The West Sussex Safeguarding Children Partnership

Response to a Legacy Serious Case Review: Child V

This Serious Case Review (SCR) was commissioned in 2018 by the former West Sussex Safeguarding Children Board (WSSCB) in line with the 2015 HM Government 'Working Together to Safeguard Children'. An independent safeguarding specialist, Adrienne Plunkett was commissioned as the lead reviewer and author to complete this SCR, as she has particular experience of cases involving Fabricated and Induced Illness (FII), which was the key feature of this case. The Significant Incident Learning Process (SILP) methodology used to review the case is an accredited and recognised systems-based approach that ensures full participation by the front- line practitioners involved with the family. The review process is overseen and supported by a Review Panel of independent senior staff from involved agencies, that the reviewer uses as a sounding board, and where necessary to provide necessary context on organisational policies and practice.

This case involved the fabricated and induced illness (FII) of a young child residing in West Sussex, over a number of years. There was also evidence of neglect and physical abuse which the review found were not adequately addressed by the professionals involved. The child received medical treatment and professional input from a variety of agencies and service providers, including a number that were located outside the West Sussex area. Whilst the review identified areas of good practice, in particular that agencies did come together in order to try to understand the child's complex needs better and plan services, it also found that there was significant learning for all agencies involved in terms of recognising and responding robustly enough to potential concerns about FII.

Fabricated or Induced Illness is a form of abuse whereby a child suffers harm when the main caregiver exaggerates or deliberately causes symptoms of illness in the child. In over 85% of cases this type of abuse is caused by the child's biological mother. It is a rare but harmful and potentially lethal form of abuse and is recognised as being the most complex and challenging of situations for child protection professionals to identify and respond to. Evidence shows that even the most skilled professionals find it difficult to identify.

The report and its recommendations were agreed and accepted by the then West Sussex Safeguarding Children Board and have been published by the West Sussex Safeguarding Children Partnership alongside this Partnership response. The recommendations from this review are detailed below, together with the learning and actions taken by the Partnership and its partner agencies to improve the response to this type of abuse in West Sussex.

Recommendations/ Actions

1. The Partnership to ensure that the revised fabricated and induced illness guidance reflects the key learning of this SCR, that the FII training has been accessed by key staff across agencies and the guidance is being embedded into practice. Practitioners and front-line managers need to be equipped with sufficient knowledge and understanding to apply the guidance with confidence when dealing with concerns about perplexing presentation/FII.

Safeguarding Leads must provide expert advice and guidance to staff dealing with perplexing presentations/FII, to ensure that these concerns are dealt with at an early stage, and senior management need to ensure that support is in place for staff dealing with the challenges in managing cases of FII. Evidence that the guidance is embedded across agencies will be gained through staff surveys and multi-agency case file audits.

2. The Partnership to receive the report of the review currently taking place of the new multi-agency planning and review process in place for children with disabilities/complex needs (My Plan). The Board should ensure this addresses concerns about the efficacy of Child in Need (CIN) planning and how this fit with Health's multi-disciplinary team (MDT) meetings.

3. The Partnership to consider how well-equipped, knowledgeable, and confident practitioners working with children with disabilities/complex needs across the multi-agency network are to recognise, assess and manage safeguarding concerns and what additional training and support may be required. The need for professional curiosity and an open mind should be promoted.

4. The Partnership to ensure that there is greater clarity about the type and purpose of multi-agency meetings, notably Professionals Meetings; how they fit with local policies and procedures, e.g. child protection, child in need. They should not be a substitute for a Strategy Meetings. It should be clear who is the Lead Professional and how the meetings will be chaired and recorded, and how decisions and actions will be reviewed.

5. The Terms of Reference and governance arrangements for the Reflective Practice Group (Previously Perplexing Cases Group) to be reviewed, importantly considering how this process fits with WSSCP's structure and child protection procedures.

6. The Clinical Commissioning Group to follow up the lack of monitoring of the prescriptions for epilepsy rescue medication and consider whether any further advice is required for local health services.

7. The Pan Sussex Child Protection and Safeguarding Procedures Manual should be amended to include guidance that when the information on which the decision-making of a previous Strategy Meeting is based changes significantly, a further Strategy Meeting should be convened to review that earlier decision-making.

8. The Partnership should ensure that practitioners understand that information is a dynamic process and that the principles of information-sharing and confidentiality are embedded in

training and communications, so practitioners know that when making a decision about sharing information, the wellbeing and safety of the child always takes priority.

9. The Partnership should promote the Pan Sussex Child Protection and Safeguarding Procedures Manual's Resolution of Professional Disagreements, encouraging respectful challenge and escalation as appropriate.

Actions Taken to Address the Learning and Recommendations.

Since the completion of the report the following actions have been taken to address the recommendations. Significant work has been carried out to strengthen the Pan Sussex guidance around FII to assist staff in recognising and addressing this complex form of abuse. Specific FII training was provided to multi-agency staff in March 2018 and early learning practice sessions were delivered specifically to the Children with Disability Service in 2018. Additionally, a presentation on identifying FII was made to the West Sussex Annual Conference in November 2019 to 200 multi-agency staff and training sessions are ongoing across the partnership. In addition, individual agencies have provided internal briefings for staff and have been raising awareness in their own organisations.

Since the Ofsted inspection of West Sussex County Council's Children's Services in 2019, significant work has been undertaken with the Children with Disability Service to improve safeguarding practice. This has included mandatory safeguarding training and coaching and mentoring of managers across the workforce. Supported by Hampshire, the local authority Improvement Partner, a programme of work is also being undertaken to improve the quality of social work practice across children's social care, including the children's disability team, to ensure an understanding of 'what good looks like'. This has involved workshops on assessment and planning and guidance has been developed to strengthen management oversight.

In addition, Tri-x procedures and practice guidance and tools are now easily accessible via mobile devices for managers and practitioners within Children's Social Care on the Children First Tile on The Point (West Sussex County Council website). Significant work has also been undertaken to ensure the robustness of professionals' meetings where children's services are involved, including both child protection and child in need meetings. This includes the chairing and recorded of meetings and tracking and review of decisions and actions. An Updated Child in Need (CIN) Framework will be completed by October 2020 which will strengthen multi-agency safeguarding practice for children in need.

The Multi-Agency Neglect Strategy and toolkit was launched by the partnership in March 2020, with an emphasis on understanding the child's lived experience and impact of neglect on the child. Training has been delivered to multi-agency staff by the Safeguarding Partnership and Children's Social Care in relation to the strategy and toolkit. In addition, the partnership is developing core practice standards to strengthen accountability and responsibility for safeguarding practice across all agencies.

The hospitals involved in this review have undertaken a number of immediate measures to strengthen safeguarding practice around FII as outlined in this report. These include changes to electronic recording systems, increasing the safeguarding resource and ensuring pre-discharge

planning meetings are held for all complex cases and establishing a pathway for staff to escalate concerns when parents do not visit children who are inpatients. In addition, the learning from this case has been disseminated through the health network.

The terms of reference and governance arrangements for the Reflective Practice Group (Previously Perplexing Cases Group) have been reviewed and a decision made to cease this group in light of the findings of this Review. There will still be the opportunity to discuss complex cases and live practice issues though the Partnerships new multi-agency Safeguarding Liaison group, which will commence in September 2020. The Clinical Commissioning Group are following up the lack of monitoring of the prescriptions for epilepsy rescue medication.

The Information Sharing Agreement for Safeguarding Partners and Agencies working with Children and Young People was revised and updated as a result of findings from SCRs, to ensure all agencies are aware of when and how to share information appropriately, to ensure proactive safeguarding of children and young people.

Significant work has been undertaken to promote the Pan Sussex Child Protection and Safeguarding Procedures Manual's Resolution of Professional Disagreements policy and this is now discussed at the end of each WSSCP training session. There was also a dedicated session during Safeguarding Month in November 2019, delivered to 198 multi-agency practitioners to develop a more detailed understanding of the policy and how to use it. The Partnership is completing further work to encourage professional curiosity, promote respectful challenge and will be monitoring and auditing the use of the resolution process on an ongoing basis.

Further briefings and learning materials have been drawn up to coincide with the formal publication of the findings from this SCR. Additionally, the West Sussex Safeguarding Children Partnership will be seeking evidence and testing via its new Quality Assurance and Scrutiny Framework that the learning from reviews is sufficiently embedded and driving practice improvement.