



Serious Case Review

Child V



Independent Reviewer and Author: Adrienne Plunkett

Date: September 2020.

CONTENTS:

Page No.

1.	Background to Serious Case Reviews	3
2.	Significant Incident Learning Process (SILP)	3
3.	Process for the Serious Case Review	3
4.	Family Engagement	4
5.	Pre-Scoping	5
6.	Scoping Period: Key Episodes	5
7.	Themed Analysis: Terms of Reference	7
8.	Examples of good practice	21
9.	Recent developments	22
10.	Key learning	23
11.	Conclusion	26
12.	Recommendations for West Sussex SCP	28

Appendixes:

- Appendix A: Glossary
- Appendix B: References

1. Background to Serious Case Reviews:

1.1. This SCR was undertaken in line with the Local Safeguarding Children Boards Regulations 2006 which outlined that LSCBs should undertake reviews in specified circumstances.

5 (1)(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

5 (2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.2. Given the timeframe for this Serious Case Review (SCR), it was commenced under the guidance contained in Working Together to Safeguard Children 2015, Chapter 4,¹, which emphasised the importance of LSCBs developing a Learning and Improvement Framework and outlines that reviews should be completed in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- Is transparent about the way data is collected and analysed;
- Makes use of relevant research and case evidence to inform the findings.

1.3. Working Together 2015 encourages LSCBs to use a variety of models for undertaking SCRs, including the systems approach. The Significant Incident Learning Process (SILP) is one such model.

2. Introduction to the Significant Incident Learning Process (SILP)

2.1. The SILP methodology reflects on multi-agency work systemically. It engages frontline staff and their managers in the review, focussing on why those involved acted in a certain way at that time. Importantly it recognises good practice.

2.2. The SILP methodology adheres to the principles of;

- Proportionality
- Active engagement with practitioners
- Involvement of families
- Learning from good practice

3. Process for this Serious Case Review:

3.1. In 2018, the Chair of the Local Safeguarding Children Board (LSCB) made the decision to undertake a SCR in respect of Child V. It was agreed that the criteria had been met under Chapter 4, Paragraph 8, Working Together to Safeguard Children 2015.² There were concerns that Child V had been seriously harmed due to fabricated or induced illness and

¹ Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HMG, March 2015.

² HMG, March 2015.

there was cause for concern as to the way in which the Local Authority, Board partners and other relevant persons had worked together to safeguard the child.

3.2. Furthermore, a decision was taken that the SCR would be undertaken using the SILP methodology and a Scoping Meeting to discuss the Terms of Reference was held. The Scoping Period was from Mother's pregnancy with Child V to the child's admission to hospital in 2018. Relevant agencies were requested to submit an Agency Report and a briefing for Report Authors was held in March 2018.

3.3. Due to parallel processes there was a delay in holding the SILP Learning and Recall Events and an Interim Report was prepared to identify immediate learning and recommendations that the Board could take forward. The Learning and Recall Events took place in January and March 2019.

3.4. The current definition of fabricated and induced illness (FII), used in this SCR, is ³.

There are three main ways of the carer fabricating or inducing illness in a child. These are not mutually exclusive and include:

- *Fabrication of signs and symptoms. This may include fabrication of past medical history;*
- *Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents;*
- *Induction of illness by a variety of means.*

It can involve reported concerns about both the physical and mental health of the child, such as difficulties in the autism spectrum. ⁴

3.5. In recognition that there is a spectrum of presentations, the SCR will also refer to 'perplexing presentations' or 'medically unexplained symptoms' ⁵. The 2013 RCPCH Child Protection Companion extended FII to embrace 'the commoner wider range of perplexing presentations or medically unexplained symptoms', where the clinical information may 'not add up', leading paediatricians to consider 'what's going on?' (WGO Syndrome)⁶. The Companion recognises that the impact on the child is similar whether they are victims of FII or of the wider spectrum of perplexing presentations.

3.6. Working Together to Safeguard Children 2015, defines physical abuse as:

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.⁶

4. Family Engagement:

4.1. Child V's parents were advised that the Serious Case Review was being undertaken by the LSCB and that they would be invited to contribute to the review when appropriate.

4.2. Recently the parents have been offered the opportunity to meet or speak with the Lead Reviewer, but they have both declined to be involved in the review.

³ Safeguarding children in whom illness is fabricated or induced, Supplementary guidance for Working Together to Safeguard Children, Chapter 1, 1.5. DCSF, 2008

⁴ Bass and Glaser. Early recognition and management of fabricated or induced illness in children. Lancet 2014, 383, 1412-21. Published Online March 6, 2014.

⁵ Perplexing Presentations (including FII), Child Protection Companion 2013 (2nd Edition) Royal College of Paediatricians and Child Health.

⁶ HMG, March 2015.

5. Pre-Scoping Period

5.1. Child V lived with biological parents, older sibling and two half-siblings. Mother was a teenager when she had her first child.

5.2. Child V's Father has older children, one of whom was the subject of a Child Protection Plan in 2008/09 and was made the subject of a Special Guardianship Order.

5.3. Immediately 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 in a public place. This raised concern about the supervision of the children and CSC undertook an assessment. Parents co-operated and it was planned social work involvement would cease before Child V's birth.

6. Scoping Period:

6.1. Mother presented late⁷ 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. The prematurity meant that the counselling offered to women who book late in a pregnancy was not provided, there was no discussion at the multi-agency Ante-Natal Concerns Meeting, convened by the Midwifery Service, and the Health Visitor was unable to complete the ante-natal assessment visit.

6.2. 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 in relation to apnoea episodes and feeding. Assessment by the Speech & Language Team at Hospital 1 evidenced Child V had a strong sucking mechanism, and bottle feeding was to be encouraged, however, Mother appeared reluctant to persevere with this.

6.3. Hospital 1 referred Child V to Hospital 3 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.

6.4. Hospital 3 referred Child V to Hospital 6 in respect of the reported feeding difficulties and for consideration of insertion of a PEG-J. Hospital 3 made an error in interpreting the referral letter from Hospital 1 and wrongly believed that an abnormal swallow had previously been detected. Hospital 3 was unable to complete a feeding assessment whilst Child V was an inpatient. Hospital 6 planned to undertake further tests, but Mother was keen for the gastrostomy to be inserted and this went ahead, when Child V was aged 7 months, without further investigations. There was a lack of medical reviews and Child V continued to be enterally fed until being placed in foster care, aged two years.

⁷ Late Booking is defined as presenting for maternity services after 20 weeks. It is always important to remember that unless the woman genuinely has not been aware she is pregnant she has still concealed her pregnancy up until the point she has accessed antenatal care. A booking appointment with a midwife should be around 10 weeks ([NICE 2008](#)). A woman who presents to antenatal care late in her pregnancy should continue to be assessed with the reasons for the delay in presentation and associated risks as part of the assessment, even once booked and attending for antenatal care. Concealed Pregnancy, Pan Sussex Child Protection and Safeguarding Procedures. Updated March 2019.

6.5. There were some concerns in relation to the neglect of Child V. Early on health staff were concerned about Child V's care, 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.

6.6. Whilst Child V was a baby the family were referred to the Children's Access Point⁸ by the Children's Community Nursing Service and Hospital 1. 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 Hospital 1's Safeguarding Meetings.

6.7. During the Scoping Period there were three incidents when there were concerns about physical harm to Child V. These related to a fractured femur whilst an inpatient at Hospital 3, 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 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.

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

6.9. 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.

6.10. 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.

6.11. 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, Hospital 1.

⁸ Children's Access Point (CAP): Single point of contact at this time for referrals to Children's Social Care.

6.12. 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.

6.13. 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. Concerns included poor weight gain and whether there was a need for epilepsy medication, nasal suctioning⁹ and a tracheostomy, as reported by Mother. 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.

6.14. 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.

6.15. Admission for assessment was arranged for Child V at Hospital 4. 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.

7. Themed Analysis:

7.1. Effectiveness of multi-agency working:

Information sharing is essential for effective safeguarding and promoting the welfare of children and young people. It is a key factor identified in many serious case reviews (SCRs), where poor information sharing has resulted in missed opportunities to take action that keeps children and young people safe.¹⁰

7.1.1. Agency Report Authors have commented that co-ordinating Child V's care became increasingly challenging due to the large number of medical practitioners and agencies involved with the family. However, the lack of effective and robust multi-agency processes did not support the co-ordination. The CSC Report Author highlights '*the lack of comprehensive minutes of meetings, action plans and health chronologies, which would have supported and enhanced the communication between all professionals.*'

⁹ Suctioning is used to clear retained or excessive lower respiratory tract secretions in patients who are unable to do so effectively themselves. This could be due to the presence of an artificial airway, such as an endotracheal or tracheostomy tube, or in patients who have a poor cough due to a variety of reasons such as excessive sedation or neurological involvement.

¹⁰ Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers. DFE, 2018.

7.1.2. Despite this, it is very apparent that there was a considerable amount of hard work, liaison and communication between agencies. A plan was put in place when Child V was discharged from the Special Care Baby Unit, involving the Health Visitor undertaking enhanced visiting and the Neo-Natal Outreach Nurse providing support, followed by the involvement of the Children's Community Nurses (CCNs). Hospitals 3 and 6's Agency Reports note the good communication between the hospitals and with the CCNs. There was a planned handover between Hospital 6 and the local hospital. Hospital 1's Report notes evidence of regular communication between the Consultant Paediatrician, Dietician and the Children's Community Nursing Team to monitor Child V's progress, weight and health needs. The Social Worker worked hard to arrange multi-disciplinary meetings.

7.1.3. However, local health services, including the referring Hospital and the GP, were not always in receipt of up to date information, e.g. there was no discussion between the Respiratory Clinic, Hospital 3, and Hospital 1 about the plan to refer Child V to the Gastrostomy Clinic at Hospital 6. The Respiratory Consultant had not understood that the CCN service was not provided by Hospital 1 so, whilst liaising with CCNs, had failed to liaise with the Consultant Paediatrician. Some clinic letters from secondary and tertiary hospitals were received in a timely way, others took several months. This becomes an issue as delays leave gaps in communication between health providers that parents can step in and fill. The NHS FT 1's Author notes that Mother often provided information regarding recent hospital attendances which '*negated the need for dialogue between the professionals involved in Child V's care*'. It is not uncommon when children have complex health needs that parents can be viewed as experts regarding their own child. However, Davis, Murtagh and Glaser¹¹ warn that many carers '*act as conduits for information between professionals and this may become a route for misinformation*'. Examples of this have been identified, including Mother reporting that Child V required deep suctioning, Hospital 3 was considering a tracheostomy and informing Hospital 7 Child V was already being investigated for high sodium levels. **(Learning point).**

7.1.4. There was limited liaison by other agencies, including within Health, with the GP. From birth Child V was under the care of a several hospitals and all medical conditions were diagnosed in secondary care. The family had open access to the children's ward at the local hospital and could seek advice without needing to go to the GP, which is not unusual for children with complex needs. The GP was informed of Hospital 6's concerns about the lack of parental visiting by a letter from the Safeguarding Nurse. The CCG Report Author notes that, helpfully, this was summarised in the child's GP records, making the information easily accessible. However, the information was not added to Mother's records; if it had been the GP could have prompted a discussion during her next consultation.

7.1.5. The GP was not informed of the Early Help or CIN plan nor that the family were receiving support from CSC at any point, and therefore the GP did not have knowledge of, or a role in, the multi-agency activity.

7.1.6. At the Learning Event there was a discussion about the fact that practitioners' roles and responsibilities were not clear. There was a general presumption that a professional was taking a lead role, but a lack of clarity about who this was. Some Agency Report Authors, e.g. CSC and NHS FT 1, commented that there is no evidence that there was a key health professional co-ordinating Child V's care, which would have been helpful. The CSC Report notes that social workers had difficulty arranging meetings, speaking to and getting a response to emails from Consultants and a single point of contact in Health was required. It

¹¹ Davis, Murtagh and Glaser: 40 years of fabricated or induced illness (FII): where next for paediatricians? group.bmj.com. April 2018.

is therefore interesting that Hospital 1's Report notes there was a Lead Consultant Paediatrician in the Acute Trust, and from July 2016 a Community Paediatrician to co-ordinate Child V's health care. If the Health Visitor, Social Worker and CCN were not aware of these arrangements, there must be a question about the quality of communication and how effectively this lead role was being performed. **(Learning Point)**

7.1.7. The CSC Agency Report Author highlights that the Team Manager, CDT, considered health professionals were '*unwilling to address their concerns in an open and transparent way directly with the family*' and were '*unwilling to stand by their worries in meetings.*' The CSC Author reflects that there was no forum for professionals to have an '*unfettered discussion*' about concerns and to challenge each other and considers that Professionals Meetings should have been convened to fulfil this purpose, to give practitioners time for reflection. In fact, the most appropriate course of action would have been to follow the FII guidance and convene a child protection strategy meeting which would provide the most effective opportunity for practitioners to openly share concerns and agree a plan of action which would safeguard the child.

7.1.8. There is evidence that Mother was able to 'split professional. The parents had complained about the care received from Hospital 1 and had requested that Child V's medical care be transferred. There appeared to be a sympathy for Mother's perspective from the Health Visitor and the Psychologist, Hospital 3, and the latter discussed with Mother making a complaint. Staff at Hospital 1 were not aware of this. In addition, there were different perspectives between Hospital 1 and CSC about what should be expected of the parents in caring for Child V. These dynamics may well have impacted on the quality of interagency communication and undermined the co-ordination of Child V's care. It is well recognised that mothers who perpetuate FII are more likely to complain, threaten legal action and attempt to split practitioners in the way that is apparent here. **(Learning Point)**

7.1.9. The issue of professional status and hierarchy has been considered during the review and this is certainly a factor that needs to be borne in mind by practitioners when there are concerns about perplexing presentation/FII. Children are likely to be referred to specialists at centres of excellence and it is understandable that local practitioners, e.g. community nurses, will feel reluctant to challenge their opinions. Therefore, practitioners will need the support of managers and Safeguarding Leads to do so. **(Learning Point)**

7.1.10. A number of specific examples have been identified which raise concerns about the effectiveness of multi-agency working including:

- Whilst an in-patient at Hospital 3, the administration of oxygen was commenced as a temporary short-term measure to stabilise Child V's breathing and reduce apnoea episodes. The CCNs were requested to undertake follow-up sleep studies, which gave normal results. Information was sent to Hospital 3, however, this was not received by the Respiratory Consultant and there was no further follow-up by the Consultant or the CCNs. This lack of communication led to Child V being administered oxygen for considerably longer than was necessary.
- Concerns were raised by Mother at Hospital 3 about Child V's feeding difficulties and reflux. Evidence presented indicates that the Speech and Language Team (SALT), Hospital 3, believed that SALT, Hospital 1, had identified an unsafe swallow, which was incorrect. SALT, Hospital 3, undertook a '*bedside assessment*' which raised concerns about Child V's swallow and a referral was made to Hospital 6 for the insertion of a PEG-J. Whilst a PEG may have been beneficial in helping to stabilise Child V's weight at this time, the procedure was undertaken without either hospital undertaking further

tests, e.g. a videofluoroscopy swallow study. There is evidence that Mother had shown reluctance towards bottle feeding, which may have been a factor in her keenness for enteral feeding to commence.

- It was concluded that the possible explanation for Child V's subdural haematoma was a rare condition. However, three months later genetic tests were negative. CSC and Hospital 1 were advised that close multi-agency networking and vigilance was necessary. There is no evidence that this information and advice was shared with other agencies, notably the Police. This should have triggered a further Strategy Meeting in order to review the information and reassess the level of risk to Child V. **(Learning Point and Recommendation)**
- There were different perspectives between Health and CSC practitioners over how the family was viewed. During April/May 2016 health practitioners raised concerns about Child V's poor weight gain and the difficulties in gaining parental agreement to admission for observation. CSC's view was that the health practitioners did not understand the challenges that the family were facing, i.e. the focus was on the needs of the parents rather than the needs of the child.
- Despite Child V being admitted to hospital in a life-threatening condition with suspected salt poisoning, information was not sought from health practitioners working with the family, e.g. CCNs, and the allocated Social Worker was not informed of the safeguarding concerns. Safeguarding information was not easily accessible in the medical records, which is being addressed by the Safeguarding Team, Hospital 1.

7.1.11. Considering the reasons behind these communication difficulties, it is apparent that from early in Child V's life practitioners were faced with a complex situation, which over time became increasingly complex. This complexity was exacerbated by the interactions between multiple professionals and agencies working with the family. The Triennial Analysis of Serious Case Reviews 2011 – 2014¹² highlights that the complexity and dynamics within the family may be mirrored in the responses of professionals and hence *'the more complex a case, the more complex the inter-agency working becomes.'* The Analysis suggests that *'Authoritative practice is an appropriate response to such complexity and manager and service leads have a responsibility to model authoritative practice.'*

7.1.12. **Multi-agency meetings:** The review has attempted to gain an overview of the planning processes for Child V and develop an understanding of whether this was through the CIN process or the MDT meetings.

7.1.13. **Multi-Disciplinary Team Meetings (MDTs):** MDT meetings are generally organised by health practitioners when children have complex health needs to review the care plan. However, in this case, some were arranged by Health and others by the Social Worker and there were difficulties in securing attendance, so that the right people were not always present. There are no minutes for any of the MDTs. Health practitioners do not produce minutes; any resulting actions are recorded in the child's medical notes, which can make it difficult to track progress. GPs are not routinely invited or informed of the outcome. At the SILP Learning Event professionals highlighted that there is confusion about terminologies used, i.e. MDT/Professionals meetings, the purpose of meetings and which meetings parents

¹² Pathways to harm, pathways to protection: A Triennial Analysis of SCRs 2011 to 2014. University of Warwick, University of East Anglia, May 2016.

should attend. This raises a concern about practitioners' understanding of the purpose/objectives of meetings

7.1.14. **Professionals Meeting:** At the MDT meeting in September 2017 serious concerns were raised about Child V's care, notably in relation to weight gain, the need for deep suctioning and Mother's wish for a tracheostomy to be inserted, which led to the Professionals' Meeting in November 2017. There is a question about whether a Strategy Meeting under the FII procedures should have been convened at this point in order to escalate the level of concern, gain greater clarity about Child V's medical conditions and put a plan in place to oversee medical treatment and any further investigations. There is no evidence the local and national guidance were considered.

7.1.15. **Child in Need (CIN) Planning:** From December 2016, the family received a service from CSC's Children with Disabilities Team. The basis for the team's involvement was that Child V had been assessed as a child in need ¹³, due to the complex medical condition. A CIN plan was drawn up and CIN visits are recorded. However, there is no evidence of CIN meetings being held or of the CIN plan being regularly reviewed in line with procedures, i.e. a minimum of three monthly during the first year. The CSC Report Author has suggested that in view of the challenges of getting professionals together, the MDT meetings were seen as a substitute for CIN meetings. However, there is no evidence they fulfilled the key task of reviewing and updating the CIN plan. Any child receiving a service from CSC should have an up to date plan and it is of concern that one was not in place. The CSC Report Author notes that the CIN Plan focussed very much on Child V's health and did not address the social and emotional issues for the family. It also lacked timescales and accountability. ¹⁴
(Learning Point and Recommendation 2)

7.1.16. **Perplexing Cases Group (PCG):** It is evident that practitioners' concerns about the discrepancy between Mother's reporting and clinicians' observations were increasing when Child V was discussed at the PCG by the Children's Continuing Care Nurses in December 2017. It is understood that this is a reflective multi-agency meeting; an anonymous forum where practitioners can bring cases for 'support and supervision'. Case responsibility lies with the practitioner and advice from the Group is dependent on the information supplied at the time of the discussion.

7.1.17. Notes of the PCG in December are available, the names of attendees are noted but not their role and agency; the same with the two actions agreed, where practitioners are identified by name or initial. Actions do not have a timescale. The Group suggests linking with all the professionals involved in Child V's care to ensure a coordinated approach. However, information about the discussion and the actions agreed was not shared with practitioners working closely with the family. This is of concern as it may have influenced the response when Child V was admitted to hospital in a life-threatening condition later in December. The role of the Group is to provide support and supervision but is not operational. There may be some confusion here, as supervision implies that its role is operational, when it would appear to be advisory/consultative. **(Recommendation 5)**

7.1.18. In analysing the effectiveness of multi-agency working, consideration needs to be given to the pressures on all services, notably health and Children's Social Care. Reduced

¹³ **Section 17 Children Act 1989.** A child is 'in need' if: S/he is unlikely to achieve or maintain, or have opportunity to do so, a reasonable standard of health or development without provision of services by a local authority, or if Her/his health or development is likely to be significantly impaired or further impaired without such services or S/he is disabled.

¹⁴ West Sussex Children's Services Procedures Manual, Child in Need Plans.

resources across public services mean that practitioners and managers are often operating in challenging circumstances, with increased workloads. This reduces the time and space available for reflection, face to face discussions and following up 'loose ends', which is crucial when there are developing concerns about a perplexing presentation/FII. Such cases absorb a great deal of professional time and thought. Additionally, as has been identified in many SCRs, there is the continuing issue that electronic patient information systems are not integrated, so that practitioners cannot gain an up-to-date overview.

7.1.19. **Summary:** Overall, the evidence presented to the SCR suggests that there was a lack of effective information-sharing and multi-agency planning for Child V. It is apparent that there is a need for greater clarity about how the processes in Health and CSC fit together to ensure that there is effective assessment, planning and review for children who are believed to have complex needs. How do Health's MDT meetings fit with the CIN processes and vice versa? How can it be assured that concerns raised at MDTs are shared with all health practitioners and CSC? There are no minutes of some MDT meetings, which makes it difficult to review a child's progress and actions agreed. Additionally, if the MDT meetings are used as the planning process does that lead to a greater focus on a child's health needs, rather than a more holistic approach?

7.1.20. 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 total needs. CIN plans can also manage risk, as long as it remains safe to do so. **(Learning Point and recommendation)**

7.2. Assessment of family functioning and level of risk to Child V:

7.2.1. Much of the evidence from Agency Reports strongly suggests that 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 influenced practitioners' approach to safeguarding concerns. The CSC Report Author notes that from early on Child V was viewed very much as a child in need with a life-limiting condition, rather than a child in need of protection, the drive was to set up a support plan for Child V to be cared for at home. The role of the Social Worker, CDT, was to co-ordinate services.

7.2.2. However, it should also be noted that there were different perspectives between CSC and Hospital 1 during 2016. Health practitioners were concerned about the family's lack of engagement in Child V's care and lack of visiting when an inpatient. The Social Worker was of the view that health colleagues were not understanding of the difficulties the family faced. The CSC Report Author suggests that there was not enough sharing of information and face to face discussion between practitioners to understand the bigger picture.

7.2.3. It is evident that none of the agencies gained a full understanding of the family functioning or of Child V's position within the family. A chronology of Child V's health care was not completed, which would have assisted practitioners in understanding involvement with health agencies and helped to identify emerging patterns.

7.2.4. Evidence regarding Child V's early months raises concern about the quality of the attachment between Mother and child and the impact this may have had. Mother's presentation in pregnancy was viewed as a late booking¹⁵ and it is known she had requested a termination. There was a lack of opportunity to access counselling for late bookers and for antenatal assessment by the Midwife, as well as for the pre-birth assessment

¹⁵ **Concealed Pregnancy**, Chapter 8.10, Updated February 2018. Sussex Child Protection and Safeguarding Procedures

by the Health Visitor. Child V was born prematurely, requiring hospitalisation for eight weeks. There were concerns about the lack of visiting whilst the baby was in hospital and delay in discharges home. There are suggestions that Mother was fearful of caring for Child V and 'angry' when the plan was put in place for total bottle feeding. It is understood that this early information had not been shared with the Health Visitor and Neo-Natal Nurse, nor with CSC.

7.2.5. From the records it is difficult to gain a picture of Father's role in the family. However, practitioners report that there were no indications of domestic abuse in the parents' relationship and no evidence that father was aggressive or intimidating in his behaviour. When practitioners visited, he tended to 'take a backseat' and Mother would provide information and ask questions.

7.2.6. Whilst Child V was an inpatient at Hospital 6 from April to June 2016, there was a significant lack of engagement by the parents and concern about the infrequency of visiting, i.e. no visits for 23 days. Parents were required to complete competencies in feeding Child V through the PEG-J but they failed to do so and there was concern that by not completing the training were intentionally delaying discharge. This was raised as a safeguarding concern; however, the Hospital Social Worker's view was this would not meet the threshold for a referral to MASH or CSC involvement and this concern was not raised with local agencies. The adverse emotional and psychological impact of prolonged separation upon a young child has been accepted for many decades and the reason parents are encouraged to stay with their child in hospital. This raises a question about whether the emotional harm caused by this neglect was fully recognised by staff at Hospital 6, at the very least it should have prompted a discussion with the local CSC.

7.2.7. It would appear that the focus was very much on the parental difficulties and not on the needs of the baby. Government guidance highlights that in deciding whether to share information with CSC, practitioners '*must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgement*'. Practitioners should not only consider the legality and impact of sharing information, but also the impact of not sharing information.¹⁶ They may have the missing piece of a puzzle. Agencies do not have to be 100% certain that a referral will be accepted by MASH before making the referral, direct communication between agencies, i.e. telephone discussion, can clarify this. **(Learning Point)**

7.2.8. There is a question about whether the relevance of this early history was fully recognised in assessments and work with the family. Bass and Glaser¹⁷ highlight that FII can represent an abnormality in the attachment system between mother and child and attachment theory might be relevant in understanding the dynamics with FII. Certainly, there were indications of difficulties in attachment as highlighted below, but there is no evidence that these factors were pulled together, and importantly their significance recognised. **(Learning Point)**

- Late presentation in pregnancy
- Denied request for a termination.
- Premature, traumatic, birth and period of hospitalisation post birth.
- Mother's resistance to bottle feeding rather than naso-gastric feeding.
- Concern that Mother was depressed and anxious.
- Parental lack of visiting and engagement in child's care during hospital admissions.
- Delayed hospital discharges.

¹⁶ **Information sharing:** Guidance for practitioners and managers, HM Government (2008)

¹⁷ Bass and Glaser. Published online Lancet, April 2014.

- Concerns about neglect; poor weight gain and baby being cold and left unattended.

7.2.9. NHS FT 1's Agency Report notes that the Health Visitor did not undertake an assessment, in part due to the circumstances of Child V's birth, and the overarching view was that Mother was doing a '*fantastic job*' in caring for the children. The concerns about the lack of parental visiting were not considered in detail, the focus was on the difficulties that the parents were experiencing rather than the impact on Child V. Similarly, the CCCN Report Author suggests that there was a '*complete absence*' of ongoing concern about the events that had happened in Child V's earlier life, i.e. being extremely unwell at a young age, needing ventilation after discharge, fractured femur, subdural haematoma. All these were '*dismissed by the diagnoses*' and Mother's '*plausible façade*'

7.2.10. The IPEH (now Early Help) Report Author notes that the early help assessment was not robust and the CSC Report Author notes that the Child and Family Assessment (CFA) undertaken in 2016 was delayed, lacked rigour and did not include key information about the family history. The assessment was superficial. There is no reference to the early concerns about the circumstances of Child V's birth and during the first year, i.e. discrepancies in reported and observed symptoms, parental lack of engagement and hospital visiting.

7.2.11. It is then highly significant that the CFA was not updated by the Assessment and Intervention Team regarding the uncertainty around the diagnosis of a life-limiting condition prior to allocation to a Social Worker in the CWD Team in December 2016. This meant that Child V was viewed by the CWD Service as a child with a life-limiting condition, with a family who needed a high level of support. This established the basis for work with the family for the next year and it was from this viewpoint that further information was considered. For example, the NHS FT 1 Report Author noted that head banging was accepted as '*a feature of Child V's presentation*' and an explanation for bruising, but this had not been seen by any professionals or formally reviewed, indicating a lack of professional curiosity. **(Learning point)**

7.2.12. **Risk Assessments:** There are four key instances where concerns about the quality of the risk assessment have been identified:

1. **Fractured Femur:** Whilst an inpatient at Hospital 3, Child V sustained a suspected fractured femur when in the sole care of Mother. Despite this being an injury to a pre-mobile baby, there was no discussion with the Trust's Safeguarding Lead or with MASH. Mother's explanation was accepted without challenge. As the x-ray did not evidence a fracture initially this may have lessened concern, despite it being known that a fracture may not become apparent immediately.

Information received early in the review indicated that a member of staff had been present when the injury occurred, however, further investigation evidenced that this was not so, and Mother had been alone with the child. It was concerning to note how this incorrect information had been shared with other agencies and over time had become fact.

A fractured femur was evidenced in the x-rays undertaken at Hospital 1. However, whilst Hospital 3 had referred Child V for further investigations, there was no follow-up to ascertain the outcome. **(Learning point)**

2. **Subdural haematoma:** Evidence would suggest that the cause of Child V's subdural haematoma was not investigated robustly, and any potential risk not fully understood across the professional network. Three Strategy Meetings were held, but a Section 47

enquiry was not instigated. The CSC Report Author notes that there seemed to be a determination to get an '*absolute truth*' from the Consultant Paediatrician, which was provided with the possible diagnosis of a rare life-limiting condition, cementing the view that the subdural haematoma was medically explained. This then shut down wider discussion and assessment of the family and did not promote '*a critical and curious stance*'. The Health Visitor was informed by the Safeguarding Nurse, Hospital 4, that Child V was likely to have a diagnosis of a rare life-limiting condition and non-accidental safeguarding concerns had been '*ruled out*' by CSC and medical staff. The SCR has identified that at this stage a life-limiting condition was a possibility and not a definitive diagnosis but had quickly become an established fact. This position was compounded because the Social Worker and Manager '*do not revisit in any substantial way the possibility that this injury could be non-accidental*' following receipt of the information that Child V had tested negatively for the life-limiting condition some months later. The Team Manager advised the Social Worker in the Assessment and Intervention Team to set up a MDT meeting, but it is not clear whether this was to be a multi-agency strategy discussion or a professionals' meetings. A MDT meeting was held in November 2016. There are no minutes available, though the Duty Social Worker made notes of the meeting. It appears that the need for vigilance and close multi-agency working was not addressed. This was a missed opportunity to convene a follow-up Strategy Meeting to review earlier decisions in the light of new information.

Social Care Institute for Excellence (SCIE) highlights the importance of practitioners being prepared to reconsider an earlier conclusion. and that professionals need to constantly guard against '*the tendency to cling to original beliefs, searching only for information that supports them and devaluing or reframing new information that counters them.*' '*Sound judgements can only be achieved when a professional revisit their initial assumptions in the light of fresh evidence or a fresh view of the existing evidence.*' In order to achieve this, practitioners, need to employ a reflective approach and recognise that '*the ability to change their mind is imperative*'¹⁸. They need to maintain a '*healthy scepticism*' . **(Learning point and Recommendation)**

There has been consideration as to whether if a Section 47 enquiry ¹⁹ had been commenced this may have shifted the focus towards a greater consideration of the potential risks to Child V. There are mixed views as to whether the threshold for a Section 47 enquiry was reached, but given that Child V had a serious unexplained head injury, it took several days for the potential diagnosis of a life-limiting condition to be raised and protective steps were put in place in respect of V's siblings, on balance there were clear grounds to initiate a Section 47 enquiry.

The CSC Report Author notes that the Child and Family Assessment did not provide a reliable starting point for involvement by the CDT. The transfer summary did not include relevant safeguarding information. Additionally, by the time of allocation it was an out of date piece of work. The overarching view of the parents was positive, and this set the tone and direction for future work with the family. The CSC Report Author notes that following Child V testing negative for the life-limiting condition, there

¹⁸ When child protection professionals are confronted by new information about cases. Community Care, 18 Sept 2009.

¹⁹ **Section 47 (1)(b), Children Act 1989.** A local authority is under an investigative duty 'where they have reasonable cause to suspect that a child who lives or is found in their area is suffering or is likely to suffer significant harm.

was 'no analysis of risk or revisiting the CFA to ensure that it had captured and addressed the need for vigilance.'

- 3. Preloaded Syringe:** Child V attended the Hospice in April 2017 with a pre-loaded, unnamed, syringe of epilepsy medication, four times the prescribed amount. The Hospice sought clarification from the GP and informed the Consultant Paediatrician, who promptly followed this up with the parents.

In the course of the SCR, this incident has been looked at more closely. From May to November 2017 the GP prescribed 32 doses of buccal midazolam. This is a significantly high number and raises concerns about the monitoring of the long-term medication.

(Recommendation 6)

Given the Mother's statement that she would administer four times the dosage to Child V and the high number of prescriptions issued, it is considered that this required further investigation. The CCG Report Author's view is that this should have triggered the Significant Incident (SI) process and hence a more robust investigation.

- 4. High sodium and glucose levels:** The lack of a referral by Hospital 7 to MASH and of information sharing with the allocated Social Worker indicates a lack of recognition of the potential serious risks to the child. Child V had presented in a serious life-threatening condition, with high glucose and sodium levels, without a medical cause, and there was concern about intentional salt poisoning. In addition, staff had observed no clinical signs in respect of Child V's chronic health conditions and had ascertained that Mother had given false information about previous similar episodes being investigated by Hospital 1. The Trust's view was that there was not conclusive evidence to make a child protection referral in respect of FII, they were not 100% sure. Further that there were no grounds to obtain an Emergency Protection Order to retain Child V in Hospital. However, it appears the Trust made these decisions without discussion with other health practitioners working with the family, e.g. Health Visitor, Children's Community Nurses and Social Worker.

Given Child V's admission in a life-threatening condition, without a medical explanation, the concerns should have been sufficient to discuss the safeguarding concerns with the allocated Social Worker. In view of the increased concerns about Child V's care and the possibility of FII at that time, it is highly likely that a Strategy Meeting would have been convened and a Section 47 enquiry commenced. The Local Authority, with legal advice, would have considered whether there were grounds to apply for an emergency protection order. It is the responsibility of the LA to make this decision not health practitioners.

There is a question as to whether a child who had presented at hospital with unexplained serious physical injuries, where NAI had been considered, would have been discharged home without a discussion with the local MASH/CSC, which could indicate professional anxiety about raising concerns in respect of FII. Therefore, there is a question about whether this decision was based on a need to be confident that there was conclusive evidence of FII, rather than on Child V's need for protection. At the Recall Event there was a discussion about the need '*to believe the unbelievable*'.

7.2.13. **Summary:** There were indications prior to Child V's birth that Mother was ambivalent towards the pregnancy and in Child V's early months signs of attachment difficulties and that Mother was experiencing difficulty in meeting Child V's needs. However, these concerns were not pulled together, analysed and the impact recognised. It would have been

important to understand what the meaning of this child was for this Mother, given the complex issues around the birth.²⁰ It appears little is known about Father's role in the family and in the care of Child V. There is evidence that safeguarding concerns were not followed up robustly and concluded in three key events, namely the fractured femur, subdural haematoma and raised sodium level.

7.2.14. It is very clear that the overarching view was that this was a family in need of support in caring for a child with complex health needs, although there was some challenge to this by Hospital 1 early in 2016. Thus, the focus appears to have been on the parents' needs, rather than Child V's needs, including the need to be kept safe from harm. NHS FT 1's Agency Report Author's view is that the child's voice was not heard and there was a '*general concentration on the needs of Child V's parents and an inadequate effort to keep the child at the centre*'. '*When practitioners empathise strongly with parents, the voice of the child can be overtaken by the needs of the parent.*' When practitioners are focussed on supporting a family it is important that they remain alert to signs of possible neglect and abuse, which may require a shift in their thinking as highlighted by SCIE.²¹ Overall, there appears to be a lack of professional curiosity and scepticism, which hindered reflection and assessment. **(Learning Point)**

7.3. Recognition of FII/Perplexing Presentation

Paediatricians' early recognition of perplexing presentations preceding fabricated or induced illness and their management might obviate the development of this disorder.²²

7.3.1. As has already been highlighted, evidence suggests that overall practitioners considered they were caring for a child with complex health needs, a child in need, and working with a family that needed support. It is clear that this view influenced their approach to safeguarding issues.

7.3.2. It is apparent that there were early signs of a perplexing presentation.²³ By the time Child V was just three months medical practitioners at Hospital 1 were becoming '*puzzled*' by the pattern of discrepancies between how Mother presented Child V's health needs and clinical observations and results of tests, e.g. feeding and respiratory difficulties. Safeguarding concerns were escalated to the Safeguarding Team and the Named Doctor. Practitioners spoke at the Learning Event of being '*surprised*' at the level of medical intervention following Child V's referral to Hospital 3, i.e. administration of oxygen and insertion of a gastrostomy, and thought they must have '*been missing something*'. During admissions to Hospitals 1 and 3 in March and April 2016 whilst some health issues were identified, the symptoms reported by Mother were not always supported by clinical observations. In November 2016, concerns were discussed at Hospital 1's weekly Safeguarding Meeting.

7.3.3. At the same time the Consultant Paediatric Neurologist, Hospital 4, was also '*puzzled*'. Mother had reported that staff at Hospital 3 were considering a tracheostomy when there were no medical indications for such a procedure. The Consultant Neurologist approached colleagues in Hospitals 1 and 3. The Respiratory Consultant, Hospital 3, was clear that a tracheostomy was not being considered and the possibility of FII was raised. Plans were

²⁰ Reder, Duncan and Gray: Beyond Blame, Child Abuse tragedies revisited, Brunner-Routledge, 1993.

²¹ When child protection professionals are confronted by new information about cases. Community Care, 18 Sept 2009.

²² Early recognition and management of fabricated or induced illness in children. Bass and Glaser, published online Lancet, March, 2014.

²³ Perplexing Presentations (including FII), Child Protection Companion, RCPCH, 2013.

being made for Hospital 4 to co-ordinate Child V's medical care, however, there is no evidence that these concerns were escalated to Safeguarding Leads or shared with other practitioners working with the family, notably the Social Worker and CCNs.

7.3.4. The Royal College of Paediatricians and Child Health's Child Protection Companion, 2013, ²⁴ highlights that *'The common starting point for both 'Perplexing Presentations' and fabricated or induced illness (FII) is that the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting upon the child's health or social wellbeing. There is a spectrum of presentations, with the rarer 'true' FII involving deliberate deception of medical services by the carer; which may involve actions to falsify specimens or investigations, or induction of actual illness in the child, and the commoner wider range of 'perplexing presentations' or 'Medically Unexplained Symptoms' that should be considered in the same way but do not necessarily involve deliberate deception. These presentations are primarily verbal accounts and descriptions by the carer.'* Evidence would suggest that by the end of 2016 there was increased evidence of a perplexing presentation, which was being recognised by the Consultants. Therefore, action in line with local and national guidance was required but was not pursued.

7.3.5. The Child Protection Companion refers to perplexing presentations as the What's Going On (WGO) syndrome? and when dealing with such situations recommends the following good practice:

- Following local and RCPCH guidance.
- Preparation of a detailed medical chronology.
- Paediatricians should avoid iatrogenic harm ²⁵ and only undertake tests or treatment that are clearly indicated – the temptation to keep investigating must be resisted.
- Admission to hospital can be helpful in order to differentiate between erroneous and true reports of signs and symptoms.

7.3.6. Similarly, Ball and Glaser ²⁶ stress that to reduce harm to the child, and possibly avoid the development of FII, as soon as doctors feel perplexed, i.e. things do not make sense, they should establish the child's involvement with health services and what is or not wrong with the child. Responsibility at this stage rests with the paediatric services. This approach may encourage medical professionals to raise concerns earlier, as they do not have to be confident that the concerns have reached the level of FII. Glaser and Davis suggest that early identification of perplexing presentations may help to reduce the potential for iatrogenic harm, help to restore normal functioning and reduce the need for later safeguarding interventions. ²⁷

7.3.7. The Child Protection Companion ²⁸ highlights that in approximately half of all FII cases, a chronic medical condition co-exists with FII. Child V's prematurity meant that for the first few months of life the child presented with several health concerns, requiring medical treatment and follow up. However, it appears that despite these medical conditions improving or resolving, e.g. need for oxygen, Mother continued to present a child with

²⁴ Perplexing Presentations (including FII), Child Protection Companion, RCPCH, 2013.

²⁵ Definition of iatrogenic: Due to the activity of a physician or therapy. For example, an iatrogenic illness is an illness that is caused by a medication or physician. MedicineNet

²⁶ Ball and Glaser, March 2014.

²⁷ Glaser and David: Forty years of fabricated or induced illness (FII): Where next for paediatricians? Paper 2: Management of perplexing presentations including FII. 4 April 2018. Published by group.bmj.com.

²⁸ Child Protection Companion, RCPCH, 2013.

complex health needs and this was how the child continued to be viewed by medical practitioners and hence received unnecessary, invasive, investigations and treatment. This was compounded by the possible, though not definitive, diagnosis of a life-limiting condition. It appears that some of the diagnoses of Child V's medical conditions were based on parental reporting and there was an over-reliance on Mother's reporting. The approach taken was very much 'Mother knows best'. Glaser and Ball warn against this over-reliance.²⁹

7.3.8. The London Child Protection Procedures, 2.4.3.³⁰ encourage professionals to concentrate on the interaction of three variables in identifying and recognising fabricated or induced illness:

- The state of health of the child, which may vary from being entirely healthy to being sick;
- The parental view which at one end is neglectful, and at the other end causes excessive intervention either directly or indirectly;
- The medical view, which is equally on a spectrum from being dismissive at one end to performing excessive intervention or treatment at the other.

7.3.9. Dr Danya Glaser³¹ suggests that the starting point for FII is '*carers, usually mothers, who have (s) an underlying need for the child to be recognised and treated as ill/more ill*'. The child becomes the vehicle for the mother to fulfil her own needs, including her need for attention, for recognition as a heroic mother, and for financial or material gain. In this case, Child V's early months in hospital meant that Mother received considerable support and attention, which may have been difficult for her to relinquish. Fathers may support the mother but may also be unaware or absent. In order to have her needs fulfilled the mother engages doctors through erroneous reporting, including exaggeration and inventing, persistent insistence on more investigations/referral and falsification. The doctor becomes involved by examining and (over) investigating the child. Tests may be undertaken to reassure the parent, but also for fear of not treating a child with a serious condition. The RCPCH Child Protection Companion 2013 advises that '*a parent learns by 'trial and error' to fabricate convincingly and that doctors may inadvertently 'coach' the parent in the course of taking repeated clinical histories from the parent.*'³² Davis, Murtagh and Glaser warn doctors of inadvertently taking on the role of '*co-abuser*' which must be a difficult concept for doctors to contemplate.³³

7.3.10. The behaviour of parents, notably mothers, can be extremely challenging for practitioners in dealing with cases of FII. In the course of the review we have identified that Mother's reporting of symptoms encouraged practitioners to undertake interventions and treatments. Practitioners have spoken about Mother being '*eloquent*', '*plausible*' and '*knowledgeable*' about Child V's conditions and that she regularly presented the child at hospitals was viewed as positive. Practitioners found it difficult to get a clear and consistent picture from Mother about Child V's health, e.g. CCCNs. The Consultant Paediatrician, Hospital 1, acknowledged that the referral to Hospital 3, was due to Mother insistence; locally clinical observations had not evidenced the symptoms Mother was reporting.

²⁹ Ball and Glaser, March 2014.

³⁰ Fabricated or Induced Illness, London Child Protection Procedures, 5th Edition, 2017.

³¹ Fabricated or Induced Illness (FII): A Wider View and Alternative Approach. BASPCAN Masterclass, November 2017.

³² Perplexing Presentations (including FII), Child Protection Companion, RCPCH, 2013.

³³ David, Murtagh and Glaser, 40 years of fabricated and induced illness (FII): Where next for paediatricians? Paper 1: Epidemiology and definition of FII. ADC Online, 4 April 2018.

7.3.11. There is evidence that Mother's wish for Child V to be enterally fed was a key factor in the surgical insertion of the PEG-J. From the age of a few months Mother was reporting that Child V had difficulties with feeding, and she demonstrated some resistance to persevering with bottle feeding. It is apparent that Hospital 3 made an error in interpreting the information provided by Hospital 1 regarding whether or not Child V had an abnormal swallow, did not complete a full swallowing assessment and referred Child V to Hospital 6 for the procedure to be undertaken. Hospital 6 anticipated undertaking further tests, but Mother was keen for the procedure to go ahead and it was performed without the planned investigations. Thus, it appears Mother was able to exploit the lack of effective communication between the health professionals.

7.3.12. During the SCR process consideration has been given as to whether there was sufficient evidence to support the decision to continue enteral feeding and insert the PEG-J. It is evident that there are mixed views about this as the swallowing assessments by SALT, Hospital 1, were positive and further testing by Hospitals 3 and 6 was limited. In addition, various factors have been identified, which may have impacted on the quality of the mother/child attachment, and this may have contributed to the reported difficulties as feeding may not have been a nurturing experience. However, Mother consistently reported feeding difficulties and there was concern about Child V's weight gain, which the insertion of the gastrostomy would help to stabilise. The biennial report of learning from SCRs 2009 – 2011³⁴ highlights that *'it is not helpful to consider poor weight gain for babies as a purely mechanical feeding problem and a contextual understanding of the different reasons why parents appear not to be nurturing the child is very important.'* Therefore, the parent-child relationship and quality of attachment also need to be considered. This has resonance for this review. **(Learning Point)**

7.3.13. The longer the parental behaviour continues, the greater the challenges posed to effective multi-agency working. The more hospitals and clinicians become involved, the more difficult it becomes to maintain timely communication, as does piecing the picture together and gaining an overview of the child's condition and treatment. The Named Doctor, Hospital 1, has suggested that indications of FII were possibly obscured by the diagnoses and involvement of the specialist clinics at the tertiary hospitals, which gave them credibility. This indicates the importance of early recognition and management in line with RCPCH guidance, i.e. Responsible Paediatrician to oversee medical care.³⁵ **(Learning Point)**

7.3.14. Despite the earlier concerns in 2016, it appears that it was not until the MDT in September 2017, when practitioners were requesting greater clarity about Child V's medical conditions, that concerns about FII became clearer. Hence the convening of the Professionals' Meeting in November 2017 and discussion at the Perplexing Cases Group initiated by the CCCNs who considered that there was a mismatch between Child V's diagnoses and Mother's reporting. It is significant that the CCCNs brought a *'fresh pair of eyes'* to the situation, which was valuable. However, this should have been a time for practitioners to reflect on the information available and access the national and local FII guidance, which should have led to a multi-agency Strategy Meeting and a Responsible Paediatric Consultant being identified to oversee Child V's medical investigations and treatment. The situation was further compounded in December 2017 when Hospital 7 took the decision not to raise safeguarding concerns about possible salt poisoning with the allocated Social Worker because staff were not 100% confident there was evidence of FII.

³⁴ New Learning from serious case reviews: A two-year report for 2009 – 2011. Brandon et al. July 2012. DoE.

³⁵ Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians Royal College of Paediatrics and Child Health, 2009, reviewed 2012.

7.3.15. There is no evidence that local or national guidance was accessed by any of the practitioners. It is important to try and understand why there have may been a reluctance to name, highlight concerns and make a referral regarding FII. The reasons may include:

- Lack of knowledge and understanding of the indications of perplexing presentation/FII and of its impact on children.
- Lack of confidence in knowing what action to take.
- Medical practitioners' fear of getting it wrong and the child has a genuine, rare, medical condition which explains the reported, but not observed, symptoms.
- Fear of taking a different approach to members of one's teams/other medical practitioners.
- Fear of parents complaining and/or taking legal action against a member of staff/Trust. Social media has become a mechanism for parents to attack and threaten doctors. This can seriously undermine a practitioner's confidence.
- Will not get a positive response from CSC/MASH unless have sufficient evidence to be 100% confident of FII.
- The emotional challenge of facing up to having inadvertently become involved in the abuse of a child, as a 'co-abuser'³⁶, and causing iatrogenic harm.

7.3.16. **Summary:** Evidence presented to this SCR would suggest that there were early indications of a perplexing presentation and concerns developed during 2016, which led to discussions between Hospital Consultants about the possibility of FII. However, it was not until November 2017 that the concerns were discussed at a Professionals' Meeting and December 2017 at the Perplexing Cases Group, and then not all practitioners were aware of this discussion and the outcome.

7.3.17. Worryingly, there is no evidence that the relevant local and national guidance was considered at any point by any of the professionals working with the family. Earlier recognition and action in line with RCPCH guidance may well have prevented the development of Mother's behaviour, Child V undergoing unnecessary invasive tests and treatment and presenting in a life-threatening condition in December 2017. **(Learning Point and Recommendations 4/5)**

8. Examples of 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.

³⁶ David, Murtagh and Glaser, April 2018.

- Hospital 1 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 CCCNs 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.

9. Recent developments:

- **West Sussex Safeguarding Children Board:**
 - FII Training Event held in March 2018.
 - FII guidance is being updated and will be disseminated. This needs to be targeted to key frontline staff and managers.
 - **Pan Sussex Procedures** in respect of late bookings and concealed/denied pregnancies are being reviewed and the early findings from this SCR will be considered. The additional vulnerability and psychological needs of women where a request for a termination has been declined are recognised in the procedures.
 - **Pan Sussex Escalation Policy** in place.
- **Children's Social Care: Children's Disability Team:**

March 2019: Policy and guidance supporting the alignment of Children in Need (CIN) work by Children's Disability Team with Children's Social Care. Introduces two categories of CIN for children with disabilities:

 1. Disability Complex Needs: Under Section 17, Children Act 1989, disabled children are CIN by virtue of their disabilities. Work will follow a visiting regime of minimum 3 monthly, with reviews minimum of 6 monthly.
 2. CIN: Where there are additional issues impacting on the child's welfare and development, e.g. linked to parenting concerns, neglect issues, mental health, substance use, domestic abuse. Under Section 17, Children Act 1989, where the child is unlikely to achieve or maintain a reasonable standard of health or development, or to be impaired or further impaired, without the provision of services from the local authority. CIN will follow the

same processes for all CIN open to Children's Social Care in West Sussex (monthly visiting, with 8 weekly CIN reviews)

CIN are worked with in a way that seeks to improve their safety and their lived experiences, with clear outcomes linked to stepping down/escalation. Children with Complex Needs will continue to receive social work support and intervention that is proportionate and delivered in partnership with parents/carers. My Plan is the assessment and planning tool for children within the Lifelong Service; 'Signs of Safety' the practice framework to support risk assessment and safety planning.

Additionally:

- Early learning practice sessions delivered to the CWD teams.
- Social Worker from Children with Disabilities service is based in MASH.
- Group Manager, Children with Disabilities Service, attends the Reflective Practice Group (Previously Perplexing Cases Group).
- **Hospital 1:**
 - To reduce silo working and promote co-ordinated approach electronic patient records (EPR Evolve) have been introduced. Dieticians and physiotherapists are using the EPR system and email correspondence is being scanned onto the system. From 2018 safeguarding records are stored electronically for practitioners to access.
- **Hospital 3:**
 - Increased resources of the Safeguarding Team and availability to attend internal and external meetings.
 - Safeguarding Team to hold pre-discharge planning meetings for all complex cases.
- **Hospital 6:**
 - Establishing a pathway for staff to escalate concerns when parents do not visit children who are inpatient.
 - Parent visiting record to be more visible on wards.

10. Key Learning:

- Fabricated or induced Illness is child abuse which results in significant harm to children. It has short-term and long-term physical, emotional and psychological impact on children, 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. **(Recommendation 1)**

- The importance of following local child protection procedures, as these provide a framework for safeguarding children, but also for managing practitioners' concerns and uncertainties, particularly where there are concerns about perplexing presentation/FII. **(Recommendation 1)**
- Early recognition, and action, in respect of perplexing presentations (What's Going On?) is essential. This can help to reduce the development of fabricated or induced illness in children. The longer the behaviour continues the more difficult the task of understanding a child's conditions and treatment becomes. **(Recommendation 1)**
- All practitioners, including Police, require a basic understanding of the features of perplexing presentations and FII and key practitioners require a more in-depth knowledge, e.g. Safeguarding Leads, Community Paediatricians, Children's Community Nurses. **(Recommendation 1)**
- Practitioners should be mindful of the potential risks of an over-reliance on parental reporting and of parents becoming conduits of information between health practitioners, which can lead to a lack of direct contact between practitioners and to misinformation being provided. There is a danger that parental reporting can become fact over time, without an evidential base. Medical practitioners should record how information is obtained, i.e. parental reports, clinical observations and results; in this way a pattern of discrepancies can be identified. **(Recommendation 1)**
- Medical practitioners need to consider whether investigations and treatments are being pursued due to parental reporting and insistence, practitioner's anxiety or in the best interests of the child. The needs of the child should always be paramount. and the least restrictive care should be provided. Parents should be involved in decision-making, but clinical decisions rests with the medical practitioners. **(Recommendation 1)**
- Value of collating an overview and timeline (Chronology) of the child's presenting symptoms and diagnoses, investigations and treatment, when there are developing concerns about a perplexing presentation/FII. **(Recommendation 1)**
- All 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'. **(Recommendation 1)**
- The importance of supervision and support for practitioners dealing with concerns regarding perplexing presentations/FII and of managers being aware of the challenges faced by practitioners, which may require additional support and a co-ordinated approach by the organisation, managed by a senior officer. **(Recommendation 1)**
- The value of the role of Safeguarding Leads in providing advice at an early stage and co-ordinating with other organisations when necessary. **(Recommendation 1)**

- Importance of early concerns about perplexing presentations/FII being shared with all practitioners working with a family and a multi-agency approach being taken, with a Lead Paediatrician being identified to oversee and co-ordinate a child's medical care and a medical chronology being completed. The focus should be on actively excluding FII. The plan should be communicated to all practitioners working with the child and family, including the child/family's GP. GPs receive a high volume of letters and reports and any areas of concerns should be highlighted by direct contact. **(Recommendation 1)**
- All practitioners, notably Midwives and Health Visitors, need to be mindful of the potential impact of a late booking, an unwanted pregnancy, a traumatic birth and a baby's prematurity on the quality of attachment when undertaking assessments. FII can be a manifestation of an abnormality in the attachment system. Midwives supporting Mothers post-birth should access ante-natal records and ensure that significant information is shared with the Health Visitor. **(Pan Sussex Procedures being revised)**
- When there are unexplained concerns about feeding and weight gain, there should be a dual approach, which investigates possible medical causes, but also considers the parent-child relationship, and quality of attachment, and whether this might be having an impact. **(Recommendation 1)**
- The adverse emotional impact on the child of neglect through a lack of parental engagement/visiting whilst the child is an inpatient should be carefully considered and further enquiries undertaken. The focus should be on the impact on the child, not on parental difficulties. **(Developments at Hospitals 4 & 6)**
- The importance of timely referrals to MASH in respect of children where there are immediate child protection concerns. It is not necessary to be 100% confident that the concerns meet the threshold of child protection, another agency may also have highlighted concerns. Agencies should not be prevented from raising concerns/making a referral by 'second guessing' what the response may be. **(Recommendation 1)**
- 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. With parental agreement, 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. CIN plans can manage risk, as long as it remains safe to do so. **(Recommendation 2)**
- Practitioners working with families where a child in need has a disability should remain professionally curious and alert to the possibility of safeguarding concerns. Children with disabilities are at increased risk of abuse and neglect which is not always recognised. There can be a reluctance to challenge parents who are seen to be under considerable stress.³⁷ **(Recommendation 3)**

³⁷ Safeguarding Disabled Children, Practice Guidance Department for Children, Schools and Families, 2009.

- The role of 'Professionals Meetings' should be clarified, including under what guidance/procedures they are being held. They should not be a substitute for strategy meetings convened under the child protection procedures. **(Recommendation 4)**
- All multi-disciplinary/professional meetings should be recorded, noting the type and purpose of the meeting, areas of concern and actions agreed, with timescales and responsibilities identified. The role and agency of attendees and those sending apologies should be noted. Through this a common approach can be achieved and progress monitored. All practitioners actively involved with a family should be invited to meetings and if they cannot attend minutes should be sent, e.g. tertiary hospitals. **(Recommendation 4)**
- There should be greater clarity about the role and function of the Reflective Practice Group (Previously the Perplexing Cases Group) and how this fits with parallel processes. **(Recommendation 5)**
- When a decision in child protection enquiries is based on a medical observation and that observation is subsequently changed, undermining the validity of the earlier decision, all agencies must be informed of that change and should review their original decision-making in the light of the new information, e.g. at a follow-up strategy meeting. There is a need for a reflective approach and practitioners should maintain professional curiosity. **(Recommendation 7)**
- Information sharing is more than just the sharing of information; it is a dynamic process. There needs to be a checking back of what has been shared to ensure a common understanding of the significance of the information, agreement regarding the actions to be taken and by whom, follow-up and timely recording. **(Recommendation 8)**
- The importance of direct communication, i.e. face-to-face meetings/telephone discussions; letters and emails are not a substitute as this helps to build professional relationships. Direct contact/discussion between community services, District General Hospitals and tertiary hospitals leads to better understanding of a child's medical needs, particularly in situations where there is a discrepancy between parental reporting and clinical observations. There is a need to be mindful of the impact of status and hierarchy which can lead to a reluctance to challenge another's view and escalate concerns. **(Recommendation 10)**
- Importance of practitioners knowing when and how to escalate concerns within and across agencies, including between health trusts, in line with WSSCB guidance.³⁸ **(Recommendation 9)**

11. Conclusion:

11.1. This Serious Case Review related to a very young child and concerns regarding physical abuse, child neglect and fabricated or induced illness. There has been an imperative to

³⁸ WS SCB Escalation guidance

understand why a fundamentally well child was viewed as having a life-limiting condition and underwent long-term unnecessary, invasive, investigations and treatments, including being fed enterally, administered oxygen and prescribed medication for epilepsy. Understandably, this impacted significantly on the child's quality of life, restricting childhood experiences, and limited overall development. The Review has been highly complex, very much reflecting the real challenges for practitioners in dealing with cases where there are concerns about a perplexing presentation/fabricated and induced illness.

11.2. There is evidence of considerable multi-agency activity and communication, and that practitioners were striving to ensure the family were supported and Child V's health needs met. Several multi-agency processes were operating in parallel, including Child-In-Need Reviews, Multi-Disciplinary Team Meetings and Professionals Meetings. However, the overall picture is very confused, with a lack of co-ordination and effective information sharing, notably between health practitioners in secondary and tertiary care. Inevitably, this undermined the effectiveness of the multi-agency safeguarding network. The increasing number of hospitals and professionals involved with Child V meant that communication between medical practitioners became more challenging, but also more essential. It has been suggested that the high level of multi-agency activity gave an illusion of safety for Child V and the risk of emotional and physical harm was not recognised.

11.3. There was a lack of recognition of the significance of the period pre and post Child V's birth, and of the impact of this on the quality of the parent/child attachment. Following birth Child V had additional medical needs relating to prematurity, leading to a period of hospitalisation, but on discharge Child V was progressing well and feeding normally; it was anticipated that this progress would continue. However, Mother regularly presented Child V at hospital reporting health concerns. Whilst it is recognised that Child V did have some health difficulties, evidence supports the view that Mother's reporting led to unnecessary and prolonged medical investigations and interventions, which meant Child V was perceived as a seriously unwell child. It appears that Mother presented as very knowledgeable medically and there was an over-reliance on parental reporting, rather than clinical observations.

11.4. There were instances when there were concerns about serious physical harm to Child V, including a fractured femur, subdural hematoma and salt poisoning, but investigations did not follow procedures, were not sufficiently thorough nor brought to a robust conclusion. From the point of the potential, though not definitive, diagnosis of a life-limiting condition, the approach by agencies was one of support for the parents in caring for a child with complex needs and of meeting Child V's health needs. This was the lens through which further information about Child V and the family was viewed. There was a lack of professional curiosity and indicators of risk were not recognised and acted upon.

11.5. There were early indications that there was a discrepancy between what Mother was reporting and clinical observations, and doctors were puzzled; what the RCPCH refers to as a perplexing presentation. These concerns came to the fore at various stages during the Scoping Period and increased during 2017. However, at no point did the practitioners reference or consider implementing the national and local Fabricated and Induced Illness guidance, which would have provided a framework through which to oversee and manage the ongoing medical investigations and interventions. Where FI is a factor, it is not uncommon for children to have medical conditions which are exaggerated, and the framework supports practitioners in ensuring medical treatment is appropriate and proportionate.

11.6. Evidence presented to the SCR suggests that there was a reluctance by professionals to follow up on indications of perplexing presentation/FII and the review has sought to understand what underpinned this reluctance and hence why such concerns were not acted upon sooner. Concern about FII is one of the most complex and challenging situations that child protection professionals face and it appears that they may experience varying degrees of anxiety, even fear, due to a combination of factors. These include the hierarchical nature of relationships between practitioners, fear of being wrong and they are treating a seriously ill child with a rare condition, the threat of complaint, legal action and adverse publicity on social media platforms and the emotional impact of inadvertently becoming involved in a child's abuse and causing iatrogenic harm. This highlights the importance of practitioners having support, reflective supervision and access to expert advice, as well as, on occasions, the need for a co-ordinated multi-agency approach, overseen by senior managers.

11.7. Significant learning has been identified for single agencies and for multi-agency working. However, the most important lesson for practitioners is the importance of consulting and adhering to national and local child protection procedures, whether this is in relation to concerns about physical harm, neglect or perplexing presentation/fabricated and induced illness.

11.8. FII should be dealt with as early as possible and in accordance with guidance. It requires effective direct communication and close multi-agency working between practitioners. This may prevent fabricated and induced illness developing, but importantly will provide a framework for managing medical interventions and ensuring that the child does not experience unnecessary medical investigations and treatment. The longer the behaviour continues the more difficult it becomes for practitioners to gain an understanding of the child's medical conditions and treatment and to work effectively together to safeguard the child.

11.9. Each agency involved in the SCR has an action plan and below are the recommendations for West Sussex Safeguarding Children Partnership (WSSCP). The Partnership will take forward the multi-agency recommendations, monitor the implementation of actions by individual agencies and disseminate the key learning at briefings for practitioners and managers.

13. Recommendations for West Sussex Safeguarding Children Partnership:

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 should 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 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 sharing 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.
10. The Partnership should share the learning from the SCR with NHS England (London) as this highlights the need for greater co-ordination and information sharing between primary, secondary and tertiary health services.

Glossary:

APPENDIX A

- CSC: Children's Social Care
- CAP: Children's Access Point
- IPEH: Intervention, Integrated Preventive Earliest Help
- CDT: Local Authority Children with Disabilities Service
- MASH: Multi-Agency Safeguarding Hub
- PCG: Perplexing Cases Group
- CCN: Children's Community Nurse
- CCCN: Children's Continuing Care Nurse

References:

APPENDIX B

- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HMG, March 2015.
- Safeguarding children in whom illness is fabricated or induced, Supplementary guidance for Working Together to Safeguard Children, DCSF, 2008
- Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians Royal College of Paediatrics and Child Health, 2009, reviewed 2012.
- Child Protection Companion 2013 (2nd Edition) Royal College of Paediatricians and Child Health.
- Fabricated or Induced Illness, London Child Protection Procedures, 5th Edition, 2017.
- Concealed Pregnancy, Chapter 8.10, Updated February 2018. Sussex Child Protection and Safeguarding Procedures
- Unexplained injuries to young children, Chapter 8.4., Sussex Child Protection and Safeguarding Procedures.
- Information sharing: Guidance for practitioners and managers, HM Government (2008)
- Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers. DFE, 2018.
- Reder. Duncan and Gray: Beyond Blame, Child Abuse tragedies revisited, Brunner-Routledge, 1993.
- When child protection professionals are confronted by new information about cases. Community Care, 18 Sept 2009.
- Bass and Glaser. Early recognition and management of fabricated or induced illness in children. Lancet 2014, 383, 1412-21. Published Online March 2014.
- Fabricated or Induced Illness (FII): A Wider View and Alternative Approach. BASPCAN Masterclass, November 2017.
- Davis, Murtagh and Glaser: 40 years of fabricated or induced illness (FII): where next for paediatricians? group.bmj.com. April 2018.
- David, Murtagh and Glaser, 40 years of fabricated and induced illness (FII): Where next for paediatricians? Paper 1: Epidemiology and definition of FII. ADC Online, 4 April 2018.

- New Learning from serious case reviews: A two-year report for 2009 – 2011. Brandon et al. July 2012. DoE.