Serious Case Review of Child T

Learning Briefing

Introduction:

The East Sussex Local Safeguarding Children Board undertook a Serious Case Review (SCR) of Child T who died in hospital at the age of 18 years and 6 months due to a complication caused by his Type 1 diabetes. Child T lived with his mother and was an only child. He was diagnosed with Type 1 diabetes at the age of 13. Child T went in to hospital three months before he died. The condition he was in was shocking, he was in an extremely poor state both physically and emotionally. His death was sudden and unexpected.

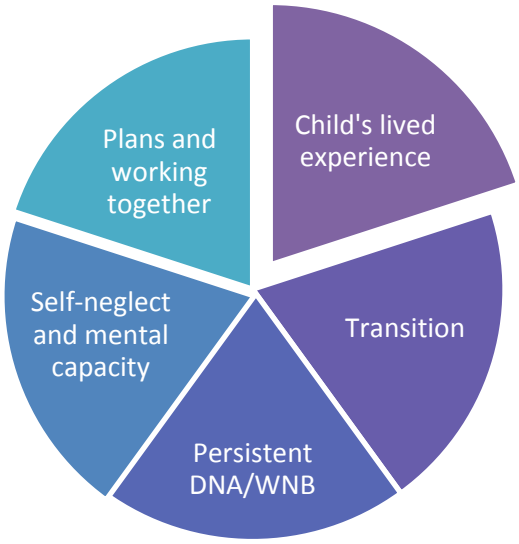
What is a Serious Case Review?

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

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

Key features and learning:

- Neglect and self-neglect identified.
- Significant history of missed appointments, including lack of engagement with diabetes care.
- Limited consideration of child T's lived experience.
- Trust placed in what Mother said, without considering impact on child T, and without checking it out.
- Persistent 'did not attend' and 'was not brought' (DNA/WNB) but lack of professional curiosity or ownership about why.
- All 16-17 year olds should be subject of children's safeguarding procedures.
- Schools and colleges have a role in child's health and wellbeing – it is not just a 'health' issue.
- Need for greater understanding of impact of diabetes (and other serious health conditions) by non-health professionals.
- An adult safeguarding enquiry was being undertaken at the time of Child T death, however, there is learning around self-neglect, mental capacity, and inherent jurisdiction.



- The review identified a number of transition points. They were all likely to have had an impact on Child T, and on the professional involvement with him

- At times of transition there can be increased risk for children with serious health needs. However it provides a good opportunity to seek and share information, reassess, re-engage and put plans in place for the child's future care and support

- Where there is more than one agency involved with a child, and there are concerns, all professionals involved have a responsibility to initiate a plan that is written down and reviewed as necessary that outlines the expectations of professionals and family

Recommendations:

This SCR identified 5 recommendations to strengthen safeguarding practice:

1) The SCR is shared with the East Sussex Safeguarding Adults Board (SAB)

2) The LSCB and SAB ensure that learning from this review is extensively shared and, through a quality assurance process, ensure that the required improvements have been made.

3) The LSCB makes a formal request to the Department of Health that the NICE guidance regarding service provision for children with diabetes is reviewed to ensure that education providers are also invited to take responsibility and the initiative in ensuring that appropriate diabetes education and practical information is in place for school and college age children

4) The LSCB makes a formal request to the Department of Education that the guidance for supporting children with medical needs in schools is reviewed to include clarity regarding the need for education providers to take responsibility and the initiative in ensuring that appropriate diabetes education and practical information is in place in school and colleges

5) The LSCB and its partner agencies to ensure that any child with a serious health condition has a written down multi-agency plan to coordinate and review the child's health care and support needs

Action taken since the review:

Each agency that contributed to the SCR identified single agency learning for their Service which forms an action plan. The action plan is overseen by the LSCB Case Review Group. The following actions are an example of actions already taken:

- ✓ The LSCB wrote to the Department for Health and Social Care, and the Department for Education as per the SCR recommendations
- ✓ Agencies have reviewed and updated their training to include: non-engagement, non-compliance, disguised compliance, and recording of safeguarding incidents
- ✓ Agencies have reviewed, updated and promoted their DNA/WNB policy
- ✓ Targeted learning for schools and colleges via the Super Designated Safeguarding Lead Network Meetings.

Further Reading and Useful Links:

Full SCR report: Child T SCR Report

Neglect toolkit: the East Sussex Neglect Strategy and Operational Practice Guidance and Neglect Toolkit and Matrix helps assist practitioners in identifying and assessing children and young people at risk of neglect. This guidance lays out identifying and responding to neglect across the Continuum of Need, assessment and care planning guidance, and threshold for step up. It provides guidance on the use of chronologies and discusses culturally competent practice.

LSCB Multi-Agency Training on Neglect

The LSCB runs training for multi-agency professionals on neglect. More details can be found on the East Sussex Learning Portal:

www.eastsussexlearningportal.org.uk

Pan Sussex Safeguarding and Child Protection Procedures

When was the last time you used the Pan Sussex Child Protection and Procedures Manual? You can also sign up for alerts.

Serious Case Review Briefings:

The LSCB will be holding briefing sessions on the findings of this serious case review and other local and national reviews later in the year.

Contact Us:

Telephone: **01273 481544**

Email: **lscbcontact@eastsussex.gov.uk**

Website: **www.eastsussexlscb.org.uk**

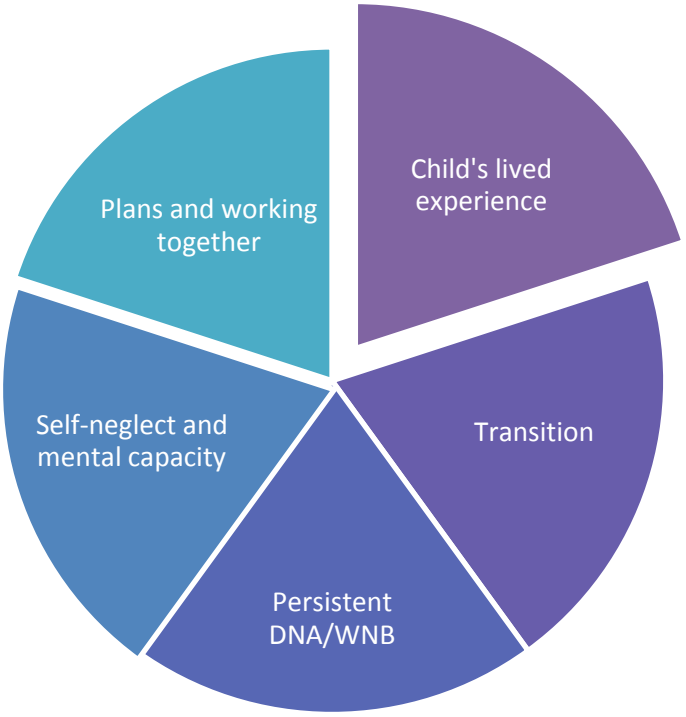
If you think a child is being harmed or may be at risk of harm, please contact SPoA Mon-Friday 8.30am-5pm
Phone: 01323 464222
Email: 0-19.SPOA@eastsussex.gov.uk

If you urgently need help outside of office hours you can contact the **Emergency Duty Service** on **01273 335905** or **01273 335906.**

Learning for practice

Learning has been identified in this review regarding the need to ensure that frequent missed appointments and poor compliance with medication for a life threatening condition receives a **robust response** that considers the risks associated with the lack of engagement. This should include children being treated within adult services between the ages of 16-18**.** Learning was also identified about the need to consider a child's lived experience, improving consideration of mental capacity and knowledge of self-neglect, and the need for a written down and reviewed plan, involving the appropriate professionals and the family that identifies the support required.

The LSCB invite you to discuss some of the issues raised in this serious case review in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.



Points for discussion:

DNA/WNB

What do you/your team and agency do about children who do not attend appointments, or are 'not brought'?

What would you do if you become aware that a child was DNA/WNB to another agency?

Signs of neglect & lived experience

What are the signs of neglect that might have been evident in a family like this?

How confident are you/your team at recognising neglect, including the neglect of serious health conditions?

How do you/your team consider a child's lived experience, and include a child's voice in your work?

Transition

At times of transition there can be increased risk for children with serious health needs. However it also provides a good opportunity to seek and share information, reassess, re-engage and put plans in place for the child's future care and support – how does this happen in your agency?

What do you consider to be the key transition points relevant to this case?