



Learning Review

Child G

Review report

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1. Introduction to the case & Learning Review

1.1. Based on statutory guidance¹ Portsmouth Safeguarding Children Board determined that it was appropriate to conduct a review examining the circumstances of agency involvement with an adolescent, who for the purposes of this report, will be known as Child G. Whilst not meeting the criteria to conduct a Serious Case Review, the Board considered there to be an opportunity to learn about the quality and effectiveness of the agencies involved with Child G. As such, a Learning Review was considered the best way to achieve this.

1.2. Child G, who at the time of writing this report is 18 years old, is diagnosed with a degenerative and life limiting condition which requires full time care and support.

1.3. The case is deemed appropriate to review as there had been concerns about neglect and the Mother's ability to meet the care needs of Child G, despite considerable ongoing support and packages of care from health professionals and children's services. The aim of the Learning Review is to capture areas of learning to inform improvements from a safeguarding perspective; the Review does not comment on the quality and effectiveness of the health and medical provision in place for Child G.

2. Process for conducting the Learning Review

2.1. Portsmouth Safeguarding Children Board recognised the potential to learn lessons from undertaking a review into the agency involvement with Child G and family; particularly focusing on the manner in which agencies worked together to safeguard children.

2.2. The Board commissioned Kevin Ball as the Independent Reviewer². The approach taken has adhered with the principles as set out in statutory guidance³. A model of learning using systems ideas based on a Soft Systems Methodology⁴ has been adopted allowing '*... an action orientated process for inquiry into problematical situations in which users learn their way from finding out about the situation, to taking action to improving it ...*'. As such, the process has been able to capture and identify opportunities for professionals and organisations to learn and improve safeguarding practices from a whole safeguarding system perspective.

2.3. Following the decision in January 2018 by the Independent Chair of the Board to commission this Review the following steps were taken;

- Terms of reference for conducting the Review were set by the Case Review Committee⁵,
- Briefing session of single agency authors for those organisations that had, and still may have, contact with Child G and his family,
- Single agency reports and chronology were requested and submitted⁶. This process provided each agency with the opportunity to reflect on their involvement with Child G and his family – from both a single agency

¹ Working Together to Safeguard Children, HM Government, 2015 (Amended 2017).

² Kevin Ball is an experienced independent safeguarding consultant, with specific experience of chairing and authoring case reviews, and a background in children's services.

³ Working Together to Safeguard Children expects case reviews to be conducted in a way that; recognises the complex circumstances in which professionals work together; 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; and makes use of relevant research and case evidence to inform findings.

⁴ Soft Systems Methodology by Checkland, P., & Poulter, J., in Systems Approaches to Managing Change: A Practical Guide, Reynolds, M., & Holwell, S., Open University, 2010.

⁵ The Case Review Committee is a sub group of the Portsmouth Safeguarding Children Board.

⁶ Single agency reports were submitted from the following agencies;

- Portsmouth City Council Children's Services

- Care Agency 2

viewpoint but also from a wider, and more interactive systemic perspective. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice,

- A facilitated multi-agency workshop which involved practitioners who had come into contact with Child G and family. This initial workshop had three main features; firstly, to examine what happened in this case, as well as understanding the underlying reasons why events occurred as they did, secondly, to explore agency interactions and emerging themes and thirdly, to consider changes and improvements needed,
- A further facilitated multi-agency workshop with the same group of professionals to examine the learning arising from the Review following analysis,
- Throughout the above steps, the Case Review Committee has maintained oversight of progress and activity, offering support and assistance when necessary.

2.4. It was agreed that the timeframe for the Review would be from when concerns about Child G’s mother’s lack of engagement with any care packages offered began to seriously emerge around May 2014, and then through to August 2017, when Child G turned 18 years of age. Relevant information prior to this timeframe is also included as necessary.

3. Family structure & contribution to the Review

3.1. For the purpose of conducting this review the following individuals are relevant;

Individual:	Identified as:
Subject child	Child G
Mother to Child G	Mother

3.2. Seeking the contribution of family members has been an important consideration. Both Child G and the Mother were offered the opportunity to contribute to the Review early in the process. This initial offer was declined however a further attempt at the end of the process was accepted and both were given an opportunity to share their views. In making their views known they had the support of a carer who had known Child G for a number of years. Child G and the Mother had reflected on the involvement of the professional network in supporting them and, from their perspective, wished to convey a sense of being let down by the system which was designed to offer support. In particular they both expressed frustration and disappointment about the following issues;

- The meaningful lack of coordination of the multiple appointments Child G needed to attend, mostly in respect of health related issues, which often appeared to be duplicating tests and checks,
- The difficulties associated with hospital transport arrangements often turning a five minute health appointment in to a considerably longer task just because of the transport issues,
- Some professionals appearing to treat everyone that suffered with the same condition as Child G, in the same way, despite the nuances of individual circumstances and symptoms; from their perspective there was little personalisation in the support offered,
- Feeling like they were not listened to and that if a range of professionals (health and social care) really took the time to listen to what was being said by both Child G and the Mother, there would have been a far greater appreciation of the support needed,
- The considerable frustration with the wheelchair for Child G, and not receiving personalised care to address some basic needs,

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|--|-------------------------|
| - Portsmouth City Council Adult Social Care | - Secondary School A |
| - Portsmouth Hospitals NHS Trust | - College A |
| - University Hospital Southampton NHS Foundation Trust | - Advocacy Service |
| - Solent NHS Trust | - Hospice 1 & Hospice 2 |
| - Hampshire Constabulary | - GP Practice |
| - Care Agency 1 | - Wheelchair Service |

- Both Child G and the Mother recognised that some professionals (some health, social care, education and hospice staff) were trying to be helpful yet their experience of some others was less than helpful.

Both Child G and the Mother recognised that the past could not be altered, but were clear that they wanted the review to provoke learning and improvement for the professional network so that other children and their parents who were in similar circumstances did not experience the same problems.

4. Summary of relevant case history: prior to, & during, the early timeframe under review

4.1. Prior to the timeframe under review, Child G had been supported by the Local Authority Children’s Disability and Special Educational Needs (SEN) services since 2008, having been assessed as a child with a disability, and having a Statement of Special Educational Needs issued. Records reveal a persistent pattern of Child G not being brought to health related appointments; two out of five in 2011, two out of six in 2012, and eight out of 11 in 2013. Child G’s diagnosis was later in life than usual, thought to be due to the missed appointments hampering diagnosis.

4.2. During the early timeframe under review, in May 2014, the documented chronology continues to highlight a developing picture of either inconsistent engagement or non-engagement with professionals by Child G’s Mother, and to an extent by Child G. In June 2014, Secondary School A, Child G’s school, made a referral to the Children’s Joint Access Team⁷ expressing concern that Child G was being neglected and experiencing weight loss. This referral was not accepted requiring the School to make a further re-referral. Respite care organised for Child G was cancelled by the Mother without obvious reason. A wheelchair delivered in July was reported as being far from ideal due to difficulties manoeuvring in the house.

4.3. In August 2014, Hospice 1 – which offered respite care and a support package - completed a home visit to further assess Child G’s needs. Child G was described as ‘... *quiet and withdrawn* ...’. The engagement by the Mother with professionals was discussed; the Mother agreed that her preference for future contact would be via text or e-mail. Problems with the wheelchair persisted. Concerns were expressed by the Educational Psychologist that Child G was looking thin. The Children’s Disability Team were aware that a number of medical appointments had been missed, that Child G was not eating sufficiently and was appearing to be losing weight.

4.4. In October 2014 an annual review of Child G’s Statement of Special Educational Needs took place (later transferred to being an Education, Health & Care Plan in 2015), during which the concerns were discussed. In November and December 2014 Children’s Disability Team identified further concerns about Child G’s weight and diet. During this month the Paediatric Consultant wrote to a range of professionals including Child G’s Mother, expressing concern about Child G being severely underweight with the Community Paediatrician noting that Child G had ‘... *not been seen by anyone in health for over two years ... safeguarding being considered with this [child] but ... a very challenging case given the prognosis ...*’. In February 2015 a summary of missed appointments with the paediatric team between February 2012 and February 2015 was created; out of 10 appointments, six had not been attended, one was cancelled and only three were attended. A similar summary of missed appointments with the Occupational Therapist was also created for the same time-frame; out of 32 appointments, 23 were attended with nine home visits attempted but with no response. Meetings were convened in May 2015 due to concerns about neglect of Child G given the missed health appointments, decrease in weight, poor personal hygiene, sores and poor school attendance. Initially these were under the remit of Child G being a Child in Need, however this later shifted to become a Strategy Meeting⁸. The Police became involved, as per procedure, however no joint visit was conducted; the Police rationale being that there was no evidence of wilful neglect.

4.5. In summary, the period between May 2014 and May 2015 reveals a complex picture of multiple health professionals being involved in Child G’s life, seeking, offering and undertaking a range of assessments. Alongside health professional’s involvement, Children’s Services and the Local Authority Special Educational Needs Inclusion

⁷ Joint Access Team pre-dates the Multi-Agency Safeguarding Hub. The MASH came into effect in November 2015.

⁸ Strategy Meeting convened under section 47 of the Children Act 1989 where there is reasonable cause to suspect a child is suffering, or likely to suffer, significant harm.

Service were involved. Throughout this period those professionals who had regular contact with Child G (school, occupational therapy, physiotherapy, social worker, hospice) appeared to consistently share and express - via letters, meeting and e-mails – concerns about weight loss, and the quality of care being provided to Child G.

5. Practice episodes

5.1. In reviewing the multi-agency contact and involvement with Child G and family, and now with the benefit of hindsight, three practice episodes emerge that warrant closer examination in order to further understand what happened, and why events occurred as they did at the time. These three episodes are significant from a multi-agency safeguarding system perspective because a number of agencies and professionals were involved. As such, they provide us with the greatest insight into the quality and effectiveness of the response to Child G and family. These episodes are;

1. Child G being subject of a Child Protection Plan – June 2015 to February 2016
2. Child G being subject of a Child in Need Plan – March 2016 to March 2017
3. Child G's acute & life-threatening episode – April to May 2017

5.2. Practice episode 1: Child G being subject of a Child Protection Plan – June 2015 to February 2016

5.3. Following the Strategy Meeting in May, and the Initial Child Protection Conference (ICPC) in June 2015, Child G became the subject of a Child Protection Plan⁹ under the category of neglect¹⁰. Child G received support from an advocate during this process, to whom Child G described the relationship with Children's Disability Team as poor. The Social Work report to the ICPC comprehensively set out the history and risk, stating '*... [Child G's] condition does require the input of specialist medical professionals ... [the Mother] does not ensure that [Child G's] needs are met; as a result of this, [Child G's] quality of life is very poor ... the severity of which could result in [Child G] suffering chronic pain and/or a premature death ...*'. A Child Protection Plan was created. Child G expressed the view that such a plan was not necessary. Child G's weight began to increase and professionals described seeing more confidence and engagement from Child G.

5.4. Records indicate no success, despite multiple attempts, to engage the Mother via e-mail, face to face or telephone. The Mother did not attend either of the two Core Group¹¹ meetings held during this initial period of Child G being subject to a Child Protection Plan. A small range of professionals attended these early Core Group meetings; but attendance did not consistently represent the range of professionals working with Child G.

5.5. In September 2015, three months after the ICPC a Review Child Protection Conference (RCPC) was held, in line with expected procedures. Children's Social Care recommended that as the concerns mostly centred on health-related matters, the coordination of activity was best achieved by the Children's Disability Team and a Child Protection Plan was not necessary. Despite this view, progress had been slow and Child G remained subject to a Child Protection Plan.

5.6. In September it was suggested that Child G should be admitted into hospital for nutritional input; Child G and the Mother were opposed to this. This refusal to consent to treatment prompted the involvement of mental health professionals as it was believed that by not receiving treatment it would jeopardise Child G's health. This prompted a discussion between health professionals about potentially having to manage the situation within a legal framework.

⁹ Child Protection Plan – A multi-agency plan created in situations where a child has been judged as suffering, or likely to suffer, significant harm which aims to ensure the child is safe from harm and prevent further harm, promote the child's health and development, and support the family to safeguard and promote the welfare of the child, provided it is in the best interests of the child. The Local Authority are the lead agency for overseeing the Plan.

¹⁰ Neglect is defined as the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: provide adequate food, clothing and shelter, protect a child from physical and emotional harm or danger, ensure adequate supervision (including the use of inadequate care-givers), or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's emotional needs, Working Together, 2015, HM Government.

¹¹ Core Group – meetings which are to be held at regular intervals between Child Protection Conferences in which the objectives of the Child Protection Plan are to be monitored and driven forward. These should involve the parents/carers and most relevant professionals.

Communications between mental health professionals and hospital staff highlight discussions about Child G's capacity to make decisions, '*... the key aspect of proceeding seems to be assessing Child G's competence to make decisions to refuse treatment ... as [Child G] is 16, [Child G] is assumed to be competent to make treatment choices. The onus is on the health service to show that [Child G] is not competent in order to treat against [Child G's] will. [Child G] needs to be able to communicate ... decision and reasoning ...*'¹². The outcome of these intense discussions show that an alternative treatment plan was offered, and accepted, by both Child G and the Mother.

5.7. In October Child G is noted to have lost weight despite eating and drinking. Concerns about the wheelchair persisted. A transport worker noted that Child G's clothing smelt of alcohol some times in the mornings. During this time the Social Worker was able to visit Child G and the Mother to discuss progress, the Physiotherapist was able to meet with Child G in College A, Hospice 2 facilitated an assessment by the Community Nurse, and Child G had a four-night stay at Hospice 2. In January 2016 the transport arrangements for taking Child G were withdrawn due to continued refusal by the Mother. The Mother reported struggling to manage Child G's care needs and cutting corners in terms of using the most appropriate sanitary products to save money. An Occupational Therapist visited the family home with a Social Worker and noted that Child G raised concerns about some physical discomfort and a stomach upset; reddened hands, long nails, and scaly facial patches were also observed on Child G. The house was found to be cold. In February the Mother turned away a carer who came to the home.

5.8. Core Group meetings were held however the Mother did not attend any meetings throughout this entire period. The lead service for coordinating all health appointments was the Children's Disability Team, with the Child Protection & Court Team overseeing the Child Protection Plan.

5.9. A RCPC was held in February 2016. The decision at this Conference was split across those attending as to whether Child G should remain subject to a Child Protection Plan, however the Chair made the final decision that Child G should be subject to a Child in Need Plan¹³ instead. During this six-month episode legal advice was sought about the persisting concerns however separation of Child G from the Mother was not considered appropriate, nor would be granted by the Court as Child G was clear about wanting to remain with the Mother. In February the Community Paediatrician advised that, going into adulthood, the GP should lead on the care needs for Child G. The case was also presented to the Ethics Committee¹⁴ of University Hospital Southampton.

5.10. In summary, Child G being the subject of a Child Protection Plan appears to have had limited success, with partial (albeit not sustained) progress being made by a considerable professional network to support and promote the Mother's engagement. This period concluded with the professional focus being stepped down to that of Child in Need.

5.11. Practice episode 2: Child G being subject of a Child in Need Plan – March 2016 to March 2017

5.12. Records show that the first Child in Need meeting the Mother attended was in August some six months after this formal period of intervention began. Social work support continued from the Children's Disability Team but also with the Child Protection & Court Team remaining involved. Occupational Therapy had contact with Child G in March 2016 via College A and a home visit. In April the Mother admitted that she was still struggling. The outcome of the case being presented to the Ethics Committee was that it was advised that a clinician engages with Child G, alone, to see whether Child G had sufficient understanding about the extent of the degenerative condition.

¹² Psychiatric description of what is required in order to determine competence.

¹³ Child in Need Plan - Section 17 of the Children Act 1989 imposes a general duty on the Local Authority to safeguard and promote the welfare of children who are 'in need' and to promote the upbringing of children in need by their families by providing a range and level of services to meet those children's needs. A child in need is defined as a child: i) who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services; ii) or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services; iii) or a child who is disabled. Other agencies have a duty to co-operate with the Local Authority in carrying out this duty to assess the needs of children and to provide services as necessary.

¹⁴ The Clinical Ethics Committee (CEC) deals with any professional ethics enquiries not related to research. Sometimes when health practitioners, patients, or patients' families cannot reach agreement on important health care matters, it sometimes helps to consult a 'third party' who has some expertise in assisting in the resolution of clinical ethical dilemmas. An ethics consultation aims to identify relevant medicolegal and ethical considerations and help the parties concerned to find a way forward from an apparent impasse.

5.13. In May, Child G's attendance at College A was intermittent. Child G was described by the Mother to staff at Hospice 2 as being low in mood due to the wheelchair being uncomfortable. The Mother was also awaiting a continence assessment of Child G. Child G expressed concern that the Mother was not getting the right support. CiN meetings continued in line with expected procedure. Child G was not taken to the scheduled appointment for a continence assessment and was discharged from the service being advised to go back on the waiting list (which was stated as being 33 weeks). Mounting debts in the household were noted. The Social Worker and the new care agency were not able to gain access to the family home for several weeks, beginning regular visits at the end of July. Child G's condition had deteriorated, the wheelchair was no longer usable, and the Mother had an Eviction Notice served. In September the Children's Disability Social Worker assisted the Mother with the Eviction Notice. The case was closed to the Child Protection & Court Team but remained open as a Child in Need as Child G was now engaged with the Children's Disabilities Team. Child G's attendance had been poor at College A compared to the previous year.

5.14. In January 2017, a Child in Need meeting was held. Significant rent arrears were outlined which were not being addressed, with a continued risk of eviction. The professional focus at this time appears to have been to promote Child G's sense of independence and control – although concern about weight loss seemed to continue. Child G occasionally attended Hospice 2 without prescribed medication and being hungry. These issues were discussed at the Hospice as part of their multi-disciplinary meetings.

5.15. In February during an overnight stay Child G reported to staff at Hospice 2 that the carers had been cancelled by the Mother, showers to stay clean were infrequent and using sanitary products to go to the toilet was the preferred option – despite Child G being capable of not needing to use sanitary products. The Occupational Therapist expressed concern about Child G's personal appearance and skin condition. During a further overnight stay Child G arrived hungry, unkempt, soiled, and with sores; Child G had clearly lost weight. Hospice 2 expressed these concerns to Children's Services however it was confirmed that Child G could be discharged back home to Mother. Further CiN meetings were held in February and March respectively where the concerns were discussed. Problems with the wheelchair continued. Also in March, concerns were raised by the Children's Community Nursing (CCN) Service; these included Child G's weight loss, physical deterioration and malnourishment, a home environment that had risks from passive smoking compromising wound healing and the risk of significant harm due to the effect of neglect – which could lead to death. The CCN Service shared these concerns with Children's Disability Team who advised being aware of them but unable to do anything as Child G was Gillick competent¹⁵. In parallel to this the CCN Service also made an on-line referral to the Multi-Agency Safeguarding Hub (MASH) and followed it up with a phone call to a Social Worker from the MASH, as opposed to the Social Worker in the Children's Disability Team. The GP was involved in discussions about a possible admission to hospital given the seriousness of the situation.

5.16. In summary, this period of time reveals that despite the continued intervention by a significant number of agencies and professionals with Child G progress, and impact, appeared to be negligible.

5.24. Practice episode 3: Child G's acute & life-threatening episode – April to May 2017

5.25. In April 2017 Child G agreed to a hospital admission to receive much needed treatment – however this appears to have been after considerable negotiation and persuasion involving the CCN Service, and the Consultant Neurologist. From hospital, Child G was then discharged to Hospice 2 and then back home despite the original concerns about neglect and Mother's care remaining. In May concerns were again raised about the Mother's care of Child G by Care Agency 1.

5.26. The CCN Service conducted a home visit in early May and remained concerned about the deteriorating health and condition of Child G; this was reinforced by the Community Dietician and Care Agency 1. Records indicate a series of tense telephone exchanges between the CCN Service and Children's Social Care which revolved around Child G's ability to self-determine care arrangements, and that the options to intervene by the Local Authority were very limited.

¹⁵ Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick, or Fraser, competent, <https://www.nhs.uk/conditions/consent-to-treatment/children/>, accessed 21/05/18.

5.27. Nevertheless, a Strategy Meeting was convened two days after these telephone calls which identified that Child G was suffering significant malnutrition, poor hygiene, safety risks, and non-engagement with professionals, and that Child G could choke – the malnutrition and choking being of specific concern as they could cause death. Legal advice was sought in case Child G refused admission to hospital however Child G did agree to hospital admission, where-upon urgent treatment was provided. The intended plan whilst Child G was in hospital was to fully assess and intervene to improve Child G’s physical and mental health with a view to comprehensive assessments being conducted in the following areas; formal mental capacity in relation to life and death decisions, formal assessment under the Mental Health Act, respiratory, cardiac, nutrition, bone health, swallow, and skin integrity assessments.

6. Findings & analysis

The relevance of the above practice episodes will now be explored by way of an appraisal about the effectiveness of the multi-agency safeguarding system. As outlined in 2.3, by providing each agency with the opportunity to submit an individual report, but also participate in a multi-agency workshop, it has encouraged a reflective dialogue. Many agencies have used this opportunity to undertake a comprehensive analysis of their involvement with Child G and family and identify improvements. This section of the over-view report distils the key areas for analysis whilst also noting learning points for practice.

6.1. Summary appraisal: the multi-agency recognition & response to safeguarding Child G

6.1.1. The dominant issue and question in this case is that Child G was a young person that had contact with around 24 agencies/organisations and numerous professionals across the range of agencies and organisations, yet despite this suffered a level of persistent neglect which at one point became acute and life threatening; how could this happen? During the course of undertaking this Review, it has become apparent that the following factors all contributed to this situation arising;

- Case management became increasingly complex over time due to Child G’s physical condition and care needs, complicated by neglect but also the Mother only partially engaging with support services. This made it harder for professionals to understand cause and effect, predict outcome and orchestrate effective support.
- The physical neglect, prior to the acute episode in May 2017, was a slow and steady process which was seen and monitored by a number of professionals. Child G’s physical appearance of being neglected fluctuated over a lengthy period of time and there were, at times, divergent views expressed between professionals about how the situation should be responded to.
- The threshold for escalating concerns and intervening became confused, in part due to there being an enduring belief about Child G’s mental capacity, and right, to make informed choices. This was especially so in April/May 2017.
- Had it not of been for a small number of tenacious and vocal health professionals Child G is likely to have died; although this tenacity and persistence did, at times, create tension within the professional network surrounding Child G.
- Despite a perception that there were individual agencies and professionals taking a lead, there was no one single identified lead agency taking a holistic and strategic view about Child G’s circumstances.
- The combination of Child G having complex needs, being over 16 years of age and experiencing neglect, alongside the complexity of working arrangements increased the level of risk and contributed to problematical situations being created.
- Legal frameworks were often seen as a barrier to Child G being safeguarded.

6.1.2. One practitioner reflected, with the benefit of hindsight, that “... *there is a constant thread throughout that Child G is not ... [having any] ... needs met and the risks are increasing and outcome reducing and yet this is not always thought of within a safeguarding arena ...*”. This personal reflection by one practitioner involved with Child G’s case is expanded on, and contextualised, by Horwath¹⁶ who states “... *It can be difficult differentiating cause and effect in*

¹⁶ Horwath, J., Child neglect: Identification & assessment, 2007, Palgrave.

terms of neglect and the disabled child. ... In this context the impact of neglect on the child can become minimised, by professionals and neglectful behaviours allowed to continue because the disability masks the neglect. ... A further challenge centres on recognising that a significant number of professionals can be involved ... [who] ... may view the disabled child in very different ways, depending for example, on whether they take a social or medical model of disability ...". ...Finally, it is all too easy to empathise and over-identify with the carer to the extent that we accept parents doing their best rather than being good enough. Therefore, a key question ... to be asking ... is whether ... [we] ... would accept this level of parenting for a non-disabled child ...". Horwath has neatly encapsulated what happened in this case. By focusing on the specific terms of reference, the report will now examine the contributing factors.

6.2. The quality & effectiveness of agency decision making

Stepping up and down between Child in Need and Child Protection processes

6.2.1. Practice episodes 1 & 2 provide a summary of detail about the step-up attempts to manage the neglect experienced by Child G via Child Protection procedures and then back down to Child in Need procedures.

6.2.2. The decision to convene an Initial Child Protection Conference (ICPC) was understandable and rational based on the developing picture of neglect. There was sufficient evidence to indicate that Child G was suffering actual, or likely to suffer significant harm¹⁷ and based on statutory guidance¹⁸ this was an appropriate route to follow. The timeliness of this conference being convened was therefore appropriate and appears to have been a relief to a number of professionals outside of Children's Social Care and that the concerns were being taken seriously. Some professionals who work in a health setting have reflected that they saw the bar to securing a CPC as being higher than usual. Those working in Secondary School A had worked hard to avoid the need for Child G's case to be managed via a CPC route, providing significant levels of support.

Practice Note: When assessing risk of harm to children with disabilities, it is important that the care of the disability does not distract from, or mask, any actual or potential harm being caused. The same thresholds for intervention must be applied to children with disabilities to those without.

6.2.3. The Social Work report to this ICPC – and all other conferences - is thorough, clear and articulates the issues very well. The decision of this ICPC was unanimous in that all attendees agreed that Child G should be subject to a Child Protection Plan (CPP) for neglect; which appropriately reflected the weight of concern across the multi-agency partnership. From a procedural aspect a suitable CPP was crafted and Core Groups were convened in line with expectations. Review Conferences were also all held within expected timeframes.

6.2.4. However – and importantly - there is no reference in the CPP to considering an assessment of the Mother's capacity to change, as advocated by, for example Horwath¹⁹; *"... effective change does not occur instantly, rather it is a process consisting of a number of stages ..."*. An assessment of this nature might have been a useful exercise – both in terms of helping the Mother reflect on her care and the situation, but also to providing the professional network with new insights of how to work with the Mother. Such an assessment is something that all professionals involved with Child G could have usefully contributed to, with Children's Social Care taking the lead. Given that the Mother's care had not appeared to change over a protracted period of time and this being one of the driving reasons behind taking the matter to CPC, such an assessment would have been sensible. Neither is there any mention of using other tools to aid assessment; the purpose of assessment being to identify the needs of the child and their family, which in turn can inform intervention. These were missed opportunities.

Practice Note: "... 'Parenting capacity' and parents 'capacity to change' are linked but distinct aspects of assessment with high risk families. Parenting capacity considers parents' current ability to meet the developmental needs of their

¹⁷ The Children Act 1989 details the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children.

¹⁸ Working together to safeguard children, 2015, HM Government.

¹⁹ Horwath, J., Child neglect: Identification & assessment, 2007, Palgrave.

children; an assessment of capacity asks whether parents – when provided with the right support over a specified period of time – are able to make the necessary changes to ensure their child’s well-being and safety ...”²⁰

Practice Note: Undertaking an assessment of parenting capacity, and capacity to change, is something that all professionals can contribute to with Children’s Social Care taking the lead and coordinating assessment activity. The contribution of a range of professionals will provide a deeper and more meaningful evaluation.

6.2.5. Horwath²¹ reminds us of the benefits of using assessment tools; *“Assessment of neglect may not be seen as an urgent priority ... identifying and indeed addressing, the multi-dimensional problems associated with child neglect, is considered an impossible task, so practitioners complete a superficial assessment or take no further action. Whatever the reason for failing to complete a systematic assessment the outcome is the same: the needs of the child are marginalised”*. In Portsmouth the Neglect Identification and Measurement Tool (NIMT) had been adopted in 2015 and was therefore available to use. Such tools help untangle the often overwhelming nature of having to work with neglect; they also encourage a dialogue between parent and practitioner.

6.2.6. It is of interest to note that at the first Review CPC (RCPC), just 12 weeks since the initial meeting, the Social Worker from the Child Protection & Court Team expressed a view *“... this is a family that would benefit from regular guidance and organisation of appointments and reminders of when to make applications etc. ... [and] ... rather than co-ordinating [Child G’s] health needs through a Child Protection Plan, planning for this case needs to be transferred back to the Children with Disabilities Team”*. This is an insightful comment in that it encapsulates the very issue that everyone surrounding Child G had been grappling with – but to date, had failed to resolve. It is therefore reasonable to question the quality of the initial decision to initiate an ICPC and CPP when there is a recommendation only 12 weeks later to not have one. Parents/carers may have affected change to the point that a child is no longer at risk of significant harm in such a short timeframe however in such situations it might reasonably have been managed via a robust, yet less interventionist, Child in Need process. The ambivalence from Children’s Social Care about whether a CPP was necessary reflects a level of uncertainty about how best to manage Child G’s circumstances. The majority (not unanimous) decision was that Child G should remain subject to a CPP for a further six months despite limited progress and change.

6.2.7. The nine-month RCPC saw the Social Workers recommending the CPP should end, and a split set of recommendations across the attendees. Based on the information available to the RCPC and considering the views of those in attendance, the Chair made the decision that Child G should no longer be subject to a CPP. This reflected a degree of uncertainty by professionals about how best to manage Child G’s circumstances. From a procedural aspect, convening and going through the process of using a CPP appears to have been just that; it was a procedural response for the professional network attempting to gain a grip on something that might have been managed differently at an earlier stage. Whilst understandable, this process driven route failed to provide the solution that was needed. Overall, the impact of Child G being subject to a CPP appears to have been negligible and the carefully choreographed activity surrounding meetings had little impact.

6.2.8. It is evident that the decision for Child G to no longer be subject to a CPP not only split the thinking of the professionals on the day of the RCPC, but also had the effect of splitting the professional network in their ability to function effectively as a coherent whole. Hood²² discusses, what often are unconscious processes, describing ‘fault-lines’ in collaborative working *“... stress and anxiety can have a significant impact on practitioners and will therefore affect how they work with each other ...”*. Calder²³ refers to this as creating conditions for professional and

²⁰ Research in Practice, Assessing parents’ capacity to change.

²¹ Horwath, J., Child neglect: Identification & assessment, p.156, 2007, Palgrave.

²² Hood, R., Complexity in social work, 2018, Sage.

²³ Calder, M., Contemporary risk assessment in safeguarding children, 2008, Russell House.

organisational dangerousness “... *embarking upon forms of intervention which fail to consider the assumptions and emotional responses of the people involved ...*”.

Practice Note: When there is a recommendation to end a Child Protection Plan at the first RCPC, there is value in the professional network reflecting on the quality of the original decision-making process which instigated the original request for a Child Protection Conference to be convened.

Practice Note: It is critical for professionals to remain alert to the unconscious human processes inherent in working with children and families, especially when working with dysfunction, abuse or maltreatment. The importance for professionals having access to good quality reflective supervision or support cannot be under-estimated.

Practice Note: Whilst parents/carers have an opportunity to make a complaint and seek issues resolution via the Safeguarding Procedures, it is important for professionals to remember that they can use the escalation process at any time. Sometimes when agencies work together there may be times when a decision made by a worker from another agency is either not safe or not in the best interests of a child. If we are on the receiving end of a professional challenge we should not be offended – it’s not personal and we should remain professional. A professional disagreement protocol can; be an opportunity to reflect on our decision making; encourage professional curiosity; be a way of avoiding professional disputes that put children at risk or obscure the focus on the child; allow a way of resolving the differences within and between agencies quickly and openly. Working together effectively depends on; an open approach; honest relationships between agencies; being confident to ask questions; being confident to challenge; and ensuring the safety of the child is at the forefront of all decisions²⁴

6.2.9. Records indicate that regular Child in Need²⁵ (CiN) meetings were convened at appropriate intervals. Review of these records reveals a greater amount of ‘apologies’ being sent than people attending. Critically, the Mother’s contribution to these meetings is not apparent as she rarely attended. Therefore, when considering the quality and effectiveness of decision making it is reasonable to conclude that with such a consistent lack of engagement in the process, the Mother’s appreciation of the professional network’s offer of support would have been limited. The CiN Plan also makes no reference to assessing the Mother’s capacity to change - and yet the emphasis on ensuring Child G attends appointments and there being improvements - remains firmly placed with the Mother. The situation does however appear to fluctuate, with comments noted about the home conditions being seen, on and off, as acceptable, the Mother being “... *relatively open to professionals’ visits ...*”, Child G being “... *happy and engaged ...*” [June 2016], “... *Child G is happy with the current services being provided ... Mother frustrated over the lack of support during the summer ... several appointments have been booked ... but Child G has not attended ... as too uncomfortable in wheelchair ...*” [September 2016]. Given the ebb and flow of the situation it is possible to see how the professional network was challenged by this. This ebb and flow of change is however a common situation in cases involving neglect²⁶. Children’s Social Care have reflected that “... *there are numerous examples ... of the social worker and others doing things ‘for’ mother, rather than doing things ‘with’ which potentially over time has compounded her dependency on others as well as masking the underlying problem which could have resulted in a different course of action much earlier on in Child G’s childhood ...*”. Holland²⁷ refers to this using the terms ‘power over and power with’, noting that “... *the workers task is ... not just to find out what caregivers perception of their needs are, but also their perceptions of the relationship with the worker and how power issues are affecting that relationship, in order to work towards a more constructive relationship ...*”. Using hindsight to our advantage, practitioners have further reflected on the Mother’s experience and considered how the situation must have felt for her. Reflections include the Mother feeling, at times, overwhelmed, as though she was being judged and heavily scrutinised, threatened, disempowered and

²⁴ Acknowledgements to West Sussex LSCB professional disagreements protocol.

²⁵ Provided under section 17 of the Children Act 1989 & section 2 of the Chronically Sick & Disabled Persons Act 1970.

²⁶ Farmer, E., & Lutman, E., 2012, Challenging Practice: Working proactively with neglected children and their families, paper given by Farmer, E., at ‘Home or away: Making difficult decisions in the child protection system’ conference, 22/02/12.

²⁷ Holland, S., Engaging children and their parents in the assessment process, in *The Child’s World*, 2nd Edition, Edited by Horwath, J., 2010, Jessica Kingsley.

fearful. In discussion with the Mother she confirmed feelings of being overwhelmed, judged and frustrated by the situation as it was; often believing that other people thought her a bad person.

Practice Note: In your work with children and families, and when making decisions about children's lives, it is important to remain alert to the power dynamics in the relationship between parent/carer and professional but also other unconscious processes, such as collusion. Consideration about the levels of empowerment, or disempowerment, are critical to gaining trust and creating conditions for change and improvement to the child's safety and welfare. Working in an open and transparent manner – at all times – can empower parents to take control of their situation. Seeking reflective supervision to check for collusion and loss of focus on the child are important.

6.2.10. It is also possible to see elements of drift within the CiN process once Child G was no longer subject of a CPP, with records highlighting either inconsistent or non-attendance by some professionals, resulting in it being difficult to gain a complete picture of what progress was being made. The recording format for meetings varies, with more recent records simply appearing as a series of statements. Also, some actions are broad and lack specificity. For example, actions refer to *'Child G attending Hospice 2'*, or *'Mother to ensure that all health appointments are prioritised'*. These CiN meetings were held approximately every eight weeks. Consequently, the meetings become process driven and rather bland exercises and it becomes problematic for the professional network to demonstrate impact. Including the dates, and arrangements, for all forthcoming appointments in one single record every eight weeks, as an example, would have probably been useful for the Mother to help her plan – however records do not reflect this happening. This would also have demonstrated to her that the professional network had a grip on what was happening and how support could have been offered. At each subsequent meeting it would then have been possible to comment on progress and compliance but offer a more meaningful update. Both the Mother and Child G expressed the lack of coordination and support around appointments as being especially frustrating and overwhelming.

Practice Note: When creating a record of tasks and actions in either Child Protection Plans or Child in Need Plans, being specific, measurable, achievable, realistic, and time bounded will be useful to everybody concerned. This results in a) everyone being clear what the expectations are, including parents and professionals, b) promotes accountability, c) supports and lays the foundations for step-up or step-down decision making, and d) supports professionals to feel more comfortable to use escalation if necessary.

6.2.11. The Police had involvement on two notable occasions; firstly, in May 2015 and then again in May 2017. On both occasions their involvement related to the concerns about Child G being neglected. The first incident culminated in no joint visit or investigation by the Police being completed because it was felt there would be insufficient evidence for a criminal prosecution because of an inability to prove *'wilful neglect'*²⁸ and a *'deliberate or reckless failure to provide care'*. It was also noted that *"... it was accepted that mother genuinely believes that she knows best and that whilst her failure to engage with medical professionals may not be considered to be reasonable to others, there is no evidence to indicate that mother does not truly believe that she is not acting in the best interests of her child ..."*. A *'softer'* approach was considered the best way forward without the need for Police involvement.

6.2.12. The Police have usefully reflected on the quality and effectiveness of their decision making in this situation highlighting that *'... by failing to investigate, the Police have failed to support the multi-agency approach to tackling this difficult situation...'*, noting that such an investigation would ultimately *"... inform lawyers for the local authority then, or later, considering legal action through the Family Court ..."*. The Police's second contact, some two years later appears to have almost duplicated the first episode in that the Police were asked to undertake a joint visit with Children's Social Care due to concerns about neglect. Whilst on this occasion a joint visit was completed, the outcome was that the attending Officer's opinions appear to have been heavily influenced by the accompanying Social Worker – in that they judged there to be no neglect or physical harm; on this basis there was no further investigation. Instead the focus appears to have been on the support needs of the Mother rather than any opportunity to consider whether

²⁸ Section 1 of the Children and Young Persons Act 1933 provides that cruelty to a child must be *'wilful'* to be considered a criminal offence. The term *'wilful'* has been defined in case law to mean advertent recklessness – i.e. that the defendant was aware that some harm might be caused to the child if they did not act, and nevertheless ran that risk when it was unreasonable to do so.

a crime may have been committed, or whether the assessment by the Police would assist the multi-agency network with, what turned out to be, an acute episode during which Child G's life was in danger.

6.2.13. Alongside the individual learning for the Police about the manner in which they reached their judgements, this Review has also brought a spotlight onto the fact that between the ages of 16 – 17 years, there is no criminal charge for neglect, yet there is below 16 years and above 18 years of age²⁹. Whilst this may be the law and be seen as limiting, a degree of common sense and reasonableness must be exercised on such occasions. During the first occasion of Police involvement, the rationale of a 'softer' approach was taken (possibly seen as a common-sense approach) in order to maintain the working relationship with the Mother. The second occasion saw the Police Officer heavily guided by the Social Worker assessment. It can be argued that the impact of these decisions was that it diluted the over-riding, yet developing picture, of how effective and authoritative the professional network was in safeguarding Child G. In effect, there appears to have been no challenge to the Mother – something that a Police contribution might have added to.

Practice Note: The Police can offer a valuable, and sometimes fresh perspective, to situations relating to child safety and welfare. Initially, this is likely to occur in the MASH, but also Strategy Meetings in line with safeguarding procedures. However, seeking the contribution of the Police should always be considered where there is a query about whether a crime has been committed.

Responding to the acute life-threatening episode

6.2.14. The record of the April 2017 CiN meeting clearly highlight concerns about Child G's physical health, and these not being related to the degenerative condition. It refers to the Community Nursing Services attempts to raise the concerns to the Community Paediatrician, Children's Disability Team, the GP, Children's Social Care and the MASH³⁰. The response by the MASH was that they were unable to take any further action as Child G was already an open case to the Children's Disability Team. The response by the Children's Disability Team was that there was nothing they could do as Child G had mental capacity – the implication being that Child G understood the possible impact of the situation. One health practitioner has commented that *"... it is likely that Child G would have died within days without medical intervention ... [Child G] received expert care which ... no doubt saved Child G's life ..."*.

6.2.15. The decision making and response to this episode by the MASH to not accept the referral of concern has highlighted that the MASH will not deal with new and/or concerning information on CiN cases that are already open to Children's Social Care, instead the information needing to go directly to the existing case-holder. Additionally, the response by the Children's Disability Team that they could not respond either, left the professional network with no options about how to take their concerns forward. It is therefore understandable that this caused frustration for those raising concerns about Child G's safety.

Practice Note: The MASH is often described as the 'front door' in a local authority area. Ensuring the process for individuals to make contact with the MASH is as clear and effective as possible is critical. When concerns about a child's safety and welfare might rest on making a single, smooth and seamless contact with the appropriate authorities, it is important to make this experience as straight-forward as possible.

6.2.16. Whilst Child G was eventually admitted to Hospital for treatment, and then respite at Hospice 2, the frustrations continued into May 2017 in that differing professional viewpoints emerged as being barriers to taking a more robust and interventionist approach to Child G's deteriorating condition. These differences of opinion centred on whether Child G was safe to remain at home in the care of the Mother, or not; with one perspective being that to remove Child G from home would cause *"... too much upset ..."* and another being *"...Child G was not safe at home and was at risk of being found dead at home imminently ..."*. These polarised and split perspectives continued for a further two days until a Section 47 Strategy Meeting³¹ was convened during which all health professionals present emphasised the

²⁹ There are inconsistencies in what age the law considers you a child. The Children Act 1989 defines a child as a person under 18 while the Children and Young Persons Act 1933, which provides legal protection for children from abuse and neglect, defines a child as under-16 years old.

³⁰ MASH – The MASH is multi agency and brings together services such as from social care, education, health, police and children centres. The MASH aims to work together to offer the right help at an early stage to families who need support.

³¹ Section 47, Children Act 1989, [Portsmouth LSCB Procedures](#)

gravity of what they considered Child G's situation to be. One practitioner commented "... *the strategy meeting was by far the most emotive and challenging I have ever attended, and I have attended many in my role ...*". The outcome of this process was that Child G and Mother agreed to being admitted to hospital and treatment.

6.2.17. This acute incident exposed different styles of thinking between professional disciplines and 'fault lines' in collaborative working, as described earlier by Hood³². In this situation, it appears that Children's Social Care were guided by their legal limitations and belief that Child G had a right to self-determination. This can be viewed as a rule based, or technical-rational, style of thinking³³, by Children's Social Care in that there were laws and procedures to follow. Whereas those professionals from a health background, it appears, were guided by their knowledge of Child G's current condition and the possibility of death. This can be viewed as a skill based, or socio technical, style of thinking³⁴ by those health professionals most closely involved in working with Child G – often seen in the medical profession which is based on an 'expert' model and which permits some discretion. Each agency, or profession, appears to have reframed their functions to reflect their own disciplinary specialism, with Children's Social Care – for a short period of time – concluding that the threshold for statutory intervention was not met. Reason³⁵ refers to these styles of thinking, and behaving, as being the inevitable human contribution of working in complex organisational structures. Calder³⁶ refers to such situations being fertile ground for professional dangerousness to emerge, and Munro³⁷ refers to this as differing forms of cognitive reasoning when working in a caring profession. Neither style is wrong with both having their merits but also pitfalls; the challenge being to overcome them for the greater benefit of Child G and reaching a common-sense solution. Whilst the situation was overcome, it is evident from practitioner reflections that there has been an emotional impact on the professional network.

Practice Note: In situations where there are professional differences, or disagreements it is worthwhile considering the following strategies as a potential solution³⁸:

- Whilst the focus may be on the immediate presenting concern, there may be value in reviewing a child/family's case records to look for repeated patterns of behaviour and recurring risk indicators; history is often a good predictor of future behaviour and may help unblock stuck or bias thinking,
- It may be helpful to test assumptions in order to either confirm them as a risk factor or eliminate them e.g. whether Child G had been assessed as having mental capacity in the current situation,
- Imagine taking the opposing point of view in the dispute and consider reasons why their judgement may be wrong or different,
- Seek reflective supervision, either 1:1 or within a group setting,
- Be alert to any bias in forming your viewpoint (often formed on vivid, concrete, emotive, and recent experiences) and attempt to express them when discussing concerns,
- When formal meetings need to be convened, e.g. Strategy Meetings, consider having two impartial and skilled people manage the meeting; one who manages the content/subject matter and one to manage the process/human dynamics.

³² Hood, R., Complexity in social work, 2018, Sage.

³³ Reason, J., 1997, Managing the risks of organisational accidents, Ashgate.

³⁴ Ibid, Reason, 1997.

³⁵ Ibid, Reason, 1997.

³⁶ Calder, M., 2008, Professional dangerousness: Causes and contemporary features, in Contemporary risk assessment in safeguarding children, 2008, Russell House.

³⁷ Munro, E., 1999, Common errors of reasoning in child protection work, London, LSE Research articles online.

³⁸ Ibid, Munro, 1999.

This ensures sufficient attention is given to both aspects and can often have the result of breaking entrenched dynamics,

- When reasonable efforts have been made, but dispute remains, the use of the escalation protocol may assist. Involving senior managers in challenging situations, rather than those working directly with the child/family may help.

- Building trusting working relationships is critical to effective multi-agency child protection work. Trust plays an important role when faced with ambiguous, unpredictable and risky situations and trusting one another is a precondition for undertaking meaningful action. Re-building trusted relationships requires an acceptance of one's own vulnerability, risks and expectations of one another (whether it be at individual or organisational levels). Taking a restorative approach may support any breakdown in relationships.

6.2.18. Underlying, and complicating, this dynamic was the knowledge that Child G had been assessed as having sufficient mental capacity to determine medical treatment.

Mental capacity & decision making

6.2.19. A consistent theme throughout the management of Child G's case concerns whether Child G understood the implications of the degenerative condition and the impact of not accepting appropriate health and medical related treatment. Consideration about Child G's mental capacity to understand these issues had been explored in September 2015 when Child G was only just 16 years old by a clinical Psychologist. However, records indicate that at this time no formal mental health assessment appears to have been conducted because Child G and the Mother accepted the offer of treatment; the exploration about mental capacity seemingly being an informal 'assessment' based on clinical experience during a hospital admission. The supporting evidence in records to verify this is weak and offers little to learn from. Despite a referral being made to CAMHS (Child & Adolescent Mental Health Services), and efforts made to offer appointments and engage with Child G and the Mother, neither were ever seen by a mental health professional any further.

6.2.20. Children's Social Care sought legal advice in February 2016 and the conclusion was that removal and separation via the Child Act 1989 using Care Orders (due to the neglect) would not be appropriate nor be granted by the Court as Child G made it clear about wanting to remain in the Mother's care. This was an indication that Child G's views, and mental capacity to make informed decisions were being taken into account. It would be rare for a child to confirm that they would want to be separated from their own mother, and at times, the role of the professional is to argue about difficult decisions. Children's Social Care and Children's Disability Team) have noted that "*... although Child G's capacity to make key decisions was taken into account during our intervention, especially during the 17th year ... these were not formally documented on the case record thus not providing an audit trail of such consideration ...*".

6.2.21. Discussions about care and treatment continued in this vein until the acute episode in April/May 2017 with no additional assessment being conducted until Child G was admitted into hospital. Despite the admittance, it finally proved unnecessary to conduct a formal mental health assessment under the Mental Capacity Act 2005, as Child G agreed to treatment.

6.2.22. It is therefore of significant interest to note that a contributing factor to the manner in which Children's Social Care viewed how Child G's situation could be managed seems to have been based on an assumption that there had been an assessment of mental capacity. In fact, it appears, no such assessment was ever completed other than an informal discussion which identified that depression and anorexia were not apparent. The September 2015 test of whether Child G had capacity lacks specificity and the language used '... an assessment of capacity ...' seems to have had the effect of generating a level of meaning for the professional network that was unjustified; the words used were over-interpreted and became embedded in judgements and decision making. In effect, this assumption had created a myth about Child G's right to be self-determining. This myth influenced other professional's views and became a truth, having the impact of throwing people off course and affecting judgements.

6.2.23. At this time Child G had not been fully briefed about the likely impact of refusing treatment. Child G's ability to self-determine was therefore based in an incomplete understanding. The judgement about capacity has to relate to

the specific issue where treatment may be necessary, rather than a general assumption about universal capacity³⁹. Capacity may change over time or be dependent on circumstances. One example of this concerns Child G's capacity during the acute episode during which severe malnutrition was evident, to the point that it is highly likely to have impacted on cognitive functioning, although it is noted that when given the full facts about the situation by a Consultant, Child G opted to be treated.

Practice Note: There is nothing wrong with revisiting previous decisions made on cases, questioning and re-evaluating the information and decisions, and changing direction; this is especially important to do in cases that have been open and ongoing for a number of years, and in the light of new information or changing circumstances. Applying a fresh level of analysis may provide a necessary turning point in the management of a case and be in the child's best interests.

6.2.24. The assessment also seems to be based on the concept of Gillick competence, which has its roots in a young person being able to make informed decisions about sexual health related matters. It could be argued that to apply this level of thinking to the situation Child G faced was flawed. As one practitioner insightfully reflected that *"...Child G was not an independent and worldly wise 17 year old making a relatively minor decision about a procedure or sexual health issue – [Child G] was an isolated child made immensely vulnerable through illness and a degree of malnutrition that in its own way could seriously impair thinking ..."*.

6.2.25. It seems inconceivable that professionals would permit a highly vulnerable child to die of malnutrition. Refusal of treatment can be overridden by a parent, or those with parental responsibility, or the Court because there is an overriding duty to act in the best interests of the child – especially so in circumstances where refusal may lead to death⁴⁰. A submission to the Court of Protection, it appears, was not necessary in this case as Child G did ultimately agree to treatment.

Practice Note: Recording thinking, and decision making, is vital to supporting effective case management. It allows new workers to a case the opportunity to understand what has occurred in order to plan and shape future interventions. It is also a basic expectation of professional practice and provides an account of the professionals practice with service users.

6.2.26. In summary, the quality and effectiveness of agency decision making was, at times, based on incomplete information or un-tested assumptions, for example the Mother's capacity to change given effective support and Child G being informed about the diagnosis and having mental capacity to make informed choices. Whilst procedures were followed in attempting to provide support and protection to Child G, largely their impact appears negligible.

6.3. The quality & effectiveness of support offered to Child G & family

Support in responding to Child G's complex needs

6.3.1. Once diagnosed, Child G had been in contact with statutory agencies since 2008 having been identified as a Child in Need and requiring a Statement of Special Educational Needs. Agencies and professionals therefore had ample time and opportunity to explore, understand and predict the actual and likely support needs for Child G. The prognosis for Child G, given the degenerative nature of the condition, was fairly predictable. It must be argued that the support needs for the Mother – given the known developmental pathway of Child G's support needs – were also fairly predictable. The Statement was later transferred to an Education, Health and Care Plan (EHCP) in 2015, in line with expectations. An EHCP is designed to bring a child's education, health and social care needs into one single legal document with a clear mechanism for monitoring and reviewing. The EHCP for Child G appears to be a comprehensive document which clearly does cover all of the above elements and provides an outline of a support package. It does make reference to Child G being subject to a Child Protection Plan due to neglect *"... due to lack of attendance at medical appointments, engagement with professionals, and concern around his weight"*. Review of the EHCP was scheduled for 10 months after its creation but with no one single agency or professional identified as taking a lead in

³⁹ Mental Capacity Act 2005, Code of Practice, 2007, The Stationary Office.

⁴⁰ Care Quality Commission Brief guide: capacity and competence to consent in under 18's, December 2017.

monitoring its implementation. Stated outcomes do not reflect the challenges a number of the named professionals were facing – at a rudimentary level - in getting Child G (and Mother) to attend medical appointments or engage with professionals. Ensuring Child G’s basic physiological and safety needs is not conveyed as being of fundamental importance⁴¹ - despite it being known that these were basic and priority issues for Child G at the time of the EHCP being reviewed. The EHCP was discussed by practitioners as still having a greater focus on the educational elements, potentially being a legacy of the former Statement of Special Educational Needs.

Practice Note: Children who have complex needs are especially vulnerable to abuse and/or maltreatment. These children are also likely to have an EHCP in place and have a number of professionals involved in their lives. When a threshold of actual or likely significant harm has been achieved, attending to the child’s basic safety and welfare needs has to take priority over other matters. This requires close, and regular, monitoring by an experienced and skilled practitioner/s who is able to galvanise and coordinate the multi-agency network.

6.3.2. A number of professionals have commented that the physical management of Child G’s condition should not, ordinarily have been a complicated issue; however, the ability to actually manage it was severely impacted by the lack of engagement with professionals over a sustained period of time, especially on health related matters. In practice this meant that Child G did not attend or was not brought to what might be considered routine health appointments over a period of at least six years. Examples of these include;

- Dietician, Continence, Specialist Paediatric and Paediatric Service appointments not being attended over a sustained period of time.
- Multiple failed attempts to conduct home visits, often on a weekly basis, by the Children’s Physiotherapist and Occupational Therapist Service, finding no response.
- Attendance at College A not being at a sufficient level, and no response from the Mother when contacted.
- Numerous unauthorised absences from Secondary School A, albeit with a reflection from the School that “... *relationships between school and home were not always smooth but it is equally clear that Child G’s mother came to school to ask for support with showering, wheelchair issues and when there was a concern about Child G at College (having left the School already)*”.
- Attempts by the Advocacy Service to contact the Mother to offer Child G advocacy support, on 12 separate occasions, via both home and school.

6.3.3. In essence, the support actually received by Child G and the Mother, was far from what was being offered. With the benefit of hindsight, the efforts of many professionals might be viewed as somewhat disjointed – despite best efforts at the time. Due to the inconsistent engagement by the Mother and Child G it also created difficulty in setting appropriate goals and reviewing progress, for example in relation to care planning and programmes of support. Capacity in the Children’s Disability Team was an issue with relatively high caseloads against reduced management capacity and a vacancy. The reflections of professionals who did have contact over the life-time of their agency involvement does provide us with some insights. These include critical insights from Child G’s involvement with Hospice 2;

- During the admission in November 2015 [to Hospice 2] Child G “... *had a long conversation with a member of staff ... that the Mother did not get the right support and had to do everything on her own ... the help that had been offered ‘those people only nag’ ...*”.
- In September 2016 Child G “... *had a long conversation with a member of staff with reference to the housing ... and attempts to evict ... The member of staff asked Child G how the Mother was ... [and Child G] stated that she was finding life stressful but did not want to talk to anyone about it as they would go behind her back*”. Child G expressed concern that the Mother was not in good health herself.
- “*Child G’s expectations were that the care package would fail, as in the past professionals had broken promises or not delivered what they said they would*”.

⁴¹ Abraham Maslow’s model of human need often depicted as a hierarchy and the importance of achieving basic physiological and safety needs before being able, or motivated to, progress to more sophisticated levels of fulfilment or achievement e.g. educational achievement or self-identity.

- Attempts to train the Mother to support Child G's feeding, but her becoming "... increasingly anxious and eventually refusing to continue the training ..." ⁴²
- In relation to the frustrations around Child G's wheelchair "...Child G and Mother were somewhat understandably disillusioned with the provision and even more reluctant to engage and invest in the process which takes time and effort ... seeing all health services as the same entity ..." ⁴³

6.3.4. It is not unreasonable to conclude that the Mother and Child G found the multitude of professionals involved, appointments and meetings, as overwhelming. This view would have been formed over a number of years and their confidence in the professional system to offer support would have been steadily eroded over this time. This view was confirmed by the Mother in speaking with her. Despite some good efforts to rationalise some of this by, for example the Queen Alexandra Hospital offering combined clinical appointments; there is a sense that the professional response was unconsciously overwhelming a parent who was struggling. This is supported by references to the Mother having some mental health issues, feeling anxious, feeling that professionals might be spying on her and being let down by services, such as the wheelchair service. Munro⁴⁴ notes, *"It's all about relationships. We are talking about dealing with people with problems, with painful stuff. You have to know someone, trust them. They must be reliable and be there for you if you are going to be able to talk about the things you don't want to. The things that scare you"*. Research⁴⁵ confirms that the mothers of children with a disability are at increased risk of poor mental health compared with mothers of typically developing children.

6.3.5. Despite three separate referral attempts for Child G to benefit from independent advocacy, Child G only received support from an independent Advocacy Service on one occasion, that being the ICPC in August 2015. This proved a positive intervention and one that Child G is reported to have valued. Considerable efforts were made by the Service to contact the Mother (12 separate occasions plus visits to Child G's College), to further seek Child G's views however all of these were unsuccessful. Notwithstanding the difficulties in linking Child G with an advocate, it is evident that there was benefit to this even on this one occasion. There is merit in considering whether the Mother would also have benefitted from having her own advocate. Marchant⁴⁶ notes, *"Parents have traditionally been expected to act as advocates for their disabled children and it is still often felt that parents are likely to be the child's best advocates. For many children this is undoubtedly the case, and most parents will also take into account the child's own views and feelings. However, informal advocacy usually means the adult acting on their perception of the best interests of the child, rather than representing the child's own view"*. As noted above during the Police interaction in 2015, there was *" ... no evidence to indicate that mother does not truly believe that she is not acting in the best interests of her child ..."*. Whilst introducing yet another person into the already complicated set of dynamics may seem unnecessary, such a role may have greatly assisted and been well placed to articulate issues and concerns on the Mother's behalf in a way that she was unable to herself.

Practice Note: Children with multiple and complex needs, should always be offered an advocate when there is an expectation that they express their views and contribute to their own care arrangements.

Practice Note: Parents/carers of children with complex needs, or who are themselves experiencing multiple adversities may benefit from having their own advocate to help them navigate the professional network. Consideration should always be given to this as an option and it being seen as a source of support to enable them to

⁴² Portsmouth Hospital Trust report.

⁴³ Solent NHS Trust report.

⁴⁴ Munro, Professor E., The Munro Review of Child Protection – Interim Report, The Child's Journey, 2011, Opening statement by a parent in Family Perspectives on safeguarding and relationships with children's services, The Children's Commissioner for England, June 2010.

⁴⁵ Gilson, K., Davis, E., Johnson, S., Gains, J., Reddihough, D., Williams, K., Mental health care needs and preferences for mothers of children with a disability, 12/02/18, Child Care, Health & Development, Wiley.

⁴⁶ Marchant, R., Making assessment work for children with complex needs, in The Child's World, 2nd Edition, Edited by Horwath, J., 2010, Jessica Kingsley.

offer their child good enough care. Assessments should always consider the likelihood of parents with complex needs having mental health difficulties.

6.3.6. Whilst being subject to a CPP and having two Social Workers may have seemed an appropriate professional intervention at the time, actually having a Plan of this design against Child G's name appears to have achieved very little. Similarly, due to events occurring as they did in April/May 2017, it is reasonable to question the benefit of Child G being subject to a CiN Plan, despite this being a statutory requirement due to Child G's disability. In part, this is because of the lack of engagement by the Mother in the process, but also the duration of time Child G has been seen as a Child in Need, and the intermittent attendance by professionals over a significant and sustained period of time. The contribution and benefit of additionally having an EHCP – as an over-arching plan - is unclear despite the considerable efforts, often on a 1:1 basis, by Secondary School A to maintain Child G's educational development.

Support in responding to neglect

6.3.7. Parenting a child with a degenerative and life limiting condition is challenging. When an additional factor – such as neglect – is added to an already complex situation it will inevitably complicate matters. Horwath⁴⁷ helpfully categorises neglect; in this case the categorisation can be seen in a number of forms with Child G;

- Medical neglect – Clearly seen in this case by Child G not consistently brought to health and medical appointments or having access to the most appropriate health professionals.
- Nutritional neglect – Clearly apparent in this case given the malnutrition, weight loss and acute life-threatening episode, but also Child G being given junk food and high sugar content drinks of a regular basis.
- Emotional neglect – It is reasonable to conclude that given Child G's limited ability to have any form of independence, within his own home, as well as externally, but also the limitations of the interactions that he would have experienced more generally, Child G's emotional development and sense of self-worth would have suffered.
- Educational neglect – Child G missed a substantial part of formal education.
- Physical neglect – Child G experienced pressures sores, malnutrition, and other basic physical care needs.
- Lack of supervision and guidance – Limited evidence to indicate that this type of neglect occurred although Child G's reliance on sanitary products, when not needed, may be considered in this context.

6.3.8. Horwath also confirms what has been found to be so in this case *"... children who are particularly vulnerable to medical neglect are children with complex needs. These children are often more dependent than other children on their carer being able to recognise and meet their specific health needs ... may require intensive and extensive medical support for many years. These medical demands can place a strain on carers, particularly those living in poverty and without support systems ..."*.

6.3.9. It is on this basis that undertaking an informed assessment of parenting capacity, neglect and capacity to change – as previously stated - becomes a critical exercise; the contributions from all professionals would have been invaluable. The Mother was known to have financial difficulties, which manifest themselves through attempts to save money on sanitary products, struggling to pay household fuel costs and having significant arrears for housing, and facing eviction. The effects of differing levels of poverty and impoverished circumstances must not be minimised. Knowing exactly where to target intervention translates into a more meaningful package of support.

6.3.10. Whilst the neglect of Child G spanned many years from earlier childhood, the added complication of dealing with neglect of through adolescence into young adulthood means new challenges are faced by those in a caring role.

⁴⁷ Horwath, J., Child Neglect: Identification & Assessment, 2007, Palgrave.

These changes and developments over time went un-assessed. Research into Serious Case Reviews⁴⁸ & ⁴⁹ & ⁵⁰ highlights that not only are disabled children particularly vulnerable to abuse and neglect but that adolescents have a higher likelihood of suffering serious harm; with relevant factors being that professionals over-estimated the parent's ability to cope with caring for a disabled child, families not keeping appointments or having a large number of appointments, and issues of disability masking the child protection concerns.

Practice Note: Engaging with children and families, where adolescent neglect is a feature, may require a different professional mind-set to the one adopted when working with younger children. This is especially so, when working with adolescents with complex and long-term health issues. Thinking about, and following through with action, on the following issues may be helpful: transition arrangements from Children's Services to Adult Services at the earliest opportunity – possibly adopting a life-time care pathway model where a young person's needs and support are predictable, advocacy, and appointing a lead professional to coordinate health, education and care provision.

System architecture increasing complexity

6.3.11. During the period covered by the three Practice episodes outlined above it has become apparent that there was no one single agency or professional taking an active holistic and strategic view of the steadily deteriorating situation for Child G. One practitioner noted “... when I first met Child G (2015) ... I remember being really shocked and thinking I had never seen anyone so malnourished in my professional career ... I remember wondering how [Child G] could have got to this point ...”. This is a powerful reflection in that it questions how the professional network and multi-agency welfare system allowed such a situation to occur as early as 2015.

6.3.12. It is evident from the documents submitted to this Review, but also discussions with those closely involved, the system in Portsmouth (which will not be unique) for assessing, planning and intervening in the lives of children with complex needs has itself, become complex. It consists of a large number of agencies, all containing their own range of professionals and disciplines and each of which has its own systems, policies, procedures and working practices. On top of this there is an expectation that these individual agencies will work together to provide packages of support but also keep children safe. Nonetheless, the cornerstone of contemporary child protection practice is to collaborate and jointly take responsibility for safeguarding and promoting the welfare of children.

6.3.13. In this case, Child G was subject to a myriad of professional interactions, systems and processes. The complexity of working arrangements – it can be argued – increased risk. When multiple professionals became involved, as happened over the course of time, it added increasing layers of complexity. The oversight and management of this pathway therefore became more critical in order to maintain a focus on Child G. Examples of this include:

- The oversight of Child G's Education, Health & Care Plan by the Local Authority SEND Team who appeared to have oversight of the case yet being divorced from any active management in coordinating it or noting it failing. The main holistic and strategic activity appears to be conducting an annual review,
- The Children's Disability Team coupled with the Child Protection & Court Team,
- Patients with this type of degenerative and life limiting condition are managed by a number of doctors – this requires coordination, collaboration and sharing information,
- Allied health professionals, such as Physiotherapists, Occupational Therapists, Continence Advisers, and Dieticians each offering health appointments,
- Adult Social Care steadily becoming involved to support a transition from the Children's Disability Team to Adult Services,

⁴⁸ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, University of Warwick & University of East Anglia, May 2016.

⁴⁹ Neglect and Serious Case Reviews, University of East Anglian & NSPCC, January 2013.

⁵⁰ Ofsted, Learning lessons, taking action: Ofsted's evaluation of serious case reviews 01/04/07 to 31/03/08 & Ofsted, Learning lessons from serious case reviews: year 2, April 2008 to March 2009.

- Commissioned support, such as Care Agencies, Hospices and the Wheelchair Service needing to work with the above services.

6.3.14. It was somewhat inevitable that fault lines would appear and the support offer would be less than optimal, especially given the Mother's lack of engagement. Emergence⁵¹ is a key property of complex systems. The strength of the multi-agency system can be tested against its ability to respond to emerging issues which cannot be controlled, predicted or easily managed. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners. Examples of this emergence can be seen in this case;

- The professional response of not really knowing how best to deal with Child G's welfare once stepped down from child protection to Child in Need,
- The uncertainty caused by the assumption of Child G having mental capacity,
- The steady, unchecked, accommodation by some professionals to the Mother about her situation, at the cost of Child G's physical and emotional development,
- The split in thinking styles and operating cultures between health professionals and children's services.

6.3.15. Portsmouth Hospital Trust have reflected *"... It could be argued that there should have been a single lead agency with a clear objective around Child G's weight at that time. It is perhaps possible that each of the involved professionals felt that 'someone else' was taking responsibility for weight ..."* and *"...looking back, it appears that there may not have been sufficient clarity over which [professional] was taking overall responsibility at any given time, or whether there had been a handover of overall responsibility ..."*.

Practice Note: When there is a large group of professionals involved with a child and family, from different agencies, it is important for there to be a lead professional. It is easy to assume that somebody is doing this but is always worth checking and confirming. The lead professional does not have to be the person that has the greatest amount of contact. It should be the person that is able to take a holistic view about service provision across the partnership.

6.3.16. Marchant⁵² discusses the 'lead person' model and that, although not being the panacea for supporting children and families with complex needs, such a model does have value and can be viewed as the approach with the most common sense. Given the increasing fragmentation of services, particularly within the health economy, differing professional cultures, boundaries and processes increases vulnerability for children with complex needs and any professional response being disjointed. Calder notes *"If services are not properly coordinated, workers are not aware of the roles of other agencies or professions involved with the cases, or are simply not fully apprised of the 'facts' of a case, the probability of problems arising in case management appears to be far more likely. In extremes, this can potentially lead to the network's failure to protect the child, and perhaps leave the child open to the risk of serious injury or death"*.

6.3.17. Strategy and coordination of services are vital. From a complexity perspective, the major issue in splitting services is that it often increases complexity. Each practitioner inevitably works with the whole person, not just one part. Service users make their own minds up about who they like, and are prepared to work with, or not. It is therefore improbable to expect all of the relationships to operate in a mechanistic way simply because the people involved work for one particular agency, have their own procedures to follow and have undertaken a specific form of training. One example of where this was an issue concerns Child G's continence needs. The fact that multiple appointments had been missed meant that the Continence Service removed Child G from their caseload list with there being a 33 week waiting list. It was acutely obvious that Child G was in need of access to this service and being removed from a list to then have to wait eight months to access it again made no sense whatsoever. Had there been someone taking an overview about this situation, providing coordination and advocating on Child G's behalf it might have prevented this from

⁵¹ Seel, R., Emergence in organisations, 2006.

⁵² Marchant, R., Making assessment work for children with complex needs, in The Child's World, 2nd Edition, Edited by Horwath, J., 2010, Jessica Kingsley.

occurring. Marchant⁵³ states; *“The concept of good enough parenting can be particularly challenging to apply with families of children with complex needs. Some children undoubtedly need more parenting or more skilled parenting than others; some children need ‘intensive’ parenting for much longer than others. Some children are parented in a far less supportive social context than others. Parenting a child with complex needs is, by definition, likely to be more complicated, more time-consuming, less familiar, more anxiety provoking, physically harder and emotionally more difficult. Knowing just what is involved in a child’s day to day care can operate powerfully on our expectations about what is good enough parenting. One possible consequence of realising the demands is a downward shift in our assessment standards, for example lowering expectations of what constitutes reasonable parenting ... The more complex the child’s needs the higher the risk of skewed expectations and standards ... we should not expect less for certain groups of children”*.

Practice Note: Maintaining a balance on the welfare of the child versus supporting the parents/carers to ensure that welfare is at a good enough standard can therefore be challenging; this is especially so for children with complex needs that require intensive care and support. Using assessment tools can help benchmark standards, and by implication, the levels of support needed over time.

Practice Note: *“Complexity makes it hard for practitioners to understand cause and effect, predict outcomes and control the course of events. To manage complexity, the team around the child may need to operate as a strategic unit rather than a collection of tactical interventions. When complex cases become ‘stuck’, professional networks may need additional support and consultation from specialist agencies”*⁵⁴.

Support, engagement and resistance

6.3.18. A critical factor throughout was the Mother’s lack of engagement. As already stated, there was no explicit assessment completed throughout the time of Children’s Services involvement specifically exploring the Mother’s capacity to change. This is despite the persistence of limited engagement. Without the Mother’s participation it proved very difficult to offer meaningful support. To support learning in this area, it is helpful to consider research completed about working with highly resistant families⁵⁵. This research highlights three potential characteristics of families that are resistant;

1. Families that are dangerous
2. Families that are unresponsive to various type of interventions
3. Families that do not respond to treatment in a timely manner

6.3.19. It may also be helpful to consider, within the above three types, different features of reluctance, including;

- Engagement: families’ behavioural compliance with expectations and demands of tasks required
- Motivation: an internal force that moves people to behave in a particular way
- Denial: when individuals’ accounts are inconsistent with the objective truth
- Resistance/ambivalence: when clients are motivated and engaged but are stuck at a certain point due to conflict between their wishes and fears.

Practice Note: When working with parents/carers who fail to engage with professionals, it is important to remain alert to becoming desensitised to the child’s needs and safety, normalising neglect, downgrading the viewpoints of other professionals who have a different perspective, over-identifying with the parent/carer, ignoring the cumulative effect

⁵³ Marchant, R., Making assessment work for children with complex needs, in *The Child’s World*, 2nd Edition, Edited by Horwath, J., 2010, Jessica Kingsley.

⁵⁴ Hood, R., How professionals experience complexity: An interpretative phenomenological analysis, *Child Abuse Review* Vol 24: 140 – 152, 2015, Wiley.

⁵⁵ C4EO, Effective practice to protect children living in ‘highly resistant’ families, March 2010.

on the child, and developing a fixed view about how the case should be managed. Seeking a skilled, fresh and impartial perspective on a regular basis may help avoid falling into these traps⁵⁶.

Specialist services for Child G

6.3.20. Child G was in receipt of a number of specialist services – continence, physiotherapy, occupational therapy and a wheelchair service. One single feature that stands out from the chronology, documents and discussions where specific support could have improved the quality of life of Child G's life relates to the wheelchair. Throughout the timeline difficulties with the wheelchair persisted – whether it be comfort, fittings or suitability. One practitioner reflected that *"The wheelchair provision throughout appears ... [to have] ... resulted in Child G being confined to bed with no other means of getting out and about for over a year. The mental anguish this must have caused to a young person with a life limiting condition is unquantifiable ..."*⁵⁷. This particularly relates to a specialist motorised wheelchair. From a safeguarding perspective it is relevant for the following reasons;

- Causing psychological harm from being unable to attend College for 18 months, meet with peers and attend age appropriate activities.
- Causing physical harm due to the extensive delays in providing a suitable wheelchair contributed to the development of pressure ulcers, and Child G was unable to change posture.

6.3.21. It is important to understand the factors which may have contributed to this happening. The Wheelchair Service experienced a change in how it was commissioned and managed in 2014 – 2015. Records did not fully transfer from the previous providers, meaning they were incomplete. It has also come to light that there was a backlog of two years of work, with over 1000 open referrals. Staff who had been in post for a long time left, meaning a lack of continuity, leaving the remaining staff to respond to the backlog of work. Given Child G required specialised seating arrangements it has been found that there was no service level agreement in place to provide such services effectively and in a timely manner. Due to the issues discovered, this Review is able to report of there being a separate investigation being undertaken about this service.

6.3.22. Clearly, the above organisational issues had a significant impact on the quality and effectiveness of service delivery, although records do indicate multiple attempts by the Wheelchair Service to contact the Mother. As a consequence of the failed service delivery, a severely disabled child was further disabled by a service that was designed to empower. A perspective, and bias, evolved which portrayed the wheelchair service as being inadequate. Concerns expressed by other professionals persisted, and yet no resolution appears to have been found; professional challenge and formal escalation do not appear to have ever been considered, nor any attempts to understand why the specialist service was not able to provide an effective service for Child G. In many ways the issues about the wheelchair are symbolic of other aspects of this case; drift in responding to an issue that was steadily having a significant impact on Child G, and no escalation of how poorly the Service was responding to Child G needs.

Practice Note: In any situation, when a child is assessed as requiring specialist equipment which enables them to either function on a daily basis or be safe, and there is a failure to provide such equipment in a timely manner, the matter should be escalated until a satisfactory conclusion is reached.

6.3.23. In summary, the quality and effectiveness of support offered to Child G and family has been shown to be not as effective as it might have been. This is due to a number of contributing factors which include; Child G having multiple professionals attempting to offer support for the disability, this support being complicated by neglect, the complexity of the organisational system surrounding Child G, the lack of engagement by the Mother, and the deficits of a specialist service provision.

6.4. The quality & effectiveness of communication with Child G & family

⁵⁶ Research in Practice, Engaging resistant, challenging and complex families, 2012.

⁵⁷ Solent NHS Trust.

6.4.1. Statutory guidance⁵⁸ states “... every assessment must be informed by the views of the child as well as the family. Children should, wherever possible, be seen alone and local authority children’s social care has a duty to ascertain the child’s wishes and feelings ...”. On this basis, there are numerous examples of situations where professionals did seek the views of Child G, or attempted to, but also sought the views of the Mother. These include;

- The therapy professionals e.g. Occupational Therapy and Physiotherapy, working with the Mother and Child G over a sustained period of time and building a relationship with both.
- The attempts by the Community Paediatrician, and team, to build a relationship.
- Efforts by the Social Workers to establish a relationship with Child G by persevering with visits at both home and College.
- The efforts of the Child Protection Conference Chair to visit Child G at home and seek views about the CPC process.
- Attempts to engage the Mother face to face, by phone, e-mail or text
- The Advocacy Service’s work with Child G during the ICPC, but also their attempts to engage Child G after the Conferences.
- Hospice 1 & 2 providing Child G with a safe space in which to share and discuss any concerns – which Child G often appears to have used to reflect on some aspects of care at home which highlighted how the Mother was not providing optimum care.
- The decision to seek, and gain, an assessment of Child G’s capacity to make informed decisions.
- The involvement of the GP, particularly in relation to a frank exchange concerning Child G’s condition and prognosis.
- The efforts of the Care Agencies care staff who were able to build a relationship with Child G, and by implication the Mother over a period of time.
- Secondary School A’s young person centred annual reviews ensuring Child G’s views were taken into account.
- The interaction between Child G and the medical team at Portsmouth Hospitals NHS Trust during the acute episode.

6.4.2. All of the above examples need to be placed in the context of the high number of missed, or not attended, appointments. Many, if not more, of the above examples to seek Child G’s views were often thwarted by Mother’s influence. On occasions, records indicate that Child G’s response was coached by the Mother. In meeting the Mother and Child G both expressed a view that they did not feel listened to enough particularly in respect of care and support needs. It is however plainly apparent that Child G was expressing a mostly consistent view of being comfortable with the Mother being the main carer. There is a certain inevitability about such levels of loyalty between Mother and child especially when looking at this situation through an attachment behaviour lens⁵⁹. This reinforces the fact that professional effort needed to focus on assessing, and evaluating, the Mother just as much as Child G, as being the key to ensuring Child G’s safety and welfare.

6.4.3. A number of practitioners have highlighted that Child G was not aware of the implications of the degenerative condition, as no one professional had provided this information. During the acute episode, Child G was given full information which helped with decisions being made.

6.4.4. Whilst the ‘rules’ state that professionals must ‘... ascertain the wishes and feelings of the child ...’, it is important to remind ourselves why we do this, and not see it as a consequence-free exercise. The purpose of seeking wishes and feelings is to inform assessment, gauge levels of insight into capacity to change, and then inform intervention. The role of the professional working in a statutory agency is not simply to be-friend a service user and may involve making difficult decisions at times. For some professionals, their attempts actually had the impact of empowering the Mother by permitting her passive level of compliance to continue without challenge; thereby reducing overall compliance during a period of time when Child G needed more active management and support. Had this been the case, the acute

⁵⁸ Working Together to Safeguard Children, HM Government, 2015 (Amended 2017).

⁵⁹ Howe, D., Child abuse and neglect: attachment, development and intervention, 2005, Palgrave.

episode may have been avoidable. In many respects there were elements of collusion, albeit unconscious, between a small number of professionals and the Mother. Some of this appears to be based on a hypothesis that the Mother was profoundly affected by her child's diagnosis and having a degree of sympathy for her. Such an outcome is symptomatic of working with families who engage with professionals in a passive or partial manner. The drift and delay caused by this superficial engagement undermines and dilutes the impact of the professional response and shifts the focus away from the child's safety and welfare.

Practice Note: Statutory guidance⁶⁰ states “... no single professional can have a full picture of a child's needs and circumstances, and if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action. ... Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children with them or placing the interests of adults ahead of the needs of children.”.

Practice Note: Unconscious collusion with the parents/carers of a child can be caused by one worker having to hold, and see, simultaneously, the needs of the parent and the child. The impact on the child can be significant. Seeking effective support is critical to reducing the likelihood of this occurring as well as having effective management oversight and monitoring.

6.5. The quality & effectiveness of agencies use of information, gathering & sharing of information about Child G & family

6.5.1. Often, when conducting case reviews, the concern relates to information sharing problems between professionals and agencies, with information about risk not being communicated⁶¹. However, on this occasion a failure or lack of information sharing does not appear to have been a major issue.

6.5.2. There is ample evidence in case records to demonstrate that information about Child G's health and safety needs were communicated to a range of professionals. Notably, concern about Child G's circumstances were shared by those from a health-related profession on a consistent basis via phone calls, meetings and e-mails or letters. Records of meetings, whether they relate to Child G being subject of a CPP, CiN Plan, or other multi-disciplinary forums, express information and concern about the unfolding situation throughout the time period under review.

6.5.3. The issue in this case was, the response by the professional network. One practitioner reflected that there was “...frustration between professionals about each other's' responses and nothing being done ...”. Other practitioners have spoken about “... helplessness and frustration ... there being issues around professional disagreement ...feelings of banging your head against the wall when concerns are rejected as serious ... seeing no improvement and the system becoming stagnant ... staff distress and anxiety seeing the deterioration by not being able to do anything about it ...”.

6.5.4. As already highlighted, as there was no one single professional or agency knowingly taking a holistic and strategic perspective about Child G's situation, drift occurred. Other than the acute episode on April/May 2017 there was no single incident which prompted any professional involved to consider escalating their concern. The step-up to managing Child G's circumstances via a CPP, whilst a relief to many health practitioners involved, failed to yield the desired results of a sustained improvement to Child G's care. Information was gathered (albeit without a focused assessment being conducted as already discussed) and shared; the majority of professionals involved had known concerns yet failed to escalate these using existing mechanisms.

Practice Note: The onset of an acute episode in cases of neglect can have the effect of raising practitioners concerns about how a case is being managed and provoke a more interventionist response by agencies. Where there is no acute episode, but instead a more chronic pattern of concerns it is important to remain alert to drift, professionals being desensitised by the impact of the neglect and professional accommodation of the status quo. Drift on a case, in the short time-frame of childhood, can be significant for a child and ensuring there is regular and meaningful oversight of

⁶⁰ Working Together to Safeguard Children, HM Government, 2015 (Amended 2017).

⁶¹ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, University of Warwick & University of East Anglia, May 2016.

the child's lived experience is important. Information should be updated, chronologies re-examined and assessments of risk re-appraised.

6.6. The quality & effectiveness of any transition planning for Child G from Children's services to Adult Services

6.6.1. At the point of admission in April/May 2017, Child G was three months short of an 18th birthday. Records indicate a mixed picture about transition arrangements from children's health services to adult health services. From a health perspective Solent NHS Trust Children's Therapy Service reports that '*... the transition period for different services is at different ages and provision varies depending on age ...*'. Some of this appears to be due to non-attendance by Child G at health appointments over the course of time thereby causing difficulty in effective hand-over. It would seem logical for the age of transfer to be consistent and unified across all services.

6.6.2. The Local Authority Children's Disability Team have recorded that a referral was made to Adult Social Care in May 2016, well before Child G's 17th birthday. Records indicate that this referral was received by Adult Social Care however there appears to have been limited involvement for some months following referral – the reasons for this being unclear. The matter was however followed up with the Adults Social Worker attending a multi-disciplinary meeting some six months after receiving the referral. Further attendance at CiN meetings then took place from January 2017. The events in April/May 2017 appear to have galvanised further action, which included consideration of future options for Child G, possibility about greater control over financial and independence and a care package.

6.6.3. One of the contributing factors to a stalled transition from children's services to adult services has been cited as there being no named worker to co-ordinate the handover. NICE guidance⁶², supported by legislation⁶³ states that for children with an ECHP transition planning should begin from 15½ years of age and there needing to be a named worker. In this case, as Child G's prognosis, care and support needs were somewhat predictable there was no reason to delay arrangements. The original referral to Adult Social Care in May 2016 was clearly an attempt to do this, although resulted in a delay.

6.6.4. This Review has highlighted the vacuum in the law around there being no criminal charge for neglect during the ages of 16 – 17 years. It has also highlighted the disparity in transition ages from child health to adult health services during this age, and any disconnect this may have with the transition age from child to adult social care services. From a safeguarding perspective there is a further complicating factor, which has already been examined, relating to a child of this age being viewed as a competent minor i.e. as being assessed as having mental capacity to make decisions. Given the complexity of the issues already explored in this case, such a scenario strengthens the importance of having a lead person/agency and using advocacy during major transitions. Child G remained a highly vulnerable young person despite being assessed as having competent thinking. Whilst the actual transition from children's services to adult services, on the whole, appears to have worked well once fully initiated – it might be argued that this was simply because the professional network was forced into a situation of having to manage it due to the acute episode in April/May 2017.

Practice Note: Those children and young people who have complex needs due to disability are more likely than not to require a life-time of care and support from agencies. Life time planning and preparation for this makes sense, and having one lead agency who are able to take a holistic and strategic view might be pivotal in the success of such arrangements.

7. Good practice

7.1. The focus of this Review is to learn and improve services. As such, it is important to capture good practice which supports outcomes for children. Many examples of good professional practice have been highlighted and a selection are summarised below;

⁶² NICE guidelines: Transition from children's to adults' services for young people using health or social care services, NG43, February 2016.

⁶³ Care Act 2014 & Children & Families Act 2014.

- The agencies and professionals involved with Child G have been open and honest in their reflections and reporting, and the participation and willingness to contribute to this Learning Review has been commendable.
- The Social Work reports provided for the Initial, and Review, Child Protection Conferences are well written and provide a clear and comprehensive account of the history and issues of concern.
- The Advocacy Service made numerous attempts to contact Child G and the Mother, rather than settling for a failure to engage early on.
- Evidence of good written information and sharing between Paediatric Consultants in University Hospital Southampton.
- The tenacity and professionalism of the Children's Community Nursing Service in raising the profile of Child G's situation during the acute episode.
- The tenacity and persistence of many professionals in their attempts to make contact with, and engage, Child G's Mother throughout the time period under review.
- The quality of the relationship Child G had with carers at Hospice 1 and 2 was a positive feature for Child G.
- The quality of the relationships between Child G and particular Care Worker's from Care Agency 1 and 2 was positive and strong.
- The identification of a single, and trusted point of contact for Child G's Mother at Secondary School A, which clearly improved relationships between home and school.
- The efforts of the Social Worker whilst Child G was subject to a Child Protection Plan, to establish a relationship with Child G and the Mother – which seemed to have had a positive impact.
- The levels of support provided to Child G by Secondary School A's but also their identification and referral about concerns of neglect.
- The contributions of College A in supporting and facilitating Child G's time whilst in College.
- The health and medical professionals provided expert care and intervention, which saved Child G's life during the acute episode in 2017, which included the paediatric team in bringing together a multi-disciplinary team to deliver an integrate management plan.
- The Child Protection Conference Chair's efforts to visit Child G at home for the purposes of ascertaining Child G's views ahead of the Conference.
- The service provided by Hospice 1 & 2 for Child G, who clearly enjoyed time spent there.

8. Conclusion

8.1. This Learning Review has examined the circumstances in which Child G experienced both chronic, and acute, neglect to the point of near death. It has gathered documentary information from a large number of agencies and organisations who had contact with Child G over a number of years. It has benefitted from the contributions of those practitioners who worked closely with Child G as well as those who had greater oversight of the care and support being offered. At the point the Review was finalised both Child G and the Mother were able to offer their contributions and perspectives.

8.2. The Review has highlighted many aspects of good practice. It is vital that these are used as a platform to build on and strengthen the multi-agency safeguarding arrangements across the Portsmouth area. Sharing and praising practitioners for the work they do well is important.

8.3. The Review has also highlighted a number of complicating factors and areas where practice could have been more robust, or where a different course of action might have been considered. These serve as reminders of the constant need to remain child focused but also alert to how the human factors inherent in the complexity of child protection work can divert attention away from what the child needs.

8.4. These complicating factors have included; Child G's condition which was confused by neglect and lack of parental engagement – this complicated the professional response; professional relations impeding effective joint working; thresholds for intervention and escalation being confused particularly when adding mental capacity into the mix, and no one single identified lead professional taking a holistic and strategic view about Child G's situation.

8.5. The Review has identified a number of learning points throughout – expressed as Practice Notes – for agencies and professionals to consider and use to strengthen their practice.

8.6. The Review concludes with recommendations to the LSCB, which build on the recommendations and actions already identified by single agencies.

9. Recommendations

9.1. A number of single agencies have identified learning during the process of examining their involvement in this case; as such they have completed action plans and are already working to make improvements to services. In a number of cases, actions have already been taken to avoid reoccurrence. The following additional recommendations are provided to further strengthen practice around the areas identified.

1. The LSCB to promote the learning from this Review across all relevant partner agencies, and seek assurances that it has been disseminated and embedded.
2. The LSCB to monitor implementation, and seek progress reports, on the implementation and embedding of actions from all single agency action plans,
3. The LSCB to review the current stage 5 aspect of escalation protocol to reflect a broader range of circumstances in which professionals may raise dissent or disagreement, beyond that which relates to child protection processes. Once strengthened, the LSCB, and member agencies, to promote across the workforce and monitor implementation,
4. The LSCB to collaborate with the Adult Safeguarding Board to undertake an audit examining the quality and effectiveness of transition arrangements between child and adult services. In order to focus this piece of work, consideration could be given to examining those cases where children have complex needs and the transfer of care arrangements is likely to be the most complicated,
5. The LSCB to seek assurance from the safeguarding partnership about the quality and effectiveness of the multi-agency contribution to safeguarding and supporting children with complex needs. In order to focus this piece of work, consideration could be given to examining those cases where children have been subject to an EHCP for over two years and may involve an audit of Child in Need case management to evidence purpose, pace and impact.
6. The LSCB to make relevant enquires and examine whether there are blocks and barriers to the use of the neglect assessment tools across the safeguarding partnership, given the extent of training and briefing sessions provided.
7. The LSCB to seek, and issue, clarification about the role of the MASH for when professionals from all agencies refer concerns about a child's welfare or safety, and it is an open case to Children's Services. This to include clarification about how the MASH route the contact/referral and their response to new information.
8. The LSCB to promote greater understanding across the safeguarding partnership about mental capacity, decision making and implications for safeguarding of children between the ages of 16 – 18 years.
9. The LSCB to seek assurance from the CCG about how the learning from this Review in relation to the GP Practice can be shared to other GP Practices.