Learning Review

Child G

Summary of Learning, Findings and Recommendations

Independent Reviewer: Kevin Ball

1. Introduction to the case & Learning Review

1.1. Based on statutory guidance[1] 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 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.

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,

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

- 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,
- 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. Findings & analysis

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?

- Case management became increasingly complex over time due to Child G's physical condition and care needs, complicated by neglect.
- The physical neglect was a slow and steady process which was seen and monitored by a number of professionals. Child G's physical appearance 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.
- 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.

5. Conclusion

8.1. This Learning Review 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.

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.

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.

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.

The Review has identified a number of learning points for agencies and professionals to consider and use to strengthen their practice.

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

6. Recommendations

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.