are not properly managed at home like Child V, impairs comfortable movement of the body. It is crucial that parents are aware of the risks of this condition. This can need hospital treatment within 24-48 hours, otherwise deterioration can be rapid; in the days before modern management, this disease had a 50% mortality rate. Once a diagnosis had been made there is evidence that the parents were well briefed and understood the nature of Child V's condition and the associated risks.

5.4. Practitioners working with Child V who were not doctors told this review that they had not been fully aware of all the symptoms, risks and treatment for the condition. Neither were they aware in the necessary detail of how the condition affected Child V and what optimum management would look like for him, or that the extent of the impact of and level of treatment for the condition can be very individual. This meant that the nursery was falsely reassured by having another child with the condition in the school.

5.5. The health visitor was the only health practitioner who was part of the child protection core group. The core group was over-reliant on her for providing information about the condition and its management. Health visitors are not specialists, and this is a rare

[3] Cardiopulmonary resuscitation: medical procedure which is given to someone who is in cardiac arrest.

condition. The GP told this review that better arrangements would have involved more detailed briefing of the health visitor by the GP. Whilst that might have helped the health visitor in her day-to-day contact with Mother and Child V, this would still have left her in the position of being the main conduit of information about the disease. However, what was required, especially once Child V was subject to a child protection plan, was that all practitioners working with the family had a good understanding of how the condition affected Child V and what the optimum management of it was, so that they could ensure he was being well cared for. Social care managers told this review that it is common practice for child protection or CIN plans to rely on health visitors to oversee health needs. Those working with children with complex health conditions would benefit from some reflection on whether this was always the best approach.

5.6. Link health visitors for the GP practice had Multi-disciplinary Team (MDT) meetings with the Safeguarding GP, these were conducted virtually during the Covid pandemic. Records show such meetings were held every 4-8 weeks as per the relevant guidance, with phone calls in between when necessary. Notes from meetings, including any follow up action, are entered onto the patient record so that are available to all members of the GP practice team. The primary focus of discussions about Child V was about getting condition X followed up rather than on the other condition. Practitioners told this review that since Child V's death, health visitors have attended the local GP forum to explore how communication between GPs and health visitors can be improved and how this should be recorded.

5.7. Hospital staff told us that there were leaflets about the condition for parents that could be made available to practitioners but that there were currently no specific arrangements to brief practitioners. Previously there had been a specialist nurse practitioner who could give advice, and although she was still in post during the period covered by this review, none of the practitioners involved with Child V were aware of her existence, so did not make use of her expertise. Practitioners told this review that inviting someone to child protection conferences with specialist knowledge of a child's complex long-term condition would be helpful, and both hospitals confirmed they have sent representatives to child protection conferences on occasions. While this might be so, a better setting for the necessary detailed conversation and opportunity to ask questions might be a professionals meeting or the first core group meeting after the initial child protection conference and, with parental consent, after the making of a child in need plan.[4] This would be more likely to ensure all practitioners working with the family felt confident that they know enough to be alert to indicators that the condition is not being well managed and to challenge any concerning statements that parents make. In the absence of a specialist practitioner, hospital practitioners suggested that the relevant hospital safeguarding team would be a good starting point as a route for non-specialist practitioners to access advice and information about a complex health condition.

5.8. Although the doctors involved told this review that they were confident that Mother understood the discussions they had with her, there is evidence of Mother's failure to fully

[4] Children on a child protection plan are at risk from significant harm. Children subject to a Child in Need plan are those children who without services from the local authority are unlikely to achieve or maintain a reasonable standard of health and development.

follow the expected treatment as described in the "medical neglect" theme. The consequence of non-specialist practitioners having insufficient knowledge about the condition and its treatment was that they were over-reliant on Mother as an "expert in her child's care" as she presented as appearing confident about caring for Child V. Therefore, they took at face value what she told them rather than being able to challenge her about his presentation and treatment. No non health specialist practitioner ever saw a treatment plan. These are produced by the hospital at the end of each episode of care and updated as necessary. Copies are provided to the parent and to the GP. For children with complex medical conditions requesting these from the GP could usefully be done at key points in the safeguarding process e.g. to inform strategy discussions and S47 enquiries[5], and as part of child protection plans. Had this been done at the strategy meeting/during the S47 enquiry then it is likely that more specialist medical information would have been sought and provided at the Initial Child Protection Conference.

5.9. The preliminary post-mortem reported Child V had a serious condition, but as he had other conditions as well, sepsis would have set in more quickly. Part of the management of the condition involves ensuring adequate nutrition, as one of the effects of the condition would be to lead to not wanting to eat. Faltering growth is therefore something to watch out for. As a result of the effects of his condition, the usual methods of weighing a child need to be accompanied by a physical examination. This was not something that practitioners in the community were aware of and during the last year of Child V's life he was not examined at the specialist hospital because the two appointments in 2020 and early 2021 were virtual due to the Covid pandemic. This was because he was under the care of the surgical team. As he had had a diagnosis and surgery and was believed to be well, according to accounts from Mother, he did not meet their criteria for face-to-face appointments under government mandated infection control measures. Had the surgical team known that he was subject to a child protection plan he would have been seen face to face and any occasions he was not brought to appointments shared with the social worker.

5.10. The health visitor saw and weighed all the children in September 2020, when Child V's height and weight had both increased and was moving along the same centile as at the time of the Initial Child Protection Conference. The health visitor told this review that at this point she concluded that he was growing as expected for a small child. Child V was also seen by a nurse at the surgery for immunisations where there is no evidence of any concerns about his weight in the sense of a thin appearance of his arms. Records show that when the health visitor weighed Child V in March 2021 and April 2021 his weight appeared to be back in line with what would be expected for a child of his age and birthweight. However, on both occasions the health visitor noted other symptoms. Therefore, his weight moving along the same centile as expected was not a true indicator of healthy growth, but falsely reassuring.

[5] As part of the local authority's duty to investigate under section 47 of the Children Act 1989, multi-agency strategy meetings should be held where there is reasonable cause to believe a child may be suffering or have suffered significant harm.

5.11. Practitioners told this review that the child's health records would be consulted to check that they are following their centile for weight and height. When they are seen in person in clinic, they will be routinely weighed. However, this will usually be "fully clothed", and when Child V was weighed in the community, he was "fully clothed". Currently health visitors follow the guidance from the Royal College of Physicians around monitoring weight in children.[6] This states that children under 2 years should be weighed naked, that children aged 2 to school age should be weighed without a nappy/in a vest and pants or "light clothing" and school age children should be weighed in light clothing. School age is not defined; Child V did not reach statutory school age. The guidance states that a note should be made of anything that might add to the child's weight, without specifying examples. In this case an example would be the potential impact of his symptoms. Practitioners told this review that local guidelines and support for staff are being considered especially as health visitors and practice nurses are not trained in identifying malnutrition just by looking at the child. They reported that mid-arm circumference measurement was discussed at the Joint Agency Response (JAR) meeting[7] as another way of assessing children with other conditions. However, other practitioners emphasised the importance of the involvement of a specialist clinician in monitoring weight which, depending on the numbers of children, might be a more practical approach than training all health visitors and practice nurses. The social worker told this review that there was evidence on home visits of meals being freshly prepared, so without a good knowledge of the impact of his condition the possibility of Child V being malnourished had not occurred to them.

5.12. Effective interagency communication is especially important for children with complex health conditions involving treatment by different specialties. Letters from the local and the specialist hospital were not copied to each other; they were sent to the GP who acted as the hub. If other practitioners are known about, it is good practice to copy them in. This did not happen consistently. Hospital practitioners expressed the view that it is particularly important to copy in health visitors, and school nurses for school aged children (which requires parental consent unless children are subject to child protection plans). This is because traditionally they have been expected by hospitals to be a main communication point for children's health, and to make sure they know who to turn to for advice and information about complex health conditions. However current arrangements for health visiting and school nursing support for schools does not meet this expectation for all children. This is because local practice is that schools usually only have contact with a health visitor or school nurse if the child is on a child protection or CIN plan, this means that for other children with medical conditions their ability to support children and assess whether a condition is being well managed is reliant on information provided by parents. As a result of this review the school has changed its admission form to ask if the child has had their 2-year check and to have medical plans for children with medical conditions. It would be helpful if, (with parental consent), medical information could be shared with schools to assist in producing these.

[6] https://www.rcpch.ac.uk/resources/uk-who-growth-charts-guidance-health-professionals
[7] Joint Agency Response forms part of the child death as part of the statutory child death review process in certain circumstances – see 3.3.1 of statutory guidance for criteria: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf .

5.13. Incomplete communication can lead to needs being missed entirely (for example, records show the information provided to the Family Court Advisor in March 2020 by a social worker made no reference to Child V having any additional health needs or vulnerabilities), or to assumptions that all aspects of a child's complex health condition are being monitored when there maybe gaps. In addition, responsibility for arranging referrals recommended by either hospital was left to the GP. As a result of this case, it has been recognised that it may be more effective for the hospitals to refer directly to each other where required, and copy the GP in. This would avoid delay and minimise the risk that a request for referral is overlooked at GP surgeries due to the volume of letters they receive.

5.14. One of the concerns of the surgical team at the specialist hospital was whether any food intolerances were contributing to the symptoms. However, this had been ruled out by dietician, although mother told more than one practitioner that avoiding dairy helped. This was a discrepancy that was not identified and resolved.

5.15. There was also a lack of clarity about which was the responsible service for some aspects of his treatment. In 2018 Child V was discharged in error from treatment at the specialist hospital for his condition X. No reason why was recorded on the specialist hospital's notes. He then became "lost to follow-up" for about 12 months. During this time Mother made four enquiries about further appointments for Condition X with the GP. This led to some reflection between the two hospitals who both deliver the relevant speciality as to who should review his care for Condition X. A letter from the paediatrician at the local hospital directly to the specialist hospital in October 2018 requested that the specialist hospital see him. It was agreed that his Condition X could be reviewed at his next medical condition appointment at the specialist hospital. The GP received no notification of this appointment regarding Condition X or its outcome, perhaps because of this arrangement and the fact that this was one of the appointments to which he was not brought. The combination of all the circumstances meant that Condition X was not reviewed by a hospital until after the GP made a further referral in March 2021. This review was told that this had no impact on his death but may have impacted on his quality of life.

5.16. Some of the above misunderstandings and miscommunications might have been avoided had there been a clearly designated lead clinician responsible for overseeing all aspects of Child V's medical care. This review was told that this was not considered at the time because no safeguarding concerns had been raised by a hospital clinician. Practitioners recognised that it would be useful to identify a lead clinician to safeguard the most vulnerable children whose medical care requires a range of specialities in one or more secondary care health agency. In practical terms this means children subject to a child protection plan but also children where there are emerging suspicions of potential medical neglect. Agencies' safeguarding teams could be a valuable source of advice and support in identifying those circumstances. Practitioners contributing to this review considered whether it was possible to make a judgement about which type of clinician it would be for a similar case in future. It was concluded that decisions would need to be made on a case-by-case basis.

Summary of learning; awareness and management of Child V's health condition

- It is important for all practitioners working with a child with a complex health condition to understand how the condition affects the child, what optimum treatment at home looks like and any risks of mismanagement.
- Some medical conditions have very individual impacts; knowing the needs and treatment plan for one child is not generalisable to all children with that condition.
- Practitioners need to know who to turn to for information and advice about complex health conditions; safeguarding teams at hospitals are a useful starting point.
- When a child has a complex health condition, especially if it is an unusual one, it can be helpful to have a briefing about the condition and its treatment and management at home from a specialist clinician in a setting which provides opportunities for practitioners to ask questions e.g. a professionals' meetings or a core group meeting
- Practitioners requesting copies of treatment plans from specialist health service or via the GP (with parental consent where necessary) would ensure that they are not reliant on parents' self-report as "experts in their child's care".
- There would be benefits from schools creating medical plans for children with complex health conditions and seeking parental consent to get health information provided directly to them.
- Where children have health conditions which could affect their weight, the importance of this being considered in any plan to monitor a child's weight.
- Letters from hospital about children with complex medical conditions should copy in all services/specialties known to be involved with the child, (with parental consent where necessary).
- To minimise the risk of delays and gaps, consideration should be given to referrals from one hospital to another being made directly, copying the GP in rather than expecting them to make the referral.[8]
- The potential benefits of agreeing which doctor should be the lead clinician for those children with complex health conditions who are particularly vulnerable. This would include children subject to child protection plans and any others where there are concerns about possible medical neglect.

See recommendations A,B, E & F

Theme: Response to medical neglect; response to Child V not being brought to medical appointments/accessing support offered

5.17. The NSPCC identifies four types of neglect: physical, educational, emotional, and medical. They define the latter as a child not being given proper health care which includes dental care and refusing or ignoring medical recommendations.[9] The Royal College of Paediatrics and Child Health have a more detailed definition; "where parents/carers minimise or deny a child's illness or health needs, fail to seek appropriate medical care, or fail to administer medication or treatments. This may include neglect of all aspects of healthcare, including dental care".[10] There is limited research into medical

[8] This is an issue that is currently under national debate.
[9] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/#

[10] The Royal college of Paediatrics and Child Health (2019) Child Protection Companion (2019) Chapter 11

neglect, but a trawl of Serious Case Reviews published on the NSPCC website where children with long term conditions have died shows that missed appointments is a frequent feature, as is parental lack of compliance with treatment regimes. The cases also include other issues seen in this case, over-reliance on parental self-report and practitioners lack of understanding of the impact and risks of failure to manage health conditions appropriately.

5.18. The nature of Child V's health needs required multiple attendance at different outpatients' appointments, which can be demanding for parents, especially single parents who are working. The Covid pandemic added an extra challenge as practitioners told this review that until vaccines were available Mother was fearful of leaving the house because of extended family members' vulnerability. However, from soon after Child V's birth there is evidence of concerns about parents accessing appropriate medical care for Child V; delays in seeking medical treatment, not taking up additional support or failure to take Child V to appointments either through not attending or cancelling at late notice.

5.19. We do not know whether there was a cultural element to parents' attitude to Child V's condition or the way they managed his health, or their expectations of the health service as there is no evidence that any practitioner considered or explored whether this was relevant. This was also a feature of a previous Serious Case Review (Family A) in Kingston which was published in 2015 where the recommendations included how to improve assessment practice so that practitioners routinely explore parents' individual cultural background and attitudes to the provision of services. In its response the Kingston Local Safeguarding Children Board (LSCB) recognised that practitioners required training in having what are sometimes very sensitive conversations with parents. Some multi-agency training was delivered in 2016, and the LSCB intended to evidence from individual agencies that training on diversity was being delivered and issues discussed in supervision and multi-agency meeting.

5.20. In this case practitioners told this review that Mother often mentioned elements of her cultural background, for example festivals and the fact that she had not had an arranged marriage as was usually expected. Practitioners acknowledged to this review that perhaps these kinds of discussions made them feel they had a better understanding than they did of her cultural background and the impact of it on her parenting. For example, there was no evidence that any practitioner had specifically considered whether there were any culturally influenced attitudes for either parent to Child V's health condition or treatment. Practitioners told this review that practitioners are not consistently confident to have these kinds of conversations and that some contacts and relationships promote better opportunities to have them than others. Health safeguarding leads told this review that one good opportunity for health practitioners might be at the point of diagnosis. During the police enquiries after Child V's death, it came to light for the first time that Mother was seeking advice from a doctor in South Asia which may or may not have contradicted advice given by healthcare practitioners looking after Child V. This indicates that there would also be benefits to practitioners asking parents whether there is anyone else from whom they get information and support regarding their child's health condition. This applies to all children, as some families, for example, might place reliance on homeopathic approaches.

5.21. Practitioners told this review that training on cultural competence,[11] including understanding the impact of a person's cultural background on parenting, needs to be ongoing. For all children, whatever their background, this might be best understood as how the background attitudes and beliefs of any parent affects their parenting. The partnership is planning a multi-agency audit in the autumn of 2022 to explore the impact of the training and awareness raising activity which will include consideration of the learning from this review.

5.22. The impact on children due to lack of parental engagement can be considerable and following up missed appointments causes additional pressure for practitioners. In May 2019 a letter from the specialist hospital to the GP requested assistance with missed appointments specifically mentioning the amount of effort it took to get Child V brought to an appointment. There were seven missed/rearranged local hospital appointments for paediatrics, dietician, and radiology during the period under review. These incidents were seen in isolation rather than collectively considered for their cumulative impact. Nationally work has been done to reconceptualise the idea that children "did not attend" (DNA) health appointments as "was not brought" (WNB) as children are reliant on their parents to take them. Since the period covered by this review the local hospital is embedding a system that flags three WNB (including cancellations) to the hospital safeguarding team irrespective of specialty involved. Cancelling at short notice and rescheduling appointments is also a form of delay which was not recognised at the time. Both hospitals are considering how to ensure these are also flagged as a form of WNB.

5.23. Practitioners told this review that they had been falsely reassured when appointments were re-booked and by Mother being in contact with the hospitals and GP in between appointments. Health practitioners described how national electronic patient recording systems do not support the easy identification of children not being brought to appointments as currently there is no "WNB" code for GPs, hospitals and community health trusts to use. NHS digital are believed to be considering a request to address this.

5.24. There were some creative responses to missed appointments. The health visitor arranged visits outside Mother's working hours and offered a "walk and talk" appointment. However, despite this, two appointments were still cancelled, one because of working late, and one because she said she no longer needed help with taking the children to the park. In September 2019, in response to missed appointments and mother's explanations about difficulties travelling to the specialist hospital and getting childcare, the nurse specialist saw Child V at a setting nearer her home. Records show that Mother told the nurse that Child V was very scared of hospitals, however this seems to have been taken at face value with no evidence of exploration of this. There was no evidence of any distress seen by any practitioner. As a result of Child V's weight gain being satisfactory and management of the condition appearing appropriate at the time, the consultant decided that the clinic appointment the following day was not necessary and a further appointment with the nurse specialist was arranged for December 2019.

[11] Cultural competence is defined as the ability to understand, appreciate and interact with people from cultures or belief systems different from one's own

5.25. During 2019 the prescription clerk at the GP surgery noticed that Mother had not responded to requests to come in and discuss the missed appointments at hospital, so she added a request onto a prescription as she knew Mother would see this. Whilst there is evidence that each non-attendance at a hospital or GP appointment was coded and the GP Practice policy for patients not brought to appointments was followed with clear documentation, this did not seem to make a real difference. At times the GP was falsely reassured that Mother did take Child V to appointments eventually. Since Child V's death, if a letter is received at the surgery to say a child has not been brought to an appointment, the letter is forwarded to the Safeguarding Lead GP to assess each case. If the parent fails to respond to attempts to contact them by phone and letter a safeguarding referral will be made.

5.26. GP reports were provided for each child protection conference. As a result of this case, when those reports identify that a child is not being brought for appointments the GP has recognised the potential benefits of explicitly listing the actual or potential impact of this for the child. This good practice, which recognises that it cannot be assumed that practitioners who are not health specialists would recognise the level of impact, could usefully be promoted amongst other GPs. Practitioners told this review that this learning would be disseminated at the quarterly meetings of GP safeguarding leads, this will also include the benefits of including the contact details of specialist clinicians in their reports. Local efforts to improve the proportion of child protection conferences which have a report from a GP has resulted in rates of 90% achievement: an audit of these report has been planned for the spring of 2023 to assess their quality including the adoption of learning from this review about explaining the impact of missed appointments on the individual child.

5.27. As well as missing appointments there was evidence of mother not taking up additional support offered, for example that offered by health visitor 1 after the diagnosis of the medical condition or efforts of the new health visitor 2 to contact Mother to introduce herself. Health visitor 2 made two attempts to get an Ages and Stages Questionnaire (ASQ) completed to inform her assessment of Child V's development. In 2019 she sent the parents a 27-month ASQ. This was not sent back to her and nor did the parents respond to a text or letter offering an appointment. The health visitor sent a 36-month ASQ in 2020 and Mother did not complete this either, despite reminders via two visits and two phone calls. It was finally partially completed at a visit, which is not as effective as children may not co-operate fully, so it is not a complete picture of their development.

5.28. Between January and March 2021 all three children were classed as vulnerable during lockdown, so they could have attended school, but they did not take this up as Mother was worried about the risks of Covid to family members. Whilst this is understandable, and whilst the school liaison officer made efforts to stay in touch with the family, this reduced external oversight of Child V. The children made relatively little use of the online teaching and resources provided by the school. At the time this was assumed to be because the family member, who was caring for the children while Mother was at work, was not IT literate and didn't speak English. Practitioners have since reflected that Mother was working at home and therefore, they could have explored whether she could help with this.

5.29. There is also evidence of Mother[12] not following up treatment requirements effectively at home. After the initial appointment with the paediatirican when Child V was about three weeks old and a subsequent appointment with the emergency GP, records show Mother had not understood that his need for medication was ongoing. At hospital she was shown how to do medical procedures but didn't consistently do them when needed. Fluid for these was available by repeat prescription, and Mother was asked by the GP to clarify the type of tubing needed without success. Her use of medicine with Child V was also unclear. In October 2020 the nursery was reporting that Child V was unwell. The health visitor was going to follow up with Mother after a discussion with the GP concluded that they might not be being used properly as the prescription was not being collected regularly. The health visitor accepted Mother's reassurances that she was giving these to Child V and managing his symptoms through diet. Medicines were available on a repeat prescription at the GP surgery as recommended by the consultants. These were not being regularly collected. It is not known whether this meant that the family were accessing medicines over the counter or had stopped using them. Records show evidence of Mother telling different things to different practitioners about the frequency and amount of their use. As we have seen non-specialist practitioners were not able to challenge this as they did not have a clear understanding of what the treatment arrangements should be.

5.30. As a result of this case, to avoid reliance on what parents say, the GP surgery which cared for Child V has decided that all children on CP or CIN plans will have face to face rather than phone appointments at the GP surgery. Also, that all those with a long-term health condition will be seen by a GP to have their health and development reviewed at least once annually whilst they are subject to a child protection plan and for 12 months afterwards. This is good practice, which could usefully be promoted amongst other GPs.

5.31. Mother told more than one practitioner that Child V might be lactose intolerant, but this had been ruled out. There is also evidence of more than one practitioner not checking when she reassured them that she had, or would, take Child V to an appointment/the GP. Between Mid-April and Mid-June 2021 Child V only attended nursery for three sessions. This is not what would be expected for a child whose condition was well managed, even considering Mother's fears that he would be bullied for still being in nappies. Previous bouts of poor attendance due to ill-health are also concerning but are much more apparent with the benefit of hindsight, especially as they were masked at the time by the 3 months enforced absence due to Covid restrictions. Poor attendance at nursery was identified as a concern at the CIN meeting in Mid-June 2021 which took place, as it should have done, six weeks after the last child protection conference. The agreed action was for the HV to visit the child. The following week, but Child V died before this was possible.

5.32. When there is evidence of some missed health appointments, and failure to follow treatment required for a child with a complex health condition, there needs to be a chronology of all missed and cancelled appointments, (whether rearranged or not),

[12] Prior to 2020 Father was also in the home, but records show Mother took the lead in dealing with medical issues.

support refused, and treatment not given effectively, with clear arrangements for updating and collective review by the core group. There is no evidence of any attempt to create an overview until after Child V's death. Including all appointments with all practitioners in the chronology, irrespective of their purpose, would also build a picture of the level of parental co-operation. This would enable reflection on, and action about, the quality of it and the potential reasons for any lack of co-operation, for example was it disguised compliance or barriers to attending appointments.

5.33. Practitioners told this review that compiling a chronology is a judgment call about when these are necessary as they are time-consuming. Individual agencies would consider a chronology when they saw signs of emerging concerns, for example lots of missed appointments. Chronologies would not become multi-agency unless this was co-ordinated by a social worker, and this would not happen unless someone in the team around the child/core group recognised that this might be helpful. Whilst not everyone knew that other agencies were having problems with missed appointments for example, it is reasonable to assume that if this was true for one agency it might be true for others. The health visitor told this review that Mother often cancelled/changed appointments with her but then remade them, which is a type of avoidance that is not always easy to recognise. Knowing that this was also happening at the hospitals might have sharpened collective focus on this earlier.

<u>Summary of learning:</u> Response to medical neglect; response to Child V not being brought to medical appointments/accessing support offered

- Parents cancelling appointments, even when they are re-arranged, needs to be recognised as a form of "was not brought" which could constitute medical neglect.
- The benefits to all children nationally if a Was Not Brought (WNB) code was added to patient electronic recording systems.
- Assessments and interventions should specifically consider whether there is an impact from the parents' background, attitudes, or beliefs on the care a child receives, for sick children this would include their attitude to the health condition and the treatment for it. For health practitioners an especially good time to explore this would be at the point of diagnosis.
- The benefits of practitioners asking parents whether they seek health information and support from anyone else outside the known health practitioners regarding their child's health condition.
- It is helpful to non-medical practitioners if GP reports to child protection explicitly list the actual or potential impact for the child of any non-attendance at health appointments and include the details of specialist health services involved with the child so this and other relevant information can be sought from them.
- The importance of face-to-face assessment and physical examination of children subject to child protection plans by GPs and hospital clinicians.
- Practitioners should keep in mind that self-reported information given by parents about their child's health and take up of treatment may not be accurate.
- Where a child is not being brought to appointments at one agency it is useful to explore whether this might be true for appointments with other agencies.

See recommendation C

Theme: <u>Response to domestic Abuse</u>

5.34. Records show that Mother told the police that she had suffered domestic abuse by Father for 13 years. She said she had not previously reported incidents because she thought he would change. This is a not unusual belief/hope for victims. Practitioners recognised that there may also have been cultural and family barriers to reporting the abuse or confiding in her family. The marriage had not been an arranged marriage as was the norm for her community and her family's disquiet had been increased by having to ask for money from them while Father established an income.

5.35. Father was excluded from the home by his bail conditions and then subsequently as part of the child protection plan. Whilst this was clearly necessary due to the severity of the abuse allegations and his lack of insight, this decision also had some negative impacts on the children. Practitioners told this review he seemed to be the more organised parent. He had also toilet trained the older children. Late toilet training is not unusual for children with the condition Child V had, and nursery staff told this review that Mother was somewhat at a loss at how to deal with the extra challenges. Father had strong relationship with the children, and contact arrangements were made as the children who were keen to see him. The children also had had contact with his family abroad, which was weakened after he moved out. Whilst these strengths were recognised by some practitioners there was no evidence of systematic consideration of the gaps after he had left. A social work manager pointed out that seeing the removal of the violent person in domestic abuse situations as resolving the problem is too simplistic; that social work assessments need to be much more robust in considering how the remaining parent is skilled up in terms of fulfilling the roles that the other parent once did.

5.36. Police records show Mother was initially reluctant to agree to video interviews of the children, she later agreed to this for the two older children. The February 2020 strategy discussion minutes identify Mother's reluctance to proceed with a prosecution. She stated she withdrew her statement because she didn't want Father to appear in court, and nor did she want the children to give evidence, as she didn't feel it was in their best interests. This undermined the potential success of any prosecution regarding the alleged physical abuse as there was no evidence of any injuries due to the alleged incidents not being recent. Father's immigration status may also be a relevant context as his right to remain in the UK depended on right to family life grounds. Practitioners told this review that Mother and the older children worried about Father due to the pandemic and that he would be deported. Mother felt guilty about this. The social worker tried to secure support for him from the local refugee charity, but this was not successful at the time due to limited engagement with the social worker by Father.

5.37. Domestic abuse is known to be under-reported.[13] Research indicates that that whilst pregnancy can offer a protection for some women, the risk of domestic abuse is known to

[13] The most recent report indicating this is Women's Aid (2018) Survival and Beyond; the Domestic Abuse Report 2017 Bristol: Women's Aid

increase in pregnancy or shortly after birth.[14] Booking records for Child V's pregnancy show "no domestic violence". Health managers told this review that more accurate wording which gave less risk of possible false reassurance would be "no domestic violence disclosed." Contrary to longstanding national practice there is no evidence in the records after the initial booking appointment that midwives subsequently completed "routine enquiries" during this pregnancy and the antenatal period about whether Mother was subject to domestic abuse. This is likely to be a systemic issue rather than a one off as a Care Quality Commission inspection in 2019 noted a need for improvement in doing these.[15] This review was told that there is audit evidence of improvement since the inspection. Records show the health visitor did not enquire about domestic abuse at the new birth visit because Father was present. There are no further entries regarding any enquiry about domestic abuse, if this was because Father was present then too, the record does not say so. This review was told that work to improve the consistency of arrangements for asking and recording routine enquiries amongst health visitors is ongoing.

5.38. In 2017, when pregnant with Child V, Mother attended the antenatal admissions service saying she had a pain that she thought was a cracked rib. The midwife sought advice from a registrar and was told that a fractured rib was not a likely outcome from her account of hearing a crack and having a pain after turning suddenly. Her abdomen was seen during monitoring the baby's heartbeat but there is no evidence of an examination of the rib area, and she was offered pain relief without any reflection on whether this might be a way of trying to disclose domestic abuse, or to check he baby was alright after such an incident which she did not intend to disclose. What we know now, which the hospital staff didn't at the time, was that domestic abuse is alleged to have been already been a feature of Mother's life for some years. What we don't know is whether this incident was an attempt to disclose domestic abuse.

5.39. There was a second occasion where detailed consideration should have been given to the possibility of domestic abuse. This was in 2021 when Mother presented at the hospital with serious injuries. Hospital records indicate that "domestic abuse was considered" but the record system at the time did not support the recording of details about *how* any possibility of domestic abuse was considered. For example, whether this was done solely on the basis that the cause of injury being deemed plausible, or wider discussion with Mother about her circumstances as would be prompted by training delivered since that time. Changes to the recording systems are being considered to support this. There was a MARAC[16] flag on Mother's hospital records from early 2020, it is not known whether that and any details on the record was considered. MARAC policy limits the details that can be included in the patient record, but records show that further details of the nature of the MARAC discussion including how serious the domestic abuse allegations had been and the concerns about physical abuse to the children would have been available had the staff contacted the hospital safeguarding team.

[14] NICE (2014) Public Health Guideline; Domestic violence and abuse; multi-agency working NICE
[15] https://www.cqc.org.uk/sites/default/files/20190903_CLAS_Richmond_Final_Report.pdf
[16] A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed, and safety plans agreed.

5.40. Members of the core group were aware of the injuries. They believed with justification that Father was not in the home as the social worker had made several unannounced visits. Also, the children were observed playing, doing homework and being creative in the home, which Father's strictness about tidiness had previously prevented. This fed confidence that Father was not present. During a visit by the social worker conversations with the children also suggested they had been present when the injuries occurred.

5.41. After the 2nd Child protection conference in 2020 a referral was accepted by Strengthening Families for domestic violence support work. The first session with Mother was held in the summer of 2020 and these ended a month later. Father did not engage with Strengthening Families perpetrators sessions until Autumn 2020. His input continued until 2021. The delays in offering a service had been caused initially by a suspension of the service during the first Covid lockdown and subsequently due to the resultant waiting list. Mother was more motivated to attend than Father. Practitioners described his engagement as inconsistent and wondered whether the delay providing a service may have affected his motivation. A second phase of involvement was offered to Mother in December 2020 after Father had begun receiving input as this can raise further issues for victims. Practitioners told this review that Mother declined further support as she felt overall there were too many practitioners and appointments to cope with on top of being employed. There was no feedback from the specialist service about Father's engagement until after Child V's death for reasons that are not known.[17]

5.42. There is evidence that Father always thought/hoped the couple would get back together again. Father emailed the Family Court Advisor (FCA) in Mid-April 2020 to enquire "what the procedure would be to stop the court case if myself and my wife decide to get back as a family." The FCA reported this to the social worker. In June 2021 at the (only) CIN meeting before Child V died, when Mother said she could not get leave from work to attend, records show he was not acknowledging the impact of the domestic violence and did not see the need for any further professional involvement in the event of reconciliation with Mother.

5.43. Research suggests domestic abuse can have a serious impact on a mother's mental health. Ferrari et al. (2016) surveyed 260 women accessing specialist domestic abuse services in the UK. The study found that the proportion of women in the sample who presented symptoms of depression was twice as high as that of women in UK general practice, and for symptoms of anxiety, the proportion was three times higher. The study also found that increasing severity of intimate partner violence (IPV) was associated with worsening mental health, especially anxiety and a diagnosis of post-traumatic stress disorder (PTSD).[18] This review was told that the health visitor and social workers did consider Mother's mental health, and that this was discussed at core groups. They knew she had low self-esteem but that she never displayed any symptoms of mental health difficulties, A referral for psychological therapy was made but not taken up by Mother. Practitioners

[17] Feedback is limited to the level of engagement; attendees might not participate fully and honestly if they are worried about what is going to be feedback to the social worker.
[18] Ferrari et al., 2016, cited in Birchall J McCarthy L 2021 Mental health and domestic abuse; a review of the literature Women's Aid

believed this was because she as feeling overwhelmed by all the different people involved.

Summary of learning: Response to domestic Abuse

- Whilst removal of the violent person may reduce the directly associated risks of domestic abuse, the need to recognise any positive contribution that parent made to the functioning of the family and make sure the remaining parent or someone else is able to fulfil those positive roles.
- When mothers make reports of pain/worries about a possible injury during pregnancy, consideration should be given as to whether this could be an attempt to disclose domestic abuse. This is because research indicates that that whilst pregnancy can offer a protection for some women, the risk of domestic abuse is known to increase in pregnancy or shortly after birth of the baby.
- Where women whose patient records include a MARAC flag present at hospital with injuries which could be due to domestic abuse, safeguarding teams should be contacted to find out more details about the reasons for the flag.

Theme: How agencies worked together to protect Child V and safeguard his welfare

5.44. It is important to note that the entirety of the child protection plan was during the most active phase of the pandemic which put huge pressures on all agencies' capacity and their ability to engage face to face. Some agencies also had changes of personnel during the scoping period which undermines continuity of oversight[19]. A compounding factor for the social worker was that they were newly qualified, and although support was provided by a manager, as it should have been, this was their first child protection case. They also had a high caseload.[20] Nonetheless there is evidence that the risks from domestic abuse, which research has shown causes children significant fear distress and anxiety,[21] was addressed. However, this review is because a child died from neglect of a medical condition.

5.45. Child V had a long-term condition which, with appropriate management should not have been disabling. However, practitioners told this review that in fact participating in normal activities was affected for him; for example, play and sitting and listening at nursery due to his symptoms the discomfort that this caused him. There is limited research specifically on children with long term conditions but the research on disabled children is relevant. This shows that disabled children are more vulnerable to abuse than non-disabled children.[22] The reasons for this include: attitudes and assumptions by practitioners that either believe it does not happen or accept forms of behaviour management that would be seen as

[19] The appointment of a new head teacher in February 2020, change of a teacher in the nursery class, GP surgery Safeguarding Lead absent for a year (cover provided)

[20] This was because the local interpretation of the national requirement for a 10% reduction applicable to all newly qualified social workers was from the level of cases held in the team rather than a guideline number of cases. In addition the scheme under which the social worker qualified also requires ongoing study at Masters level.

[21] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition http://www.developingchild.harvard.edu National Scientific Council on the Developing Child (2010). *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper No. 9*. http://www.developingchild.net

[22] Safeguarding Disabled Children; practice guidance (2009) Department for Children Schools and Families

abusive for any other child; a reluctance to challenge carers who are already under significant pressure; dependency by the child on others to meet personal care needs; communication barriers; misinterpretation of behaviours (e.g. self-mutilation, masturbation) that in other children might raise safeguarding concerns; isolation from other children and adults, including the family if the child is in residential care. Although the research relating to children from Black and Minority Ethnic (BAME) backgrounds is limited, there is evidence of double discrimination for them if services (including when investigating allegations of abuse) are not sensitive to their cultural and language needs.

5.46. Studies of Serious Case Reviews have shown that for children with disabilities, signs of abuse and neglect may be masked by, or misinterpreted as being due to health conditions or underlying impairments.[23] The term "Diagnostic Overshadowing",[24] which was first used to describe the misdiagnosis of other conditions for adults with learning disabilities, may have some relevance in this case as the difficulties in daily life described above were assumed to be due to his condition rather than poor management of it. All children are vulnerable to neglect. When professionals focus predominantly on protecting children from one form of abuse (in this case domestic and physical abuse) or providing support to someone considered a protective carer, they may not always notice that parental care is neglectful, especially when they regard the parent as the expert in the child's condition and lack the detailed knowledge of the condition.

5.47. There are examples of a lack of focus on understanding Child V's health needs from the beginning of the child protection process. The pan London safeguarding procedures indicate that where a hospital consultant is involved with a child, they should be invited to strategy meetings. Their ability to attend strategy meetings may be adversely affected by the short notice for convening such meetings. However, the fact that they have been invited means they have opportunity to contribute information about the child's health and care and will alert them to the existence of potential safeguarding concerns. In this case it is likely that concerns about him not being brought to appointments might then have been a focus of enquiries. Achieving for Children, which is the agency responsible for delivering children's social work services, told this review that deficits in arrangements for strategy meetings had been recognised, including that minutes are not being shared consistently, and that the work underway to improve arrangements would consider the learning from this review.

5.48. There was no child protection medical because none of the alleged physical abuse incidents were recent. A paediatrician told this review that an urgent health assessment could have been provided had it been requested, and had a paediatrician been invited to the meeting they might have suggested this. Even in the absence of any injuries, a health assessment would have given valuable insight into the state of Child V's health and the management of it. In addition, practitioners believed Mother was the victim of serious and chronic domestic abuse. It is well known that this can impact on the care of the

[23] Sidebottam P et al (2016) Pathways to harm pathways to protection; a triennial analysis of Serious Case Reviews 2011-14 Department for Education

[24] Definition of Diagnostic Overshadowing "once a diagnosis is made of a major condition there is a tendency to attribute all other problems to that diagnosis, thereby leaving other co-existing conditions undiagnosed,"Neurotrauma Law Nexus http://www.neurolaw.com/neuroglossary/ cited by Blair J (2018) Diagnostic overshadowing; see beyond the diagnosis in Intellectual Disability & Health – March 2018 http://www.intellectualdisability.info University of Hertfordshire

children through what the mother is allowed to do, who she is allowed to contact and where she is allowed to go, but also on mothers' resilience and ability to care for children adequately. Therefore, a prompt health assessment by a paediatrician of a child with a chronic health condition should have been considered as part of the safeguarding arrangements.

5.49. The chair of the Initial Child Protection Conference (ICPC) told this review that she was not fully aware of his complex needs and the specialist services treating him. Information presented to the ICPC came from Mother, who presented confidently. Although a GP report was available for child protection conferences there is no evidence that a social worker ever spoke to the GP and no-one from either hospital was invited to the child protection conference, for reasons that are not known. No-one asked Mother at an early stage "who is involved with Child V?"

5.50. The specialist hospital was never made aware by Children's Social Care that Child V was subject to a child protection plan.[25] This appears partly to be because they were not present at the ICPC and partly because currently automated notifications for such children (and those who become "looked after" by the local authority) via the digital Child Protection Information Sharing (CPIS) system only go to unscheduled care settings in hospitals i.e. A&E and minor injury departments.[26] Not all practitioners present were aware of this. Social work managers told this review that they had assumed that these notifications would automatically flag on a child's records. In addition, they also did not have the contact details for the service in the specialist hospital and may have relied on the health visitor or GP to notify the hospital. Whilst social workers should ensure that all practitioners involved with a child are aware when they are subject to a child protection plan, the usual mechanism for this is via circulation of the conference minutes which of course will only go to those practitioners known to be involved with children at the time of the child protection conference.

5.51. Staff from the specialist hospital told this review that, as there was no record of Child V being on a Child Protection Plan, they did not share any information or concerns with the social worker, nor did they receive any information, and they did not prioritise Child V for face-to-face appointments during the Covid pandemic. Practitioners told this review that each hospital safeguarding team will liaise about cases of concern between hospitals but do not routinely monitor all known safeguarding cases, just the ones highlighted by the clinicians, which did not include Child V.

5.52. The first Child and Family Assessment completed by a social worker was concluded within less than 4 weeks, in time for the child protection conference. It does not mention that Child V has a bowel condition, only that he had been referred to the specialist hospital in 2017 and seen mostly recently in 2019. Comments about Child V's health in the subsequent three updates of the Child and Family Assessment are restricted to health being considered and understood in terms of it being reported to be well managed by Mother and with involvement of appropriate health professionals.

[25] A letter from the GP to the specialist hospital mentioned this in April 2021

[26] This will change from 2023 when notifications will go to GP practices and scheduled health care settings.

5.53. The child protection plan was narrowly focused on domestic abuse and the physical abuse of the children by Father. The only reference in it to Child V's health was that the the health visitor should monitor Child V's health needs. This might be appropriate for a healthy child where confidence was high that their development was within normal ranges, but the former was never true for Child V and the latter not known at the commencement of the plan. For any child with a complex health condition sufficient information should have been gathered to understand about what good management of their health looked like, and what the impact and risks of poor management would be, and the child's health considered in detail at child protection conferences and core groups irrespective of the primary reason for the child protection plan. This is equally true for children subject to CIN plans. In addition, there was no reference to his (lack of) attendance at nursery. By this stage there had already been two bouts of absence due to ill-health although current attendance was masked by school closure due to Covid restrictions. In addition, young children are often absent from nursery due to common childhood infections so the significance may not have been recognised.

5.54. Attendance at nursery provides important opportunities to promote children's development, especially language skills for children who are bilingual, as he was. Whilst Child V would not have been of statutory school age until April 2022, there is some evidence of a recognition that he needed to be "school ready" by then but no evidence of consideration what support he might need to ensure he would be able to attend and benefit fully once he was of statutory school age if he could not attend nursery regularly due to a long-term condition that was likely to continue. Practitioners told this review that his poor attendance at nursery caused some delays in his learning. In addition, for a vulnerable child on a child protection or children in need plan, school or nursery staff should have the most contact with children and are a valuable source of independent oversight and support for children. School staff told this review that the nature of how his condition directly affected him in school and through prolonged absence did not impede his learning until after he returned to nursery in March 2020. Therefore, consideration of any need for an Education, Health and Care Plan had not started before he died. Mother could have asked for an assessment but there is no evidence that anyone discussed this with her.

5.55. Practitioners told this review that the child protection plan was replaced with a Child in Need (CIN plan) because risks of domestic abuse and physical abuse of the children were considered to have reduced and there were no concerns about engagement with the social worker. Records show that the health visitor's report to the last child protection conference was heavily reliant on Mother's report that she was managing his symptoms and that he was attending nursery. Mother also told the health visitor that she was attending hospital appointments; however, it was not clear that these were *phone* appointments at the specialist hospital due to Covid restrictions. This meant Child V had not been physically examined by a doctor/specialist nurse since December 2019 as there had also been no appointments due at the local hospital and he had not attended the GP. The potential significance of this was not recognised at the time due to a combination of a mistaken faith by those present at the child protection conference in Mother's care of Child V and a lack of recognition of the importance of a physical examination.

5.56. Consideration of the role of other adults in the household was limited. Extended family members spoke minimal English. The health visitor had never met these, the social worker had. There is no evidence that anyone had an actual conversation with them. There is also no evidence of anyone giving any consideration about speaking to them individually (which would have required the use of an interpreter to avoid reliance on Mother) as part of an assessment to assess risk and protective factors. This could have included finding out more about their role in the household in general. It would also have been useful to have sought their views about the family dynamics and the general wellbeing of the children. When Mother was working a family member was providing childcare. There is no evidence of any enquiry about whether this included any periods of sole responsibility for Child V and if so, how well they understood his condition and the treatment for it. It was known that Mother was working from home so it may have been assumed that she would retain oversight of this. There is no evidence that anyone checked.

5.57. Practitioners reported that one relative spoke English and was sporadically present staying in the house since just before Mother disclosed the domestic abuse. Social care staff told this review that they had conducted a risk assessment and viewed him as part of Mother and children's safety network and asked him to supervise contact between Father and the children.

<u>Summary of learning:</u> How agencies worked together to protect Child V and safeguard his welfare

- Research indicates that children, with disabilities or complex health conditions are more vulnerable to abuse. Signs of abuse and neglect may be masked by or misinterpreted as being due to those impairments or health (diagnostic overshadowing).
- As part of dealing with any safeguarding referral, social workers should ensure that they know all the services involved with a child, especially for those children who have specialist needs.
- Where children have complex health conditions it is useful to have a child protection medical or other form of health assessment, even when a medical is not otherwise deemed necessary, for example because allegations of physical abuse are not recent.
- Until 2023 at the earliest, the digital Child Protection Information Sharing (CPIS) system will only send notifications for children subject to a child protection plan (and those who become "looked after" by the local authority) to unscheduled care settings in the hospital i.e. A&E and minor injury departments.
- Where families become known to Children's Services because of serious domestic violence, there is a risk that this colours the focus of the Child Protection measures with a reduced awareness/focus on the health and education aspects of children's needs.
- Especially for children with complex health needs, Child Protection and Children in Need plans need to be more detailed in their focus on health, including specific actions relating to each child's health rather than, for example, relying on a health visitor or school nurse to monitor it.
- Attendance at nursery is important to support children's development, this needs to be a focus of any child protection or CIN plan.

- When children are on a child protection plan all household members should be considered in assessments and interventions, especially those household members who have some level of responsibility in providing care for children.

See recommendation D

6. PARENTS' VIEWS

6.1. Mother and Father were met with separately to provide their views. Each described their shock on finding out that Child V had an unexpected health condition, especially an unusual one that no-one they knew had ever heard of. Mother felt it was hard to take all the information in at that point. The report has described evidence of several discussions about Child V's condition and treatment for it. If she was given the leaflet about the condition this is not recorded, and she did not remember this. She suggested that it would have been useful to have been given written information at the point of diagnosis so that she could have referred to it later. She also suggested that it would have been helpful to have been put in touch with other parents whose children had the same condition. (This could perhaps be done via referral to voluntary organisations). Each parent described the practical and financial challenges of getting Child V to medical appointments, especially when Mother had to go on her own and Father mentioned the discomfort of travelling on a bus for Child V. Mother appreciated it when two appointments were arranged more locally.

6.2. Mother felt listened to by health practitioners when she had concerns or questions. Each parent felt that it had not been explained in a way they had understood that the operation might not cure Child V and that he would still likely have had symptoms for a few years, perhaps into his teenage years. They would have liked a second opinion about the diagnosis and the operation which they felt would have made it easier to come to terms with the need for an operation. Each also felt it would have been helpful to have had one person who was identified as the lead clinician for all his medical needs, who had an overview of his needs and treatment and who they could contact all their questions and concerns. Mother described trying to find out about further appointments for Condition X. A lead clinician might have been helpful with this.

6.3. Mother felt supported by the health visitor who helped her follow up queries and by nursery staff who reassured her that felt able to help with potty training and that it did not matter if he needed to come into the nursery in nappies. She also described how one of the nursery staff had been kind and helped him when he felt uncomfortable in nursery. Father was pleased that staff attending the core group and child in need meetings kept him informed about the children's health, development, and progress.

6.4. Each parent felt uncomfortable about some of the difficult conversations the social worker needed to have with them about for example, domestic abuse and contact with the children. Father gave an example about feeling that his expectations had been raised and then dashed about contact with one of his children. This might not have happened if communication about this had been put in writing.

6.5. After Child V's death Mother last saw her other children at the hospital when she was arrested. She was not told anything about where they were for 18 hours, despite asking police officers about this. Whilst police officers at the station may not have known, it should have been possible for them to find out, and this was an anxiety that could have been predicted by social workers. Mother is grateful for the support she has received from the hospital liaison staff who have been helpful in listening to her worries and answering questions and who could be relied upon to respond promptly to any communication from her. In contrast each parent felt that the police liaison service has not communicated well with them. Mother is upset that one of the children still has not had their laptop back from the police 15 months after Child V died. She told this review that a recent deadline for the return of the laptop had passed without any contact from the police.

7. POSITIVE PRACTICE

7.1. When undertaking a review, it is important to also consider the kind of positive practice that might have broader applicability to protecting or supporting other children and families. Examples not previously referred to are listed below:

Protective and supportive actions by practitioners
Even in the difficult circumstances due to the pandemic all practitioners showed empathy, flexibility, and creativity in working to empower Mother and take ownership over the children's care now as a single parent.
Child V was identified as vulnerable due to the child protection plan and given a nursery place.
The Family Liaison Officer from the school provided support during the lockdown.
A child protection medical was promptly arranged for the siblings after Child V's death.
A Chaplain of an appropriate faith was made available to support the family by local hospital staff.
Continuity of workers throughout the period covered by this review – the same social care team manager, the same Social Worker, the same health visitor and staff within the school as well.
Timely response from GP surgery to requests for information from Children's Social Care for core groups and child protection conferences.
Safeguarding reports are summarised directly to the patients' GP record in a way that makes key information clearly visible. This includes when children are subject to Child Protection plans or Child in Need Plans. Codes are added to the records of family members.
GP recognised the impact of Child V's death on his siblings who also witnessed the resuscitation attempts, and bereavement support was offered.
The school Family Liaison office had a strong relationship with Mother, and the class teacher telephoned Mother weekly.
The social worker had a good rapport with the child and had a good understanding of family dynamics.
The school fully engaged with the child protection process and there was effective

mutual communication between school staff and the social worker.
School staff described how the social worker and team manager had developed a strong working relationship with them.
Police informed colleagues in the safer neighbourhood's team of the existence of the child protection plan.

8. CONCLUSIONS

8.1. There is evidence from soon after Child V's birth that his medical condition was not being managed effectively at home, and that he was not being consistently brought to medical appointments. Individual agencies took steps to address this, but this was not identified as a safeguarding concern or recognised in any multi-agency forum until after his death. Child V was made subject to a child protection plan because of physical abuse and longstanding and significant domestic abuse. The child protection plan was insufficiently holistic to take account of his complex health needs, and those practitioners who were part of the core group were not able to challenge the poor management of his health as they did not understand the health condition and its treatment, including what optimum management would look like and the impact of this not being provided by his parent(s).

8.2. While there was evidence of good practice by all agencies this review has identified powerful learning to improve services to support and protect other children like Child V more effectively. Some changes have already been made but some of the most significant ones need careful planning and implementation.

9. RECOMMENDATIONS

9.1. The individual agency reports have made single agency recommendations. Kingston and Richmond Safeguarding Children Partnership (KRSCP) has accepted these and will ensure their implementation is monitored. To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations for the partnership

A. That KRSCP considers the best local arrangements to ensure all practitioners working with individual children with health conditions have a good understanding how the condition affects the health and development of the child, and what optimum treatment at home looks like and any risks of mismanagement.

B. That KRSCP adapts safeguarding processes and procedures to support practitioners to request/obtain information about the needs of children with medical conditions all through safeguarding activity from the beginning, referrals, strategy meetings, child protection conferences and core groups.

C. That KRSCP promotes activity to support practitioners to have the skills and knowledge to confidently explore how the background, attitudes and beliefs of any carer, including their cultural background, affects care of the child. For children with health

conditions this should include each parent's attitude to the condition and to its treatment.

D. That KRSCP seeks assurance from Achieving for Children and the local Integrated Care Board that effective arrangements are in place to ensure that:

   I. From the beginning of involvement with children who may need safeguarding, social workers identify all the services involved with a child, especially for those children who have specialist needs.
   II. GPs and scheduled care settings known to be treating children who are subject to a child protection or child in need plans are notified about the plan (with parental consent for child in need plans).
   III. The hospitals record information internally about children subject to a child protection plan (or "looked after") so that is highly visible to all hospital practitioners accessing a child's hospital records (e.g. as an alert).

E. That KRSCP requests that the Royal College of Paediatrics and Child Health considers reviewing the guidance on weighing children to include reference to best practice when a child's medical condition might affect their weight. In the meantime, consideration should be given as to how to ensure that practitioners are supported to achieve this locally.

F. That KRSCP convenes a task and finish group of health professionals to consider how best to:

   I. Ensure there are clear arrangements to ensure the co-ordination of healthcare for those children with complex health conditions who are particularly vulnerable e.g. being the subject of child protection plans or where there are emerging concerns about medical neglect.
   II. Consider (in response to the parents' views): best practice in parental education about health problems; how to recognise and respond when parents are struggling to meet a child's health care needs, including encouraging practitioners to explore reasons for missed appointments and signpost or refer parents to appropriate support; how to facilitate parents having contact with other parents with lived experience of caring for children with similar health conditions (e.g. via voluntary organisations).

G. That KRSCP draws the attention of the local Integrated Care Board to the learning from this review about the complexities of sharing information between and within health agencies, with a request that these issues be considered in future commissioning arrangements.

H. That KRSCP makes representations to NHS digital about the benefits for children of adding a Was Not Brought (WNB) code to all NHS recording systems so that it is easy to identify those children who may be vulnerable to medical neglect.

I. That KRSCP seeks assurance from each agency involved in this review that learning points have been identified from their agency reports and discussions during this review, including parents' views, and action has been/or is being taken to address and disseminate them. The partnership will also need to consider how best to ensure the learning from this review for GPs and schools is disseminated.

J. That KRSCP agrees what arrangements will monitor the impact of action arising from addressing recommendations A, B, and C.