

Serious Case Review Learning Briefing

Child V

What is a Serious Case Review?

A Serious Case Review (SCR) is a local multi-agency review, conducted in circumstances where a child has been abused or neglected, resulting in serious harm or death, and there is cause for concern in relation to how the relevant agency or agencies have worked together to safeguard the child. Since October 2019, these reviews are now called Child Safeguarding Practice Reviews (CSPRs).

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals/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.

Background:

Child V lived with their biological parents and siblings. Mother was a teenager when she had her first child and Child V's Father had older children, one of whom was the subject of a Child Protection Plan some years before. In a previous relationship there had been concerns about domestic abuse and Father's substance misuse.

Prior to Child V's birth, Children's Social Care were involved with the family due to the attempted abduction of Child V's sibling by a stranger, which raised concern about the supervision of the children. CSC undertook an assessment, the Parents co-operated, and social work involvement ceased before Child V's birth.

Mother presented late in the pregnancy requesting a termination, but this was declined as the request was outside the legal time limit. Child V was born prematurely with the usual health complications of prematurity, requiring a period in the neo-natal unit.

On discharge, Child V was progressing well, feeding and breathing without assistance, and no additional care was required. Despite this progress, the parents continued to present Child V with health difficulties, including apnoea episodes and feeding. Assessment by the Speech & Language Team evidenced Child V had a strong sucking mechanism, and bottle feeding was to be encouraged, however, Mother appeared reluctant to persevere with this.

Child V was referred for further investigations, aged three months. Studies undertaken evidenced self-resolving apnoea, related to prematurity, and the administration of oxygen, via nasal cannula, was commenced. This was planned to be a short-term intervention and the condition quickly resolved, but due to communication difficulties between healthcare professionals, the administration of oxygen continued until Child V was placed in foster care, aged two years.

Child V was referred for additional assessments in respect of the reported feeding difficulties and for consideration of insertion of a PEG-J (feeding tube). There was some miscommunication between the various medical professionals and hospitals in relation to a belief that an abnormal swallow had previously been detected. Unfortunately, an inpatient assessment was not completed; Mother was keen for the gastrostomy to be inserted and this went ahead, when Child V was aged 7 months. There was a lack of medical reviews and Child V continued to be enterally fed until placed in foster care, aged two years.

There were some concerns in relation to the neglect of Child V, including poor weight gain, being cold and left on the floor. There were numerous hospital admissions during which there were concerns about the lack of parental visiting, difficulties arranging meetings with medical staff and delayed discharges. These were explained by the challenges of caring for the other children in the family, together with financial and transport difficulties. An early help plan was recommended, but the parents failed to engage. Concerns continued regarding Child V's care and welfare, which on occasions were discussed at the Hospital's Safeguarding Meetings.

There were three incidents when there were concerns about physical harm to Child V. These related to a fractured femur whilst an inpatient at a hospital, a hospital admission with a subdural hematoma with retinal haemorrhages and an admission with high salt and glucose levels, leading to safeguarding concerns about possible salt poisoning. A referral to Children's Social Care (CSC) was made in respect of the head injury, strategy meetings were held but a Section 47 child protection enquiry was not instigated, nor an Initial Child Protection Conference convened. Referrals were not made in respect of the fractured femur and possible salt poisoning.

In addition, there were occasions when bruising was observed on Child V's face and the parents' explanation that these were caused by a toy was accepted.

The outcome of the medical investigations into the subdural hematoma was that there was a potential diagnosis of a rare life-limiting condition, which could be an explanation for the injury. However, this was not a definitive diagnosis and subsequent testing did not support the diagnosis. The Consultant Neurologist recommended that 'vigilance' and close multi-agency working was required to safeguard the child. This information was not shared with all the practitioners involved with the family, including the Police, and a further strategy meeting was not convened to review the outcome of the investigation given the new information.

A child and family assessment was undertaken by CSC, Child V became the subject of a child in need plan and case responsibility was transferred to the Children with Disabilities Team. Child V continued to be viewed as a child with a life-limiting condition, despite the lack of a confirmed diagnosis, and the family as in need of support. The focus of agencies' involvement was on providing support services, e.g. home nursing, respite care at the local children's hospice; there is no evidence that the need for vigilance was considered.

Mother had reported that Child V had 'absences' which, though not observed by clinicians, were investigated. Epilepsy can occur with the life-limiting condition and so, with this potential diagnosis, Child V was commenced on epilepsy medication. There was concern on one occasion when Mother took Child V to the hospice with unnamed syringes containing epilepsy medication four times the prescribed amount and stated that if necessary, she would administer the full amount, contrary to medical advice. This was followed up by the Paediatrician.

There were early concerns during Child V's first year about the discrepancy between Mother's reporting of health conditions and clinical observations. At times Consultants were 'puzzled',

e.g. when Mother talked of Child V needing a tracheostomy and wondered whether fabricated or induced illness should be considered. It was recognised that there was a need for close working between practitioners and steps were taken to try and co-ordinate Child V's medical care, but these were not effective.

Concerns about Child V's care increased during 2017, leading to a Multi-Disciplinary Meeting, Professionals Meeting and discussion at the Perplexing Cases Panel. The Children's Continuing Care Nurses identified a '*mismatch*' between Child V's identified health conditions and treatments and presentation at home. It was agreed Child V should be admitted to hospital for observation. The local child protection procedures and national guidance in relation to the management of cases where there was concern about FII were not consulted or implemented at any stage.

There was a large number of practitioners involved with the family and a high level of multi-agency activity. Multi-disciplinary meetings were held, though Child in Need reviews did not take place.

Admission for assessment was arranged for Child V. On the day of admission Mother was observed to physically abuse Child V and immediate steps were taken to safeguard the child. Child V became looked after by the local authority; quickly thrived and was walking and feeding normally, with no evidence of epilepsy or of the need for oxygen or suctioning.

Serious Case Review Findings

The local review found that there was evidence of good practice and areas for improvement and the review made recommendations for practice improvement. Please take time to read the summary review, which is on the partnership website:

Good practice

- ✓ GP summarised clinic letters and reports in the child's records, which is helpful for GPs responding to children with complex needs.
- ✓ Social Workers strove to bring professionals together in order to understand Child V's complex needs better and plan services.
- ✓ Children's Community Nurse raised early concerns about Child V's care with the Health Visitor and made a referral to Children's Access Point (CAP), now MASH.
- ✓ The hospital made an early referral to CAP expressing concerns about neglect of the baby.
- ✓ Social Worker and Children's Community Nurses were proactive in ensuring that Child V received urgent medical attention in December 2017.
- ✓ The Hospice identified concerns about Child V's epilepsy rescue medication and raised this appropriately with the GP and Consultant Paediatrician.
- ✓ The Children's Continuing Care Nurses identified discrepancies in how Child V's health needs were viewed and followed this up.

- ✓ Multi-agency Ante-Natal Concerns meetings enable information to be shared pre-birth and a plan put in place.

Areas to Strengthen:

- ✚ **Knowledge and understanding of fabricated or induced Illness:** There is no evidence that the local and national guidance in respect of FII was consulted. FII is child abuse which results in significant harm to children. It has short-term and long-term physical, emotional and psychological impact, which can be life-threatening. FII needs to be dealt with as robustly as other forms of abuse and neglect and in line with local and national guidance.
- ✚ **Perplexing Presentation:** From early on, there was evidence of a perplexing presentation (What's Going On?) – health practitioners were 'puzzled'. Early recognition, and action, in respect of perplexing presentations is essential and can help to reduce the development of fabricated or induced illness. The longer the behaviour continues the more difficult the task of understanding a child's conditions and treatment becomes.
- ✚ **Focus on the child:** Practitioners must maintain a focus on the needs of the child (Think Child), rather than on the day to day difficulties faced by the parents. There is a need to 'Think the Unthinkable'.
- ✚ **Effectiveness of multi-agency working:** The large number of medical practitioners and agencies involved with the family made coordinating Child's V care very challenging. However, the lack of effective and robust multi-agency processes did not support the co-ordination. Practitioners need to recognise the importance of direct communication, i.e. face-to-face meetings/telephone discussions; letters and emails are not a substitute.
- ✚ **Assessment of family functioning and understanding the level of risk:** The view of practitioners was that this was a family caring for a child with complex health needs requiring support. It is apparent that this view very much influenced practitioners' approach to safeguarding concerns. It was the lens through which concerns about physical harm were viewed. None of the professionals or agencies gained a full understanding of the family functioning or of Child V's position within the family.
- ✚ **Understanding and responding to risk:** there were four significant incidents for Child V, including a fractured femur, subdural haematoma, preloaded syringe and high sodium and glucose levels. These safeguarding concerns about physical abuse, together with the evidence of neglect and concerns about the quality of attachment, were not pulled together in a health chronology, analysed, and the impact on and risk to Child V were not recognised.
- ✚ **Child in Need planning:** Where a child has been identified as a 'child in need', CIN should be the overarching planning and review process to ensure there is a holistic approach to meeting the child's needs. All agencies working with the family should be invited to be involved in the CIN process, including the GP, and provided with copy of CIN plan with the consent of families.

Take the Learning into your Practice:

Take the issues raised in this SCR into your supervision, team meeting and group supervision.

Consider the following:

1. What further research and reading do I need to complete to understand Fabricated and Induced Illness.
2. Is there a clear plan to coordinate the multi-agency work with all my families, with leads and timescales clarified and outcomes apparent.
3. Do I have a full understanding of family functioning, including the quality of attachment and how well do I ensure that I utilise chronologies to support the analysis and understanding of the child's lived experience.
4. Do I ensure that my assessments are focused on the needs of the child, including the need for protection, and not on the difficulties and needs of parents?
5. Am I sufficiently professionally curious and check out and cross reference the accuracy of information provided using a variety of sources?
6. Am I confident in my questioning and respectful challenge of families and other professionals to ensure I understand risk and can protect children?

Resources:

Pan Sussex Child Protection and Safeguarding Procedures: Fabricated or induced illness; <http://sussexchildprotection.procedures.org.uk/tkypss/children-in-specific-circumstances/fabricated-or-induced-illness-fii-and-perplexing-presentations-including-fii-by-carers/#s4206>

Royal College of Paediatrics and Child Health (RCPCH): Fabricated or induced illness (FII) by carers - a practical guide for paediatricians;
<https://www.rcpch.ac.uk/resources/fabricated-or-induced-illness-fii-carers-practical-guide-paediatricians>

ResearchGate: Early recognition and management of fabricated or induced illness in children;
https://www.researchgate.net/publication/260681270_Early_recognition_and_management_of_fabricated_or_induced_illness_in_children

Neglect Resources:

<https://www.westsussexscp.org.uk/neglect>

