East Sussex Safeguarding Children Partnership

Evidencing Impact: Child T

Introduction:

The East Sussex Safeguarding Children Partnership (ESSCP) undertook a 'Serious Case Review' in 2018 regarding Child T. Child T died in hospital, at the age of 18, due to complications caused by his Type 1 diabetes (which he was diagnosed with at 13).

Prior to his death, Child T was in hospital for three months. On his admission to hospital he was in an extremely poor state both physically and emotionally. His death was sudden and unexpected.

The ESSCP agreed to conduct a review as they recognised the potential learning from this case about the way that agencies work together to safeguard children, including those with life limiting health conditions, and vulnerable young adults.

The full report and learning briefings can be found on the ESSCP website here:

- ESSCP Child T SCR Report (2019)
- ESSCP Child T SCR Learning Briefing (2019)
- ESSCP & SAB Joint Learning Briefing - Child T SCR

Serious Case Reviews and Local Child Safeguarding Practice Reviews

A **Local Child Safeguarding Practice Review (LCSPR)** is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death, and/or there is cause for concern as to the way in which agencies have worked together to safeguard the child.

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

Prior to 2019 these reviews were called 'Serious Case Reviews', which was conducted in the case of Child T.

Key learning:

The following learning points were identified in the Partnership Review process.

1) Child's lived experience:

- Prior to Child T's admission to hospital there was limited consideration of the child's lived experience when professionals were working with the family. Trust was placed on what Mother was saying without considering the impact on Child T, and without speaking to him directly about his life.
- Mother's avoidant behaviour was not effectively identified or challenged. This was a risk in a case where Child T had a potentially life-threatening health condition.

2) Transition

- At times of transition there can be increased risk for children with serious health needs. However, it provides a good opportunity to seek and share information, reassess, re-engage and put plans in place for the child's future care and support.
- Professionals need to remember that a person is a child until they are 18 years old. Appropriate safeguarding supervision should be sought and children's procedures followed when required.

3) Persistent Did Not Attend/Was Not Brought and neglect

- Despite processes being in place to identify neglect when a child is DNA/WNB, they were not used in this case, and a lack of professional curiosity and ownership of the case led to on-going neglect of/by Child T.
- All 16- and 17-year-olds being treated within adult health services should be subjected to children's safeguarding procedures if the need arises.
- Schools and colleges should seek information from health professionals and share concerns they have for a child's health. It is noted that NICE guidelines place the emphasis on health professionals, however education staff should also take the initiative and responsibility. A joined-up approach is essential.
- Non-health professionals should understand more about the impact of diabetes on children, including the links between mood and blood sugar levels and the wider emotional impact of the condition.

4) Self-neglect and capacity

- There is a need for all professionals to understand inherent jurisdiction and when it should be considered in relation to safeguarding concerns involving self-neglect and coercion and control in adults.
- There is a need for robust application of the Mental Capacity Act with service users who are between 16-18 years old.

5) Plans and working together

- Any unexpected death of a person, where neglect or abuse may have been a contributory factor, should be referred to the police.
- Where there is more than one agency involved with a child and there are concerns, the professionals involved have a responsibility to initiate a plan that is written down and reviewed as necessary that outlines the expectations of professionals and family.
- Where there are concerns regarding self-neglect, the hospital multi-disciplinary team (MDT) has a responsibility to implement the Safeguarding and Self Neglect procedures at the earliest opportunity and to consider the involvement of an independent advocate where coercion and control is suspected or known. Mechanisms and processes to enable this need to be considered and applied including provision by the MDT of case specific multi-agency planning and risk assessment meetings to develop an action plan to mitigate identified risks.

Evidencing Impact:

In December 2022 professionals from agencies who worked with Child T attending an 'evidencing impact' event. The event considered the impact of the learning from the review on local practice, what now works well when professionals have concerns about the neglect of a child's health needs, as well as any barriers to effective multi-agency working.

Professionals at the event identified the following changes to practice since the Child T review:

Awareness and understanding:

- ✓ Staff in schools now have much more awareness and understanding of safeguarding children within the context of health and medical conditions. Following a major awareness raising campaign, post the Child T review, training for school designated safeguarding leads, and policies were updated.
- ✓ GPs are more aware of the need to share relevant information with multi-agency professionals when there are concerns about the neglect of health conditions.
- ✓ A 'Vulnerable Learners Protocol' was developed locally, to outline the responsibilities of professionals to support vulnerable young people in their transition to Post-16 learning, including support with medical conditions.
- ✓ Social workers are more informed about inherent jurisdiction and there are now clear operational instructions in place. There is now ongoing training about mental capacity.
- ✓ There has been considerable training within Health and Schools.

Identification and assessment:

- ✓ GDPR has meant that front line professionals are much more confident to share information when they have concerns about a child.
- ✓ Quarterly liaison meetings now take place between children's services and the children's Diabetic service, meaning concerning cases are known or escalated for action.
- ✓ There is a dedicated Health specialist post in the MASH to provide health advice when making a multi-agency assessment of safeguarding concerns for children.
- ✓ Schools report there is excellent support provided by the Diabetic Service to schools.
- ✓ Local health information systems are more able to identify recurrent 'did not attend/was not brought' children and there are clearer pathways for escalating concerns.

Transition services:

- ✓ A transitions pathway within Sussex mental health services has been established.
- ✓ A Health Transition team has been established in the local hospital.
- ✓ There are dedicated 'transition' leads within the Safeguarding Team in ESHT and the Sussex Integrated Care Board.

Systems and processes:

- ✓ Child Protection and Unexpected Death Policies in the Police have been strengthened to ensure that when neglect is thought to be a feature in a child/adult death, this is fully considered and investigated.
- ✓ SPOA recognises all 16- and 17-year-olds being subjected to children's safeguarding procedures if the need arises, even if accessing adult Health services.

Individual professionals commented that they have:

"used the Child T Review in training with colleagues"

"will always make contact with families when they do not attend" *(for health appointments)*

"continue to raise awareness of self-neglect and the mental capacity act"

"escalated to managers if unhappy with the outcome of assessments"

"improved understanding that obesity, poor attendance, DNA/WNB can be indicators of neglect"

- ✓ There is better record keeping and sharing of safeguarding information between schools.

Professionals reflected that much had been done since the Child T Review to improve the 'system'. The group agreed that across the children's workforce, especially within schools, there is improved knowledge and understanding about life-limiting health conditions, and in particular how neglect of these conditions is a safeguarding issue. All professionals agreed that in the current safeguarding system, Child T would have been identified earlier.

Professionals were less confident about the impact of the Child T Review on practice, in regard to working with vulnerable young adults with multiple and complex needs.

However, positive change evidenced included the greater focus, in the child protection process, on relationship work: the relationship between the child and parent, and relationship between parent and professional. It was also seen as a positive the greater focus, by all agencies, on trauma informed practice, and how this would have informed the work with Child T and their mother.

Professionals also discussed this case in the context of the cost-of-living crisis and the impact on neglect.

Next steps:

- ✓ The ESSCP has recently initiated a multi-agency Task & Finish Group to refresh the local Neglect strategy, toolkit and matrix.
- ✓ Continued focus on enabling a culture where professionals feel able to confidently escalate and challenge. Examples included the 'Re-think' approach in Portsmouth.
- ✓ The ESSCP and Safeguarding Adult Board have recently initiated a multi-agency Task & Finish Group on 'Transitions', to ensure that vulnerable young people have the right support in to adulthood.
- ✓ Reviewing the approach to cases where a vulnerable young person has multiple and/or complex issues.
- ✓ Review the input of education representatives in SPOA and MASH.

Learning for practice

The ESSCP invite you to discuss the issues raised in this briefing in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

Points for discussion:

- What learning did you expect, or what surprised you about learning from this review?
- How curious are you about the lived experience of children who have a lifelong medical condition?
- How do you approach working with parents who are resistant or aggressive towards professionals?
- When did you last undertake training on neglect? What do you think might have changed since you last undertook training?
- When was the last time you used the Pan Sussex Child Protection and Procedures Manual?