



Serious Case Review

Child H

Review report

Independent Reviewer: Kevin Ball

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1. Introduction to the case & review

1.1. Based on statutory guidance¹ Portsmouth Safeguarding Children Board concluded that it was appropriate to conduct a Serious Case Review examining the circumstances of agency involvement with a nine year old child who, for the purposes of this report will be known as Child H.

1.2. Child H had epilepsy but also a lifelong condition that affected movement and coordination and which required specialist services. Child H died in the autumn of 2018. The outcome of a post mortem has concluded that the cause of Child H's death was as a result of bronchopneumonia coupled with complications associated with a premature birth, cerebral palsy, hydrocephalus and epilepsy. The outcome of a lengthy Police investigation is that there was insufficient evidence to pursue a prosecution and as such, no further action will be taken.

1.3. The case is subject to review as Child H had been known to statutory services for many years and at the point of his death, Child H was the subject of a multi-agency Child Protection Plan. Such a Plan is designed to offer a child a level of safety and protection from the identified risk and vulnerability factors. It is therefore important for the Safeguarding Partnership in Portsmouth to examine any opportunities to learn and make improvements.

1.4. By way of a summary, the review has highlighted a number of lessons for the Safeguarding Partnership. These include;

- All professionals should understand what it means, and what to expect, when a child is subject to Child in Need processes. Where expectations are not met professional challenge should be seen as the norm.
- All health services to children across the local area should ensure electronic databases are compatible to support timely and effective information sharing. Care pathways (and shared pathways) need to reflect this compatibility.
- There should be greater awareness about the concept of medical neglect of children across the safeguarding partnership, especially so when professionals are working with children and families with multiple risk factors.

2. Process for conducting the Serious Case Review

2.1. Portsmouth Safeguarding Children Board commissioned Kevin Ball as the Independent Reviewer². The approach taken adhered to the principles as set out in statutory guidance³ and adopted a model of learning using systems ideas based on a Soft Systems Methodology⁴. As such, the process has identified opportunities for professionals and organisations to learn and improve safeguarding practices from a whole safeguarding system perspective.

2.3. Following the decision in September 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, who also maintained oversight and quality assurance of the review process.

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, HM Government, 2015 (Amended 2017).

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.

- Following a briefing session for single agency authors, single agency reports and chronology were requested and submitted⁶. This process provided each agency with the opportunity to reflect on their involvement with Child H and his family – from both a single agency 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.
- Two facilitated multi-agency workshops involving practitioners and managers who had come into contact with Child H and family. The initial workshop (March 2019) offered the multi-agency network the opportunity to examine what happened in this case, and seek an understanding about the underlying reasons why events occurred as they did. The second workshop (October 2019) provided an opportunity for practitioners and managers to help shape the learning and improvement activity as a result of the findings.

2.4. The timeframe for the Review would be from August 2015 through to Child H’s death in August 2018. 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;

3.2. Seeking the contribution of family members has been an important consideration. Due to the Police investigation there were delays in making any meaningful approach to the parents. Once contact was possible, both parents were contacted but chose not to contribute to the review.

Individual:	Identified as:
Child H -	Child H
Mother to Child H -	Mother
Father to Child H -	Father
Sibling 1 to Child H -	Sibling 1
Sibling 2 to Child H -	Sibling 2
Sibling 3 to Child H -	Sibling 3

4. Summary of relevant case history

4.1. Summary of relevant case history prior to the timeframe under review:

4.1.1. Child H, and siblings, were subject to a Child Protection Plan during 2010 due to concerns about neglect, parental care from birth and the parents’ failure to engage with professionals. Of note, Child H was not brought to 32 appointments and the sibling had not been brought to 42 appointments (of which 30 were joint appointments with Sibling 3). Child H’s Father had engaged on a drug treatment programme with the Adult Substance Misuse Service in 2010 and was in receipt of an opiate based drug prescription. The Child Protection Plan was judged to have been effective in bringing about changes resulting in it being discontinued six months later and the case being closed.

4.1.2. A Statement of Special Educational Needs for Child H was agreed in April 2012 when four years old. At the same time Child H was assessed as a Child in Need⁷, given his ongoing level of need. Child H had the continued involvement

⁶ Single agency reports were submitted from the following agencies;

- Portsmouth City Council Children’s, Families & Education Services
- Hampshire Constabulary
- Portsmouth City Council Education Services
- Portsmouth Hospitals NHS Trust
- Adult Substance Misuse Services
- Solent NHS Trust
- NHS England
- South Coast Ambulance Service
- School A
- GP Practice
- Wheelchair Service
- A voluntary sector organisation

⁷ Child in Need - 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

of the Sensory Impairment Service, Children's Social Care, Occupational Therapy and Speech & Language Therapy. Child H's attendance at school between 2012 and 2015 was mostly positive ranging from 80 – 98%. In 2015 Child H began having medical investigations into epileptic seizures.

4.2. Summary of relevant case history during the timeframe under review (August 2015 – August 2018):

4.2.1. In reviewing the multi-agency case history, and with the benefit of hindsight, there are a number of features from case records that stand out. These are clustered below and reflect a considerably summarised account of the case history. A considerable amount of the information provided below was known or knowable at the time.

4.2.2. Father's involvement with the Adult Substance Misuse Service

4.2.3. As stated, the Father had been engaged in a treatment programme since 2010. In December 2015 the Father expressed concern to the Substance Misuse Service about the impact of his drug use on his partner and the children. A urine test was positive for opiates.

4.2.4. Between January 2016 and January 2017 the Father's engagement with the Service fluctuated with regular failures to collect his prescription for a number of days at a time or failure to attend appointments. Information relating to these failures was communicated to Children's Social Care who were involved with the family.

4.2.5. In January 2017 the Father self-reported to be fully stable on a prescription provided by the Adult Substance Misuse Service however testing showed positive results for opiate and cocaine indicating that he was not stabilised as reported. In March 2017 a further drug test on the Father was positive for illicit drugs. In May 2017 the Pharmacy contacted the Adult Substance Misuse Service advising that the Father had not collected three doses of his prescription. This prompted a discharge letter being sent to the Father with an offer of a final appointment in June. This information was shared with Social Worker 1 in the Children with Disabilities Service. In August 2017 the Adult Substance Misuse Service conducted an unannounced visit to see the Father who reported using a street substitute to manage his opiate addiction but requesting to re-start prescriptions; despite this request and efforts by Social Worker 1 to encourage him to attend, it did not result in any further contact from him. In September 2017 the Father was discharged from the Adult Substance Misuse Service due to non-attendance.

4.2.6. Information & intelligence from the Police

4.2.7. Police records highlight a significant amount of information and intelligence⁸ relating to both the Mother and Father indicating their involvement in Class A drug misuse and supply (particularly heroin and crack cocaine), along with other criminal offences. The Father was known to be linked to a number of drug dealing networks locally and across the region, but also known to misuse alcohol, and commit violent offences. During the timeframe under review 13 separate intelligence reports were received by the Police relating to either the Mother or Father being involved in the use of, or supply of, drugs – including cannabis, crack cocaine and other Class A drugs. Police records around this time indicate that it was known that there were children in the household, but information relating to the drug use/supply was not routinely shared with any other agency. Records show that it was shared on two occasions, February and July 2018.

4.2.8. Unplanned emergency admissions for Child H

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.

⁸ Police information refers to all information obtained, recorded or processed for a policing purpose. Intelligence is collected information that has been developed for action and may be classified as confidential or sensitive. Intelligence collection is a continuous process and there may be specific requirements for its recording and use; College of Policing - [Information](#) & [Intelligence](#), accessed 21/10/19.

4.2.9. Records highlight 14 unplanned emergency admissions to hospital for Child H as a result of epilepsy seizures during the timeframe under review. Prior to this timeframe Child H is not reported as having seizures. Review has highlighted that for the majority of these attendances standard procedure in terms of undertaking checks of records was not completed. This includes:

- Safeguarding checklists not being completed at-all on at least nine occasions.
- On the occasions that a safeguarding checklist was completed the Mother (when she attended) gave false information about the involvement of Children's Social Care, ticking 'no' to having a Social Worker.
- The Korner⁹ form was not completed, meaning that no social history was gathered and no prompt to complete the safeguarding checklist.
- The Child Protection Information System (CPIS)¹⁰ was not checked to see if Child H was subject to a Child Protection Plan or was a Looked after Child.
- On four admissions, Child H was not accompanied by a parent.

4.2.10. Routine health and medical care for Child H

4.2.11. As a consequence of premature birth Child H, and sibling, both had significant disabilities. Their health needs required the input on a regular basis, throughout the timeframe under review, of numerous services from Solent NHS Trust and included; community paediatric service, community nurses, school nurses, occupational therapists, physiotherapists, orthotists¹¹, speech & language therapists.

4.2.12. **2016:** In June 2016 during an appointment Solent NHS Trust Community Children's Nurse noted that Child H had gained 1Kg in weight in 12 months. This resulted in an action to discuss the matter with the Community Paediatric Service. The day after this appointment the Mother did not attend a review appointment with Child H with a Consultant Paediatrician, the School Nurse and the Dietician. The Consultant swiftly wrote to the Mother advising her to attend these appointments. Records indicate that the following week Child H had a health and medication review at a Community Paediatric Clinic and no concerns were expressed about his health needs not being met. In October 2016 Portsmouth Hospitals Trust Paediatric Team wrote to the Mother following a telephone consultation about not attending health appointments, stating *'failure to do so will result in referral to Children's Social Care as this is neglecting the health of the [children] ...'*. This letter was copied to Social Worker 1. In early December 2016 the Hospital Paediatric Team received a letter from the Community Paediatric Service following Child H's attendance at an appointment during which a comprehensive and holistic review was completed. The letter advised that due to repeated seizures his care should be managed by the Hospital acute setting. Concerns were expressed about the Mother not taking Child H to a neurology appointment, as a way of assessing other possible remedies for managing the seizures. A new medicines regime was suggested which is stated would require the Mother having training.

4.2.13. **2017:** In February 2017 an email from the Specialist Epilepsy Service was sent to Consultants expressing concern, *'... there is absolutely no point in us keep sending appointments for this child. I am not at all certain that the parents give his medication; certainly it came to light at his last admission due to seizures in November that they were only giving it once a day ... does he have a social worker?'* One response to this email was *'... I don't think he has a social worker does he? ...'*, and another *'... no social work involvement ...'*. In March 2017 there was a review by Portsmouth Hospitals Trust about Child H's epilepsy which resulted in him being discharged from the care of the Hospital Specialist Epilepsy Service back to being managed by the Community Paediatric Service. In June 2017 Solent

⁹ Korner forms provide a standardised data collection mechanism across the NHS used at the point of admission.

¹⁰ CPIS is a national mechanism available to NHS services to check whether a child is subject to a Child Protection Plan or is a Looked after Child in the care of a local authority.

¹¹ Orthotics relates to the design, manufacture and application of externally applied devices to the body, to modify structural and functional characteristics of the muscular and skeletal system.

NHS Trust highlighted that Child H had not been brought to nine appointments. In November 2017 Child H and the Mother attended a Community Paediatric Service outpatient appointment which highlighted confusion and miscommunications about the medicines dosage regime for managing Child H's epilepsy.

4.2.14. **2018:** In January 2018 Solent NHS Trust supervision notes for the School Nurse highlighted a possible need for an Early Help assessment due to non-attendance at health appointments, no hygiene pads and incorrect medication being provided to the school. Email correspondence in January 2018 from the Specialist Epilepsy Service to Social Worker 1 noted, *'Child H has not been brought to any of the epilepsy clinic appointments offered. We are unable to keep sending for him and wasting much needed appointments ... Child H is under Community Paediatric Service and those appointments will be easier for family to attend. I have checked and see that the appointments missed were March, August and November 2017. He was most recently admitted due to seizures in October, November and December 2017. There should be no confusion ... [about the medicines] ... this was confirmed by [the Paediatric Service] ... last week. I too have concerns and have voiced these to the [Community School Nurse]. ... it is very unusual for children to have repeated admissions with seizures [when] receiving their medication regularly and attending appointments ...'*

4.2.15. Child H had regular contact and involvement with the Orthotics Service and the Wheelchair Service during the timeframe under review. Often both of these services were provided via School A which inevitably meant that parental involvement was limited or non-existent.

4.2.16. Child H and family were registered with one GP throughout the timeframe under review. In March 2018 the GP queried the dosage of one of the anti-epilepsy drugs, concerned that it may be being administered at a higher dosage than prescribed by the Paediatric Service.

4.2.17. Statutory processes

4.2.18. Records highlight four different processes taking place throughout the timeframe under review, with three of these appearing to run concurrently. These include;

4.2.19. **Education, Health & Care Plan process:** In April 2012 Child H was assessed as being eligible for a Statement of Special Education Needs; this statutory assessment later transferred to being an Education, Health & Care Plan¹² (EHCP) requiring annual reviews and monitoring. Records highlight reviews as taking place in February and August 2016, February and July 2017, with a transfer from a Statement to an Education, Health & Care Plan in March 2018. Each time, there were no changes requested and the educational offer remained the same. Positive progress was always cited, the parents appeared engaged in the process for the review and a copy of the Statement, or Plan, was sent to the school, educational psychology, child development centre, Social Worker 1 and short break provision.

4.2.20. **Early Help/Team around the child process:** Records submitted indicate that some professionals were attempting to support Child H, and his family, via the Early Help/Team around the child process (TAC)¹³. Records highlight that TAC meetings were held: January, April, July and November 2017 and were convened by the School and Solent NHS Trust. In January 2017 the first TAC meeting considered the parents failure to attend appointments, lack of contact between home and school and because there was an issue with basic needs equipment from home not being sent in to school. Records from three TAC meetings show that a range of professionals attended, including Social Worker 1 and the Mother; a plan, with actions, was created at each. Records also show that not all professionals were

¹² An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs. EHC's superseded the previous system known as a Statement of Special Educational Needs, HM Government.

¹³ Early Help/Team around the child process is explained as a tier 2 service offer by the Portsmouth LSCB Thresholds Document, which describes children with early identifiable needs, often around a specific issue. These children will require some additional support to meet their needs. Support offered at Tier 2 is usually offered by a single agency approach.

consistently updated, for example the Occupational Therapy Service, the short break provision, Physiotherapy Service, and the Community Paediatric Service.

4.2.21. **Child in Need process:** Chronological records indicate that Child in Need meetings or reviews in February and June 2016 and October 2017 and June 2018 for Child H. Records relating to only the February and October meetings have been located, revealing an action plan attached to each. Throughout this period the following points are noted:

- During 2016 School A noted that; Child H's hair had not been washed on two separate occasions, various small bruises or scratches on his body, had concerns about his hygiene plus hygiene products were not always provided by the parents to the school. The School Transport Service also flagged concerns after Child H reporting that his Mother had slapped him. All of this information was shared with Social Worker 1.
- During 2017 School A submitted a further referral to the one made at the end of 2016 about bruising noticed on Child H. Child H's behaviour was observed to be deteriorating with him using offensive language.
- The Police were called to a domestic incident involving Sibling 1 and boyfriend in January and September 2017, and then in May 2018.
- Attempts to offer short respite breaks for the parents were agreed however introductory visits never actually took place and the offer was never taken up despite repeated attempts by the Service.
- October 2017: Children's Social Care supervision notes recognise the emerging signs of missed health appointments, and parents not attending short break introduction visits.
- December 2017: Children's Social Care supervision notes indicate no concerns about parenting, care or support only highlighting that a Child in Need plan still needs reviewing.
- January 2018: Social Workers conducted an unannounced visit to the family home. Also, the School Nursing Service discussed safeguarding issues and were considering an Early Help assessment. Child H had not been in school for 3 weeks. It is unclear what, if any, action was taken about these concerns.
- School attendance for Child was noted to be 96.77% in March 2016 and 92.6% in March 2017

4.2.22. In May 2018 an anonymous referral was received by Portsmouth MASH¹⁴ raising concerns about substance misuse in the home, bruising to Child H and neglect. At this time, the case was also re-allocated within the Children's Disability Service and a joint visit by both Social Workers was conducted as a handover – no safeguarding concerns were identified following the anonymous referral. Some days after this visit, records from the Children with Disabilities Service and School A indicate a Child in Need review meeting was held due to concerns about neglect. There are no minutes of this meeting however it appears that the electronic case note refers to a MASH referral being made by Social Worker 1. Records for the same day from Solent NHS Trust refer to a TAC meeting being held. Questions were raised about whether Child H was being given the correct dosage of prescribed medication.

4.2.23. In early June 2018 the MASH received a child abuse referral from School A due to multiple injuries across Child H's body. This prompted a Strategy discussion¹⁵ being convened which, in turn, resulted in a child protection medical for Child H being carried out. The medical concluded that the bruising was not consistent with the explanations provided. This resulted in an interim safety plan being put in place and an agreement to proceed to holding an Initial Child Protection Conference¹⁶. The date set for this ICPC was 18 working days after the decision was agreed. As part of the interim safety plan, the parents were asked to sign a document outlining a number of expectations; detail

¹⁴ MASH – Multi-agency safeguarding hub.

¹⁵ A strategy discussion is held under Section 47 of the Children Act 1989 which provides the local authority with a duty to make enquiries as considered necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

¹⁶ An Initial Child Protection Conference brings together family members, supporters / advocates and those professionals most involved with a child and family to make decisions about the child's future safety, health and development. [Portsmouth Safeguarding Children Board Procedures Manual - Child Protection Conferences](#)

around some of the expectations was not completed and has been left blank. During the intervening period between the agreement to hold an ICPC and it taking place, School A reported seeing further bruising on Child H. Records do not offer any insight into any action taken as a result of these reports.

4.2.24. Child Protection process: As a result of the ICPC in early July 2018 Child H was made subject to a Child Protection Plan under the category of neglect¹⁷. There was agreement that the Locality Social Worker 2 for Portsmouth Children's Social Care would lead on the child protection aspects and the Social Worker 1 from the Children with Disabilities Service would co-work and co-ordinate support services. A first Core Group¹⁸ meeting was held within procedural timeframes in July. On the same day as this meeting bruising was noted on Child H's arm and neck. In early August 2018 Child H was found unresponsive in the family home and later pronounced dead.

5. Findings & analysis

1. 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 H and family and identify improvements. This section of the report distils the key areas for analysis whilst also noting learning points for practice which can be used by practitioners, managers and trainers.

2. The following headlines provide a summary analysis;

- The steady and cumulative impact of neglect (medical and physical) was not identified by Portsmouth City Council's Children with Disabilities Service and responded to in a timely manner. Their focus was on managing Child H's disability rather than seeing a child who happened to be disabled, also being neglected.
- Non-engagement by the parents, failure to attend appointments and parental capacity to change were not robustly assessed or responded to by the professional network.
- Parental engagement with the professional network was passive; the response by the professional network was not authoritative. Some professionals found themselves being sympathetic with the Mother, inhibiting an objective and unbiased assessment, and distracting them from focusing on safeguarding Child H's welfare.
- Communication and information sharing was often fragmented, particularly across the health agencies involved due to IT databases and information records not matching with one another. Information available to the Police was not usefully used.
- Unhelpful practice and culture within the local authority Children with Disabilities Service had emerged due to organisational structuring, but also reduced management capacity. This severely impacted on the discharge of expected practice standards and created an organisational pathway which, unintentionally, failed Child H.
- Levels of knowledge across the multi-agency partnership about Child H's status as a Child in Need were either poor, or non-existent. This resulted in dual processes. Neither process had any significant long term impact on improving Child H's circumstances.

¹⁷ Neglect is 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 misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse and violence towards a carer, the needs of the child may be neglected. Once a child is born, neglect may involve a parent failing to: Provide adequate food, clothing and shelter (including exclusion from home or abandonment); Protect a child from physical and emotional harm or danger; Ensure adequate supervision (including the use of inadequate care-givers); Ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs. Working together to safeguard children, HM Government 2018.

¹⁸ When a conference decides that a child should be the subject of a Child Protection Plan, a qualified social worker must be appointed as the lead social worker to co-ordinate all aspects of the inter-agency child protection plan. The Core Group is the forum to co-ordinate this multi-agency, collaborative work and the membership will have been identified at the initial child protection conference. [Portsmouth Safeguarding Children Board Procedures Manual - Child Protection Plans](#)

- Professional challenge and escalation was extremely limited or ineffective.

5.1. Case management procedures – local knowledge, application and effectiveness

5.1.1. In reviewing all of the information submitted to this Review, and in discussions with practitioners and managers from across the multi-agency network, there are two striking issues that emerge. Firstly, the lack of knowledge across the multi-agency partnership about Child H's Child in Need status, and secondly, the limited effectiveness of the local authority systems and processes in place to manage this status. Combined, this compromised the quality and effectiveness of local multi-agency working. This finding is critical and was impactful for all other agencies involved with Child H and has to be kept in mind as a constant thread throughout this analysis.

5.1.2. Child H was assessed, and determined, as a Child in Need¹⁹ in 2012, aged four years. Statutory guidance²⁰ states '*... There is a statutory duty, under Section 17 of the Children Act 1989, for local authorities to safeguard and promote the welfare of 'children in need' in their area, including disabled children ... Where there is an EHC needs assessment, it should be a holistic assessment of the child or young person's education, health and social care needs. EHC needs assessments should be combined with social care assessments under Section 17 of the Children Act 1989 where appropriate. ... For all children who have social care plans the social worker should co-ordinate any outward facing plan with other professionals. Where there are specific child protection concerns resulting in action under Section 47 of the Children Act, careful consideration should be given to how closely the assessment processes across education, health and care can be integrated, in order to ensure that the needs of vulnerable children are put first ... EHC plan reviews should be synchronised with social care plan reviews, and must always meet the needs of the individual child*'.

5.1.3. Local policy²¹ in Portsmouth sets out that Child in Need cases held by the Children with Disabilities Service should be reviewed at least six monthly, and more frequently where circumstances require. The policy does not provide any guidance about how frequently visits or contact with the family should occur. Given the breadth and variety of individual children's needs and circumstances that the Children with Disabilities Service will be working with, permitting local and flexible interpretation of the management and oversight may be an appropriate strategy. The downside of this approach is that, potentially, it allows a six month window with limited oversight. The policy makes no reference for the six monthly review to be a multi-agency exercise and no reference to seeking information from other professionals that might be involved with the child or family – instead framing the review process as an internal and single agency exercise.

5.1.4. Records and discussions confirm that a high number of professionals involved with Child H either did not know about him being classed as a Child in Need, or did not understand the implications and expectations attached to being a Child in Need. The allocated Social Worker was not assertive as the lead professional and this was not checked by management systems. In turn, this resulted in processes unnecessarily running concurrently i.e. Team around the Child (TAC) processes, as a means of professionals attempting to coordinate and respond to concerns.

Learning point: Ensuring practitioners have the experience, skill and confidence to match the demands and complexities associated with individual cases is an important management function. Supporting practitioners to grow into these roles and acquire the skills and experience is an equally important task.

5.1.5. Legislation requires there to be a lead professional for Child in Need cases, specifically with this being an allocated local authority Social Worker. The gaps in knowledge and understanding reflect a failure by Children's Social

¹⁹ Provided under section 17 of the Children Act 1989 & section 2 of the Chronically Sick & Disabled Persons Act 1970.

²⁰ Special educational needs and disability code of practice: 0 to 25 years Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities, page 211, January 2015, HM Government.

²¹ Children with disabilities policy, section 4.1.2. Portsmouth City Council.

Care to effectively communicate to partner agencies information about the management of Child H's care planning arrangement and act as the lead agency responsible for coordinating services and specialist assessments '*... so that the child and family experience a coherent process and a single plan of action ...*'²². Over time, from School A's perspective their concerns centred on parental engagement, the provision of suitable sanitary products, medicines management, and unexplained bruises and grazes noticed on Child H. They were unaware of the drug misuse in the family home, and the domestic disputes between the older sibling and boyfriend. School A were also unaware of the relevance of Child H's Child in Need status. On the basis of the knowledge held and observed concerns, School A's response to convene a TAC meeting can be argued as appropriate and one that recognised safeguarding issues for a vulnerable child. At this time, in 2016 – 2017 a member of the School staff took on the role of the lead professional, not realising that there was an allocated Social Worker that already had this formal role.

5.1.6. From a system thinking perspective there are two issues of note here. Firstly, the strength of a complex system, such as a local authority children's services and a partnership arrangement, can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted or easily managed. Emergence²³ is a core principle of such complex arrangements, and describes '*... how local interaction give rise to overall patterns of behaviour without the latter being planned or designed. In social work, this means that outcomes emerge from a host of everyday interactions, some of which social workers can influence directly but most of which they cannot. Instead they become part of a unique configuration of social and relational dynamics, which may or may not correspond to what was planned or intended ...*'. Emergence as a concept is therefore relevant as it allows us, often with a hindsight bias, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners.

5.1.7. During the time frame under review the role of the Children with Disabilities Service was seen as one which predominantly adopted a care management role, not taking a holistic view about case management. As a Service, their perception was one that they would not be required to take an active lead in considering and managing any child protection or safeguarding issues. This resulted in a local cultural norm and mind-set emerging that this Service did not 'do' safeguarding or child protection work. Research²⁴ highlights this model of working as a potential risk factor when working with neglect and child disability which may result in practitioners '*... seeing the disability, not the child, and viewing a case essentially as supporting disability rather than supporting or protecting the child ...*'.

5.1.8. Even with taking a care management model approach, records and discussions still show that the stimulation, coordination and communication with other relevant professionals and agencies was considerably lacking – resulting in fragmented management and oversight of care planning and actual day to day arrangements for Child H. This is reflected in a) some professionals not knowing whether there was a Social Worker involved in the case (Hospital staff), b) others initiating TAC meetings (School A) when in fact Child in Need review meetings would have been the appropriate regular mechanism to raise and review issues and c) the use of chronologies, as a core social work task, not being applied to track patterns which, had it been used in such a way, could have revealed risk.

5.1.9. The origins of this emergent practice and the Service taking a mostly care management approach appear to stem from around 2015 when line management for the Service was transferred out of Children's Services directorate to the Education & Inclusion directorate. There is a view that this move steadily impacted on the Service's role and identity as a social work based service, creating cultural distance. At this time, it would have also been agreed that the Service did not progress section 47 enquiries. Although this appears to have been an active decision to adopt such an approach, practices have emerged that have unwittingly undermined and eroded the strength of service delivery

²² Working together to safeguard children, p. 18, 2015, HM Government.

²³ a) Hood, R, Complexity in social work, p. 40, 2018.

²⁴ Brandon, M., Belderson, P., Responding to child neglect: learning from case reviews, p. 228, in Gardner, R., Tackling child neglect: Research, Policy and evidence-based practice, 2016, Jessica Kingsley.

by the Children with Disability Service. The allocated Social Worker experienced two prolonged periods of sickness absence during the timeframe under review – again, a contributory factor. This serves as a good example of emergence – practices that were not planned or designed but also a new arrangement being introduced that unintentionally created an organisational pathway to failure²⁵.

Learning point: Safeguarding is protecting children from maltreatment, preventing impairment of children’s health or development, and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care. Safeguarding is everyone’s responsibility regardless of the service you work in. Child protection is part of safeguarding and relates to activity to protect specific children who are suffering, or likely to suffer, significant harm.

5.1.10. The second issue of note from a system thinking perspective is the concept of leverage. Children’s Social Care, often when having a lead role, has the ability to lever change and improvement for a child or situation. This lever is often described by the name given to it i.e. lead professional, lead agency. In this case, other professionals looked to the Children with Disabilities Service as a part of Children’s Social Care to take the lead and exercise some leverage. This is evidenced by people asking about whether there was a social worker allocated or not. Children’s Social Care therefore had a lever name ascribed to them and practitioners from other agencies had an expectation that Children’s Social Care would stimulate and coordinate multi-agency action and interaction for the benefit of Child H. Ultimately, the stimulus and coordination happened at the point that an ICPC was convened in July 2018 (despite the delays); however the anticipation from those other agencies is that this needed to happen much earlier in the process for Child H. The resultant delays caused professional frustration and appear to have resulted in a general loss of confidence in the Children with Disabilities Service.

Learning point: At times, it may be helpful for all professionals, but particularly social workers, to view their role being an ‘agent of change’. This may be directly facilitating change for an individual child or more broadly by acting as an agent, or lever, that stimulates and coordinates change by galvanising the actions of others involved with a child. It may also be by empowering families through high support and high challenge.

5.1.11. The learning review conducted by Portsmouth Safeguarding Children Board in respect of Child G (published 2019) highlighted very similar issues – no one single identified lead agency taking a holistic and strategic view about Child G’s circumstances. Given the findings from that review, the findings of this review confirm that the emergent customs in the Children with Disabilities Service were deeply embedded into the practice of working with children with complex disabilities. As a result of internal management scrutiny, and the Child G review, those embedded deficits were acknowledged by the local authority Children’s Social Care with improvement activity underway. This was recognised by Ofsted in their September 2018 inspection²⁶ ‘... *Senior leaders recognised weaknesses in the oversight of the children with disabilities team and responded by moving the team back into the children’s services directorate. This has led to improvements to the degree of management oversight, and these children now benefit from some effective help and support. There is more to do to ensure that intervention is of a consistently high quality ...*’. At the point of undertaking this review, improvement activity continues. Critically therefore, the findings from this review have to be seen with this historical context in mind.

5.2. The use of case history to inform assessment & decision making

5.2.1. Statutory guidance relevant at the time²⁷ states of assessment and analysis ‘... *decision points and review points involving the child and family and relevant professionals should be used to keep the assessment on track. This is to*

²⁵ Learning into Practice: improving the quality and use of serious case reviews, Masterclass 2: Systems thinking, SCIE & NSPCC, 2016.

²⁶ Ofsted, Portsmouth City Council Inspection of local authority children’s services Inspection dates, 3 September 2018 to 14 September 2018

²⁷ Working together to safeguard children, p.24, 2015, HM Government

ensure that help is given in a timely and appropriate way There are a number of key decision and review points at which it would have been reasonable to include and consider family history when undertaking or revising assessments. Importantly, in this context family history not only includes historical information from 2010 but should also be viewed as taking account of chronological information gathered over the course of single, or multi-agency, involvement. An event that happened yesterday may be as relevant as something that happened last month or six years ago, and forms a chronological account of professional contact with a child and family.

Learning point: A chronology is a tool to aid assessment and decision making. One should always be used to inform social work core assessments. It should provide a readily accessible overview of notable events in a child's life (and family life) and can be used to reveal patterns and experiences which may be buried in case records held by other agencies. Creating a multi-agency chronology can be a powerful tool to aid decision making. See Portsmouth LSCB website for further guidance. [Chronologies: One minute guide - June 2018](#)

From a local authority perspective these key decision and review points include;

5.2.2. The annual review of the Statement of Special Educational Needs, or Education, Health & Care Plan – conducted in February and August 2016, February and July 2017, and then March 2018;

- Review of records show that during the scheduled monitoring of the Statement of Special Educational Needs no concerns were raised as the educational provision for Child H was meeting all of his needs, his attendance was good and the educational placement at School A was appropriate. At the time, the Statement was purely focused on the educational elements of Child H's needs. On this basis, it might be reasonable to conclude that consideration of family history was less important, especially given attendance levels being mostly above 90% and positive progress being reported. However, a gap that has been highlighted by the Special Educational Needs Service is that they were not provided with any documentation relating to Child H being a Child in Need at-all in the intervening years, nor were they made aware of Child H becoming subject to a Child Protection Plan in July 2018. Although there was social worker attendance at the annual reviews over this period of time, this failed to provide any meaningful contribution in respect of social, safety or welfare issues. Evidence submitted does indicate that partner agencies were invited to contribute to the annual reviews and that they did submit information to inform the annual exercise. However, this does highlight an important gap in information exchange within the local authority from Children's Social Care to the Special Educational Needs Service. The Special Educational Needs Service has committed to remedying this situation; with an action plan in place.
- The changes to the identification, assessment and management of special educational needs under revised legislation and guidance²⁸ does widen the responsibility to communicate, exchange information and work together for the benefit of those children who have additional needs and consider health and care needs, in addition to educational needs. At the point that the Statement transferred to an EHC Plan in March 2018 the Special Educational Needs Service had not been made aware of any concerns about Child H's circumstances. There was sufficient relevant information available at this time to have justified the Special Education Needs Service being informed about the growing concerns for Child H by School A.
- This review has exposed the need for Portsmouth City Council to shake off a legacy of compartmentalised case management and align systems, procedures and processes around EHC Plans and Child in Need Plans, thereby reflecting the aspirations of statutory guidance.

5.2.3. Child in Need process and reviews;

- Children's Social Care have reflected that *'... the Child in Need plan on record in 2017 remains the same as the Child in Need plan for 2016, which indicates nothing has been achieved or changed for this child ... Until the Child*

²⁸ Children & Families Act 2014, and the Special educational needs and disability code of practice: 0 to 25 years, statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities, January 2015, HM Government.

Protection Plan was made, there was no robust single plan driving the case forward and a lack of minutes fails to draw together the information and progress during the preceding months. This becomes particularly problematic when trying to communicate or track the progress of any actions. Had clear 'bottom lines' been established and actions been communicated in a SMART plan this case may have followed a different direction much earlier. Unfortunately, there were repeat concerns that formed a worrying pattern of parental negligence that was not sufficiently well challenged or addressed promptly enough ...the frequency for visiting was never clearly established in plans or supervision ... during 2016 I could find only one recorded home visit, and there are five recorded visits in 2017 ...'. These findings are clearly worrying. It has not been possible to ascertain the number of formal reviews completed during the timeframe under review as records are incomplete, although there are records to indicate that Child H was seen at various time during 2016 and 2017.

- Three Core Assessments, which form part of the regular review of Child in Need cases, have been examined; February 2017, May 2017, and May 2018. It is unclear why two core assessments were conducted within the first six months of 2017. The February 2017 document makes a cursory reference to hospital admissions (by this month Child H had had eight emergency admissions), and a passing reference to the parents '*... have not been so good at getting him to appointments ...*'. The question that asks whether the children are currently open to Children's Social Care is answered as 'no'. The final statement of needs outlines no needs identified as a result of the assessment. The section which would provide details about who else had been involved in the review process has not been completed. The content of the May 2017 document is exactly the same highlighting a likely cut and paste exercise; nothing is different (including the spelling mistakes which highlights the level of quality assurance), with the exception that it appears that the Community Paediatric Service and School Nurse may have made contributions. During 2017 there was sufficient known information from a range of professionals for this review exercise to highlight meaningful safeguarding risks. The cursory references to two of these risks (hospital admissions and missed appointments) fails to make any link to how this might impact Child H. There was no evidence that the parents were able to organise themselves without constant support and reminders; and yet often not manage to achieve attendance at appointments even with this level of support. There is no evidence to highlight a chronological analysis of missed appointments in 2016 – 2017 or exploration of the reasons for non-engagement in any depth. There is no chronology to highlight compliance (or not) with medicines management or daily regimes. Whilst it is evident that a chronology exists and was maintained, its use as a tool to aid assessment and decision making appears negligible. The reasons provided relate to the point made above regarding the Children with Disabilities Services eroded identity as a social work based service and loss of skills.
- The May 2018 document has different content and more accurately reflects the concerning issues at the time. It opens by explicitly stating that there are concerns across the professional network regarding the lack of engagement; it does however continue to offer minimal information resulting in a weak analysis. One example of this is the use of numbers to scale concerns without any explanatory notes. The section which would provide details of who else has contributed to the review has not been completed. As a document for other professionals and family members its value is limited, especially as there are no actions or recommendations.

Learning point: Conducting a thorough and structured assessment (previously known as a Core Assessment) of a child's needs is a vital task to ensuring effective planning and intervention. Gathering information from different sources to then complete an analysis, evidence professional judgements and inform decision making is important. When the child's circumstances are complex, the importance of a robust assessment with high quality management oversight becomes more pronounced.

5.2.4. *The Initial Child Protection Conference conducted in July 2018.*

- Section 5.6 examines the practice around the time of convening the Initial Child Protection Conference in July 2018 in more detail.

5.2.5. From a Police perspective Hampshire Constabulary have identified that a significant amount of intelligence was not shared with partner agencies. This includes information relating to drug use and supply in connection to both the Mother and Father. During 2016 – 2017 the wider Police operation did make links with the household having children present however this did not result in any information being shared with partner agencies – this is despite the family home being visited four times between November 2016 and April 2017 by the Neighbourhood Policing Team. Although three of these visits were unsuccessful with no reply it does indicate a level of interest and activity by the Police, knowing there were children living at the address, that would have been of interest to partner agencies, particularly Children’s Social Care. Records indicate that the only two points where a summary of information was shared was during the Child Protection Conferences in 2010 and then in 2018 – during a confidential part of a meeting. The following reasons account for this intelligence not being appropriately shared with partner agencies:

- During the timeframe in question intelligence submitted to the Police was processed using a national system which coded information – this coding system determined whether it was information that could, or should, be shared with partner agencies or not. As part of this process further cleansing of the intelligence was possible allowing it to be reviewed, risk assessed and the coding amended before being tasked to the Police MASH team for dissemination with partners for the purposes of protecting children. This procedure was not followed due to staffing capacity.
- In this case, none of the intelligence reports received in relation to either parents made reference to any of the children in the body of information. This was a missed opportunity to make a link. As there was no research capacity within ITD²⁹ at the time, the information was not further developed resulting in a second missed opportunity to make the links. This meant that the information was not linked to the children and there was no holistic view of all the information known, which included; children living in a house where drug use and supply were known to be taking place, two of those children having complex health needs, previous child protection concerns and reports of domestic abuse.

5.2.6. Hampshire Constabulary will receive between 1200 – 1500 intelligence reports each week and there is an expectation that each item of intelligence will require assessment by staff. This reflects a significant amount of work. The Constabulary recognise now that the absence of sharing of relevant intelligence reports with partner agencies, represents a significant organisational risk in relation to their practice and to partner agencies ability to safeguard children and vulnerable adults. Whilst changes have been implemented in an attempt to reduce the likelihood of this happening again, Hampshire Constabulary have recommended that assurances are gained which evidence the learning and improvement on this issue.

Learning point: Parental drug & substance misuse is a known risk factor to children’s safety and welfare. Where information is known about situations in which children are living with parental drug & substance misuse, sharing this information with the appropriate agencies is important. Failing to share may result in serious harm or death.

5.2.7. Solent NHS Trust have highlighted that there were also difficulties in their reliance on computer systems. The Trust have noted that due to the implementation of a new computer system, from Rio to SystemOne (in 2015) information that might have influenced professionals’ assessment of the family was lost. This included information about the parents failing to attend significant health appointments for their children, information about the Mothers post-natal depression following the birth of Child H, and information about the Fathers drug misuse. The review has highlighted that although it might be possible to search for this information it would require a manual search and some insight into knowing what it was that was being searched for – all time consuming and prone to human error. This reflects the importance of using a flagging system which highlights relevant safeguarding information on the first page/screen seen by a practitioner. The impact of this data being lost during the transfer from one system to another,

²⁹ ITD – Intelligence, Tasking & Development command unit in Hampshire Constabulary.

and there being no flags meant that those Trust practitioners working with Child H (paediatricians, nurses, or therapists) were not aware of, or reminded about, significant information.

5.2.8. The Ambulance Service had significant contact with Child H, transporting him to hospital on at least 15 occasions due to seizures. Given this level of contact there is a strong argument about the benefits to them of knowing about family history and knowing about patient care plans that were already in place. This review has highlighted that they were not made aware of any risks in relation to the family and they had no access – despite it being entirely possible – to care plans. In terms of impact, this would have allowed the Ambulance Crew access to information about which drugs they could, or might not, have administered during the emergency call-outs. They would also have benefited from contextual information which may aided their initial assessment. This issues is further picked up in section 5.4.6.

5.2.9. The Adult Substance Misuse Service had substantial contact and history with the Father and oversight about his drug use. Records and discussions show that they worked with the Children with Disabilities Service by sharing information and managing, what they thought was, a plan that aimed to reduce the Fathers drug use.

5.2.10. Portsmouth Hospitals Trust have reflected on their involvement with Child H highlighting, two issues that are linked; both are relevant in terms of using family history to inform assessments and decision making.

5.2.11. Firstly, Child H not being brought for clinical appointments following emergency admissions. The Specialist Epilepsy Service were aware of the long standing concerns about Child H's non-attendance at routine appointments at the clinic but also the emergency admissions to hospital. Child H was never brought to an epilepsy assessment appointment throughout the time period under review. It was not viewed as the responsibility of this specialist Service to escalate any concerns that may have arisen out of either persisting non-attendance or acute admission. The fact that Child H had never been brought to a critical health appointment, by itself, would have warranted an escalation of professional response and potentially be seen as a child protection matter – especially for a potentially life threatening condition such as epilepsy.

Learning point: Epilepsy can be a life threatening condition, especially if not managed appropriately. Young children are reliant on their parents and carers to help them manage their epilepsy. Where there are known worries about parental behaviour and parenting capacity it is reasonable (and essential) to challenge and escalate your worries in a timely manner if there is any sense it may impact on the child's safety and ability to manage their epilepsy.

Learning point: Medical neglect is when parents or carers '*... minimise or deny a child's illness or health needs, fail to seek appropriate medical attention or neglect to administer medication and treatments. ... Whilst failing to take a child for regular health checks may appear less concerning than failing to provide treatment for an ill child, it can have significant long term effects ...*'. Children with complex needs are especially vulnerable to medical neglect. '*... these children are often more dependent than other children on their carer ... may require intensive and extensive medical support for many years ... [and the] demands can place a strain on carers ...*'³⁰.

5.2.12. Secondly, and linked, it is only now with the benefit of hindsight having gone through records that it has become apparent that there were two contributing factors which led to Child H slipping through the health systems designed to provide oversight. Firstly, forms were either not completed properly or honestly by Child H's parents when attending hospital. A Korner form³¹ allows information to be completed including names, dates of birth, addresses, GP details, and includes a safeguarding checklist for parents to complete which asks whether the child//family are known to social care, whether any family members use drugs or alcohol and whether there are any mental health issues. On a number of occasions, the form was not always completed and on several admissions Child H's parents incorrectly stated that there was no involvement from social care. The Mother, who was the parent that tended to come to

³⁰ Horwath, J., Child neglect: Identification & assessment, p 27, 2007, Palgrave MacMillan.

³¹ Korner forms provide a standardised data collection mechanism across the NHS.

hospital, was clearly not telling the truth. This was later reinforced when she denied having a Social Worker when explicitly asked by hospital staff. Secondly, the Child Protection Information System (CPIS) is a relatively new national database system that can be used on emergency admissions to check whether a child is known to social services and is either a Looked after Child or a child subject to a Child Protection Plan. As Child H's Mother did not always confirm the involvement of a Social Worker it would not have prompted this CPIS check to be completed. Child H, as a Child in Need, would not show on the CPIS system. Contributing factors to this situation occurring included;

- Parental deceit and failure to comply with standardised procedures when attending hospital.
- Staff not following standard procedure in completing forms when a child is admitted to hospital; often due to the pressures in the A&E department and this procedure not then taking place until transferred to a Ward.
- The CPIS check system not being applicable to Child in Need cases and therefore the failsafe mechanism the CPIS system provides not being useful in such situations.

5.2.13. The Wheelchair Service had a long history of involvement with Child H and his sibling, with them first being seen in 2011. Parental non-engagement was noted to be an issue at this time. Over time, the majority of contact between the Service and Child H took place in school clinics. Whilst providing a level of convenience for Child H this did mean, more often than not, that the parents were not included in any discussions or assessments. Additionally, as school clinics often reviewed Child H's needs, the changes and improvements brought about by the whole Service over time in initial assessments were not applied to Child H's case because he was an open case that was handled via reviews rather than an opportunity to undertake a complete re-assessment. Had this re-assessment been conducted, the revised format for such an exercise would have gathered information about social history, clinical background and safeguarding concerns. This lack of history was then compounded by them not being asked for, or provided with any information about emerging safeguarding concerns. As a result of these lapses, the Wheelchair Service operated in relative isolation of the parents and other professionals, and worked mainly with School A albeit in a compartmentalised way. As School A were not fully appraised of all of the concerns or features of the family's circumstances; they too had no relevant information to pass on to the Wheelchair Service. The Wheelchair Service also did not have access to Solent NHS Trust's shared database at this time and were therefore unable to view relevant background information had they chosen to do so. The Wheelchair Service have reflected that '*... the lack of information sharing with the wheelchair service could be due to the perception of the service as predominantly equipment provision – however wheelchair clinicians must manage the risk of the provided equipment and assessing and supporting family ability to manage posture and re-positioning and use of the wheelchair is a core aspect of the service provision ...*'. These deficits have been recognised and there are improved systems and processes in place to avoid working in isolation from parents.

Learning point: In cases where additional and specialist services are commissioned to assist with a child's support needs those services should always be invited to participate in regular reviews about overall case management. Failure to invite specialist services results in an incomplete picture of the effectiveness of support being provided to a child and family.

5.2.14. Parental non-engagement with the Wheelchair Service impacted on Child H significantly when a need for a new wheelchair was identified in September 2016 yet not actually provided until July 2018. Records from the Service are incomplete however there is no evidence of the parents chasing or complaining about this substantial delay of nearly two years. There is also no indication that this delay was communicated to other professionals or the Social Worker. Not only does this reflect a significant breakdown in service provision and delivery by the Wheelchair Service but also a breakdown in communication across the professional network. A recent review³² conducted by Portsmouth LSCB found similar concerning issues with wheelchair service delivery. Contributing factors in this case point similarly

³² Portsmouth LSCB, Child G Learning Review, 2019.

to staffing capacity and workload for the whole service, and the quality and effectiveness of management systems and processes being contributory factors.

5.3. The recognition & response to safeguarding issues for a child with disabilities

5.3.1. Research³³ for professionals working with children who have complex needs reminds us that '*... 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 what is involved in a child's day to day care can powerfully operate 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 ...*'.

5.3.2. From a safeguarding perspective the issues of main concern, which were known and knowable by those most closely involved with Child H were;

- Inconsistent, or non-attendance at health & medical appointments and excessive emergency admissions.
- The impact of parental drug misuse on parenting capacity
- Concerns about medicines management and the impact of this on the child.

5.3.3. Inconsistent, or non-attendance at health & medical appointments & excessive emergency admissions

5.3.4. It is now only with hindsight bias that professionals have reflected on the extent and impact of missed, or inconsistent attendance at, health/medical appointments for Child H. The impact of missed appointments on Child H was that any changing needs – acute or chronic - could not be assessed, reviewed or monitored. Research³⁴ into other case reviews has noted missed appointments as a risk factor, and failure to attend health/medical appointments is an explicit indicator of neglect³⁵. Medical neglect is also noted as a specific form of neglect by Horwath³⁶.

5.3.5. Portsmouth Hospitals Trust Safeguarding Service have reflected on their involvement whilst the children were subject a Child Protection Plan in 2010 highlighting that their interventions and support appear to have been effective in terms of supporting Hospital staff with the situation at the time, and in sharing information with Children's Social Care. They have highlighted the need to increase awareness of the 'was not brought' policy and the requirement for all Hospital specialisms to check the Patient Administration System (PAS) which can be used to gain an overview about appointment attendance across Hospital teams. Although the 'was not brought' policy was updated in May 2018 it is apparent from the findings of this review that it can be further strengthened to require a check of the Patient Administration System (PAS) for those specialist services that can access it. In this case, the PAS was not checked.

5.3.6. The Community Paediatric Service had oversight of all failed appointments and worked with other practitioners to risk assess the impact and explore future plans for medical care; this included ensuring the Mother was clear about those plans. The Specialist Epilepsy Service in Portsmouth Hospital Trust were cognisant of the need to avoid unnecessary appointments for both Child H and Sibling 3 knowing the time and effort required to respond to a high level of commitments. With this in mind, the persisting non-attendance at appointments was discussed by the Specialist Epilepsy Service and the Community Paediatric Service 18 months before Child H died. The view was that

³³ Marchant, R., Making assessment work for children with complex needs, p. 208, in *The Child's World*, The comprehensive guide to assessing children in need, Edited by Horwath, J., 2nd Edition, 2010, Jessica Kingsley.

³⁴ a) NSPCC Briefing: Learning from case reviews – health, December 2015, [NSPCC – Briefing](#) and b) Ofsted: In the child's time: professional responses to neglect, March 2014.

³⁵ Definition of neglect as outlined in *Working Together to safeguard Children*, 2015 & 2018, HM Government.

³⁶ Horwath, J., *Child neglect: identification & assessment*, 2007, Palgrave MacMillan.

attempts to manage Child H's care should not be via the Hospital Paediatric Team but back with the Community Paediatric Team – as this could potentially make attending appointments easier for the family. This discussion also flagged a concern about the parents not giving Child H his epilepsy medication as prescribed but also highlighted uncertainty about whether Child H had a Social Worker. The Community Paediatrics Team and the Hospital Paediatric Team do not share a computer system or paper notes and staff at Hospital are unable to access social care or GP records. This hampered effective information exchange. The historical information about non-attendance from 2010 not being available contributed to a partial assessment of risk about failed appointments.

5.3.7. The critical issue appears to have been uncertainty about whether Child H had a Social Worker or not – because the Social Worker, as a lead professional, was viewed as having a role in coordinating and holding oversight of care planning arrangements. Other professionals, implicitly, were looking to someone to take the lead, lever change and remedy their concerns. The use of a chronology that filtered compliance with health/medical appointments would have aided the identification of potential risk and safeguarding issues.

Learning point: Research³⁷ into neglect and Serious Case Reviews has highlighted medical neglect as an issue, commenting on '*... undue professional optimism – in particular from the medical community ...*' and a desire to balance maintaining the family's emotional health and resilience with follow up on the child's physical and medical care needs being factors. Other issues of note in medical neglect cases included a lack of engagement with fathers, parents attempting but struggling to keep up with medical care appointments and health professionals 'shielding' the family from further professional involvement.

5.3.8. It will never be known whether Child H's emergency admissions were as a result of inconsistent attendance at scheduled health/medical appointments and Child H's epilepsy not being effectively managed – either by the parents or professionals. It is easy to now see a worrying pattern of attendances that can be viewed as a potential child protection issue. At the time, there was no one person or system that appeared to recognise the importance of the growing number of admissions and non-compliance. As highlighted above, the social work chronology was not used as an effective tool to assist with maintaining oversight of this case, and communications from Portsmouth Hospital failed to elicit an appropriate response. The Community Paediatric Service did not use the information they had available about emergency admissions in a way that raised Child H's profile with any other practitioners. Staff involved at the time have reflected on their practice and sufficient assurances have been gained about this not being repeated.

Learning point: When an unexpected, significant and negative event occurs in any child's life e.g. an emergency admission into hospital with a life threatening condition, it is important for the professional network around that child to pause, examine the episode and consider what might be needed. The responsibility for initiating this opportunity to reflect does not necessarily rest with one agency although if the child is subject to an Early Help or Child in Need Plan, there will always be a lead professional appointed.

5.3.9. The impact of parental drug misuse on parenting capacity

5.3.10. Research³⁸ about working with neglect highlights '*... the carer's ability and motivation to meet the needs of their child can be negatively affected by a diverse range of parenting issues ... mental health issues, domestic violence, drug and alcohol misuse and learning disability ... carers may be unaware of the impact of their own problems on their children ... and ... whilst they may not intend to provide poor parenting their pre-occupation with their own issues can result in a lack of responsiveness and failure to consider the needs of their children ...*'. There is also considerable research about the impact of parental drug use on children's safety and welfare and includes learning from case review activity '*... substance misuse by a parent or carer is widely recognised as one of the factors that puts children more at*

³⁷ Brandon, M., Bailey, S., Belderson, P., Larsson, B., Neglect and Serious Case Reviews, p. 48 – 53, 2013, University of East Anglia & NSPCC.

³⁸ Horwath, J., Child neglect: identification and assessment, p. 110, 2007, Palgrave.

*risk of harm. The biggest risk posed ... is that parents, when under the influence of drugs or alcohol, are unable to keep their child safe ...*³⁹.

5.3.11. The Adult Substance Misuse Service demonstrated a good understanding about safeguarding issues when it was recognised that the Father's engagement with the treatment programme and his drug use were becoming problematic in 2016. He had a long history of working with the Service since 2010 as a result of the child protection planning in place at that time. His initial attendance was good and he quickly stabilised his illicit opiate use. This resulted in a positive assessment of his motivation to change.

5.3.12. At the time the professional network gave positive feedback about the Mother's engagement, having had a period of intense professional involvement to ensure the children also attended scheduled appointments. At this time the Mother was described as a non-drug user and would indicate that she was less than tolerant of the Father if he did not maintain his abstinence. This historical information is relevant because the same view of the Mother being a protective parent continued over the timeframe under review. Mother is reported as seeming very credible when talking directly to her about the Father's drug use, was clear in her stance that she would not allow him in the house using drugs and even the manner in which she spoke about certain substances seemed laced with a naivety one might expect from a non-using partner. There were no occasions when any concern arose about the Mother possibly being under the influence of drugs. This view was supported by Social Worker 1. It is now, only with the benefit of an outcome bias and testing that it has been confirmed that the Mother was a drug user having confirmed positive blood test results for cannabis and crack cocaine. The Father tested positive for cannabis and crack cocaine, with a likelihood of also using heroin. This all reflects over optimism by the professionals involved but also a lack of curiosity given the circumstances.

5.3.13. It is clear from Police information and intelligence that there were significant concerns about the Father using and supplying drugs and using the home as a base for this. Given this, it must be argued that it is reasonable to conclude that the Mother had knowledge and involvement in this. Overall, this reflects a sophisticated ability to hide drug misuse from a range of professionals over a protracted period of time. It also highlights a confirmation bias; '*... once we have formed a picture of a person or family, we have a strong tendency to keep to it, noticing any new information that supports it but tending to overlook or devalue any that challenge it ... it is a major contributor to tragedies in child protection work ...*'⁴⁰. The anchored belief that the Mother was a protective parent was not challenged by the Children with Disabilities Service or the Adult Substance Misuse Service as there was no reason to question her motives or behaviours. Given that few other professionals knew about the Father's substance misuse and few other professionals ever had the opportunity to engage with the Father, there was no reason for them to be curious about whether substance misuse was a contributory factor to the general situation. As stated, the Police intelligence was not shared thereby providing no opportunity to challenge any bias view.

Learning point: Research into other Serious Case Reviews⁴¹ states '*... without professional curiosity professionals fail to recognise risks, downplay them, or focus on parents' needs to the detriment of the child's ... professional curiosity requires professionals to think 'outside the box' ...*'. Knowing one person in a household has had a long standing addiction to illicit substances with erratic compliance on a treatment programme demands a continual level of curiosity about other adults in the house.

³⁹ NSPCC Briefing: Learning from case reviews - Parents who misuse substances, December 2013, [NSPCC Briefing](#)

⁴⁰ Munro, E., Guide to analytic and intuitive reasoning, 2009, Community Care Inform.

⁴¹ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 159, University of Warwick & University of East Anglia, May 2016

5.3.14. When the Father's failures to remain engaged with the Adult Substance Misuse Service emerged it resulted in information being appropriately shared with the Children with Disabilities Service, and joint visits being undertaken during 2016. This was again repeated in 2017 yet failed to encourage the Father to properly re-engage with the programme. His failure to remain engaged, with the knowledge of continued illicit drug use, did not appear to register with the Children with Disabilities Service as a risk factor to the children and no authoritative action was taken – due to the issues already outlined above in section 5.1. At the time, the Children with Disabilities Service was the only service that had knowledge of all emerging risk and vulnerability factors. Again, not using the social work chronology to inform assessment of a possible safeguarding issue, impacted on decision making.

Learning point: Parental drug misuse, domestic abuse, and parental mental health issues are well known risk factors to children's safety and welfare. Adding features such as disability and medical neglect into this existing cocktail of toxic and dynamic risk factors creates a level of risk and complexity that requires clear thinking about the cumulative impact on a child's safety. High quality supervision and management oversight is critical in such cases.

5.3.15. Concerns about medicines management and the impact of this on the child

5.3.16. The National Institute of Clinical Excellence (NICE) Quality Standard states '*... the quality standard for the epilepsies in children and young people specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole epilepsy care pathway. An integrated approach to the provision of services is fundamental to the delivery of high-quality care to children and young people with epilepsy, and the quality standard should be delivered by multidisciplinary teams through a local epilepsy clinical network*'. Portsmouth Hospitals NHS Trust does have an epilepsy care pathway however this appears to be a relatively recent addition in 2018. Given that there were known concerns about the administration and review of prescribed medicines to Child H from 2016 through to 2018 it is appropriate to examine this area in some detail.

5.3.17. Diagnosis of condition:

5.3.18. A review of records confirms that there were no concerns about the initial diagnosis of epilepsy for Child H, with this being appropriately completed by the Community Paediatric Service. The initial diagnosis was accompanied by a medicines regime that was considered the most effective way of managing seizures. This diagnosis was communicated to School A and Children's Social Care.

5.3.19. Prescribing of medications:

5.3.20. Decisions about the choice of medication and dosage were made by the Community Paediatric Service. Child H was not brought to a review in June 2016, nor October 2016. He was subsequently seen in December 2016, November 2017 and June 2018 highlighting long gaps between formal reviews.

5.3.21. Following Child H's attendance on the Child Assessment Unit in June 2017 medication was prescribed that could be used to manage a prolonged seizure. As a result, a written care plan for management of prolonged seizures was provided for the parents and School A in July 2017 by Portsmouth Hospital Paediatric Team. Review has shown that this was compliant with NICE guidance⁴².

5.3.22. The GP Practice was notified by letter of any changes in prescriptions and, in turn, issued prescriptions were amended. Prescriptions were then generated by the surgery on the request of either the family or the pharmacy. The pharmacy was responsible for dispensing these prescriptions. Requests made by the family for repeat prescriptions from the GP appear to have been made erratically although it has been possible to show that there was not absolute clarity about how often they should have been requested. During the medication re-authorisations at the time, the GP checked that they were issued on a relatively regularly basis. In hindsight when counting the days between issuing

⁴² NICE guidance: Epilepsy in children and young people, Quality Standard QS27, 2013

it has become apparent that gaps were often longer than they should have been. For example, one prescription for one drug should have lasted 24.4 days at the quantity given. However, it was issued after 25 days, 46 and 33 days between February and June 2018; the problem being at an initial glance they appear to be issued every couple of months. A recently published Serious Case Review⁴³ which also examined concerns about childhood epilepsy highlighted the prescribing of medicines as being problematic due to the leeway given in the prescribing and collection of medication. The tolerances associated with the medicine's management of a condition such as epilepsy may be an area that warrants further investigation.

5.3.23. The names of medications have been used interchangeably in the records i.e. the same drug will have different brand names, and the function, names and dosages of the drugs appear complex. Solent NHS Trust have noted that *'... even for well-motivated parents, providing the correct medication, dosage at the appropriate time of day would have been a challenge. Sibling 3 was also being prescribed fewer, but similar, medications, further adding to potential difficulty ...'*

5.3.24. School A were made aware of some issues with prescriptions in April 2017 when some of the labels on the medication had been incorrect and again in July 2017 where medication for Sibling 3 was refused by the GP, and in November 2017 when the expiry dates on some of the medication was very short. Positively, all of these issues were picked up by the School Nurse and resolved.

5.3.25. Practitioners at the workshop and those who have reviewed records have described that no-one had, or does have, oversight of prescriptions. It is unclear about the cross-over of responsibility between hospitals and GPs prescribing and dispensing medication; this situation is exacerbated by the electronic databases not being compatible. Solent NHS Trust has stated that there was no oversight of prescribed medications in terms of whether parents were requesting, storing or administering them correctly. A single agency investigation conducted by Solent NHS Trust has recommended that a) there should be a shared care pathway (for prescribing) between Community Paediatric medical service and the GP, and b) medicines advice at home team provides support for adult patients who have difficulty in managing medicines; there should be a similar model for non-nurse led children's services.

Learning point: When working with children in families where prescribed drugs are used on a regular basis it is important to ask questions about medicine management. This should include an assessment of how these drugs are prescribed, what advice and support is given, and how the drugs are stored and administered. It may be appropriate to cross reference the information gathered with professionals involved in the prescription and review of those drugs e.g. GPs and hospitals.

5.3.26. Dispensing of medications:

5.3.27. Review of dispensing records from the local pharmacy, for the timeframe under review, reveals regular collection of medicines prescribed; more often than not collected on the same day it was prescribed.

5.3.28. The Ambulance Service have noted one attendance when the wrong equipment was provided to the Mother to administer one of the drugs rectally. This necessitated Child H being taken to hospital.

5.3.29. School A have confirmed that all medication coming into the school must be provided by the parents, and that they were advised on the need to have clear labelling, and of the school policy on administering medicines. Often the school were not provided with sufficient medicines.

5.3.30. Without any declining health indicators it is unlikely the Social Worker would need to routinely ask if medication regimes were being adhered to. However, given the repeated reports from School A about the associated difficulties

⁴³ [Reading LSCB: SCR I17](#)

of either no medication, or inadequate supplies, this might have reasonably have prompted some kind of review of whether there were patterns and any problems.

5.3.31. Advice and support given to parents on medications:

5.3.32. The Safeguarding Service of Portsmouth Hospital Trust have highlighted that although the need for the parents to receive training on the use of medication is documented, it is unclear if any training was actually provided. The focus is also recorded as being to offer training to the Mother, with no mention of the Father.

Learning point: Avoid making assumptions that mother's provide care and support to their children when giving advice about personal care and medicines management; father's should be actively included in being given the opportunity to participate in attending appointments.

5.3.33. Despite not attending any appointments Portsmouth Hospital Trust have reflected that Child H and his parents met with the Specialist Epilepsy Service who provided verbal and written information on administration of medication to terminate a prolonged seizure. This was noted in a Care Plan in July 2017.

5.3.34. The Children with Disabilities Service have noted that there is evidence that Social Worker 1 and other professionals regularly reminded the parents to attend medical appointments for Child H and to ensure appropriate and sufficient medication was available to the school. Although a Social Worker is not qualified to advise on medications it would be reasonable to expect any concerns to be explored with the parents as part of the ongoing relationship, and then shared with the relevant professionals involved.

5.3.35. As stated above, the Mother has been described as a credible person and one who is clearly able to present as competent. In terms of medicines management it has been reported that the Mother was able to accurately recite the correct dosages of medicines required for both Child H and sibling. This portrayal of competence may have diluted the level of professional concern and given false reassurance about medicines management.

5.3.36. Storage of medications in home:

5.3.37. The Ambulance Service have described one attendance to the family home where the Father did not know where to find emergency medications stating that the Mother usually kept them with her in a bag, he did not know how to administer medications, and also did not know which medications might be appropriate to use in the situation.

5.3.38. No specific storage advice was provided by Portsmouth Hospital Trust or the Specialist Epilepsy Service. The Children with Disabilities Service have noted that there was no reference in any assessments to the safe storage of medications in the home. During an Early Help/TAC meeting the Mother advised the School Nurse that she kept the medicines in a kitchen cupboard and that they were all labelled clearly so she knew what to give and when.

Learning point: When working with children and families who have high levels of need, and where the use of prescribed medicines forms part of a health or safety plan, regularly asking and checking about medicines storage is an entirely reasonable thing to do.

5.3.39. Review of condition and medications:

5.3.40. Portsmouth Hospital Trust have reported that ongoing management and decision making regarding medication to prevent seizures was provided by the Community Paediatric Service. Following Child H's emergency attendance in January 2018 the Specialist Epilepsy Service had concerns regarding compliance with medication so an alert was put on EPRO⁴⁴ to check blood antiepileptic drug levels at the next emergency attendance. This was not completed at the next emergency attendance and despite good efforts, it has not been possible to ascertain the reason why this did not

⁴⁴ EPRO – Electronic Patient Recorded Outcome database system.

happen. These concerns were shared with Social Worker 1 and the Community Paediatric Service. Since August 2018, although not as a result of this case, the Specialist Epilepsy Service now has access to CHIE⁴⁵ so can view GP prescriptions. This does not however allow monitoring of dispensing of medication.

5.3.41. It has been highlighted that the prescription for one of the medications the dosage instruction is 'as directed' but given the dosage changed frequently because of Child H's growth, knowing the correct quantity would have been more challenging given this unspecific direction on the labelling. The Safeguarding Service for Portsmouth Hospital Trust note that although information was provided to the parents in July 2017 there continued to be concerns about whether Child H was receiving the appropriate dosages up until his last emergency attendance before his death. There is frequent liaison recorded between the Specialist Epilepsy Service, GP, pharmacy, Community Paediatric Service, School Nurse and Social Worker over these concerns however at no point is there evidence of any one professional raising the profile of the concerns to a sufficient level that provokes any meaningful action to prompt the professional network to pause and reflect on what might be happening.

5.3.42. It is now impossible to comment on whether Child H was prescribed, and taking, the correct medication and dosages for managing his epilepsy – especially given the uncertainties already outlined about the limited oversight and scrutiny of his condition. Nevertheless, it is worthwhile noting that as a result of toxicology tests immediately following Child H's death, tests for one anti-epileptic drug were consistent with its therapeutic use, whilst for two others they were significantly below the expected therapeutic range. This strongly suggests that Child H was not benefitting from the full prescribed range of drugs to manage his epilepsy. The excessive number of emergency admissions should have been seen as a potential indicator that the medication was not being administered as required.

5.3.43. Given the information set out above it has highlighted the importance of a lead professional role. It has become clear in this case that the role and function of the lead professional was not fully and effectively discharged by either health professionals who have oversight of Child H's health needs, or Children's Social Care. In practice, this meant that there were no regular, scheduled opportunities (other than annual reviews) to review and revise assessment, care planning and interventions. As these opportunities did not exist the collation, analysis and response to safeguarding concerns was not tracked or monitored to expected standards, especially those set by Portsmouth Children's Social Care. The lack of an effective care pathway between Solent NHS Trust and Portsmouth Hospitals NHS Trust did not help this. The Children with Disabilities Service have reflected that their response to Child H '*... did not recognise the impact [missed appointments] could have on Child H and prevented ... [them] ... evaluating the overall picture of inconsistent management by the parents of Child H's health needs and ability to proactively meet them. Missed appointments were seen as discreet incidents, not a pattern of parental negligence with an associated level of risk for the child ... There are regular notifications and recordings of parents not providing adequate medication to Child H's school and an increased number of seizure activity, including overnight hospital admission on a number of occasions. This is not evaluated by the agency in terms of it being a safeguarding issue until May 2018. This may have been due to a lack of professional curiosity as to why medication prescriptions could not be collected from the GP/Pharmacy on time. There was no consideration about whether the medication issues in school were also present in the home. The family had requested overnight respite since 2010, yet did not progress this when the funding was agreed. The barriers to parental non-engagement ... was never fully explored or considered as neglectful. The question as to whether parents were doing what they could/should to meet Child H's assessed needs ... is missed ...*'.

Learning point: 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

⁴⁵ CHIE – Care & Health Information Exchange database system.

– it needs to be someone who can take a holistic view about provision across the partnership and has the skills, resources and support from their agency to fulfil the role.

5.4. Inter-agency communication & information sharing

5.4.1. Portsmouth Hospitals Trust Safeguarding Service were also not been able to ascertain who the lead professional was for Child H having reviewed their records. As highlighted, the Korner form and social history were, more often than not, not completed or taken during the emergency admissions. Current Trust systems on the Paediatric Wards rely solely on paper records. Child H's notes consist of two large volumes which are many inches thick. Email correspondence had not been placed on the paper files, and wading through the significant amount of paper information would have taken considerable time. The Trust recognises the risks associated with paper records and the need to move to an electronic records system; the decision on this currently sits within the Trust's Board Assurance Framework.

5.4.2. Portsmouth Hospitals Trust Paediatric Service recognised, prior to 2018, that communication between the Hospital Paediatric Team (which included the outpatients department, the Children's Assessment Unit, and the Specialist Epilepsy Service) and the Community Paediatric Service and other agencies needed to improve; this was largely due to different services within the health sector not sharing the same electronic information systems. This recognition has resulted in improvements, notably about how written information is available to staff when the full written notes are not available. Since January 2018 written communications from other hospitals or agencies should be scanned onto the hospital EPRO database which is available to all staff seeing children in scheduled or unscheduled care. Communication to other agencies for children with epilepsy has also been the subject of improvement activity; there is now an automated system which informs the Specialist Epilepsy Service of any child attending the Children's Assessment Unit in Portsmouth Hospital with a seizure. The Specialist Epilepsy Service then informs other agencies involved, including the Community Paediatric Service. The new EPRO system also holds information about care plans, conversations and emails.

5.4.3. Although they were not involved with the Father at the time, the Adult Substance Misuse Service were also not involved in the Strategy discussion nor invited to the Initial Child Protection Conference, or involved in attending the Core Group. They had considerable information which may have been of interest to partner agencies.

5.4.4. From a GP perspective the Practice have identified three issues of note relating to effective communication across the professional network. These are;

- The GP Practice had already identified that there were difficulties in capturing changes in patient care planning arrangements set out in letters from hospitals due to the volume of letters received. This prompted a revised system to be implemented whereby medical secretaries' review each letter to highlight to the GP if there were any changes or other actions which might require intervention. In this case, this new system worked well as the GP queried the dosage of one particular anti-epilepsy medication in March 2018.
- The GP Practice has also identified delays in receiving information from hospital clinics; in one case a nine week delay on information that needed changes to prescriptions for Child H.
- The Hospital not specifying what medication a patient is taking each time they attend hospital, in letters sent to the GP Practice. This inhibits the GP cross referencing new information with repeat prescription information to ensure prescriptions are issued correctly. The practice of writing 'no change in medications' is reported as being unhelpful, particularly given the frequent changes in medication dosage and the delays outlined above.

5.4.5. South Central Ambulance Service did not have access to a system which held care plans for Child H which would have been useful to the ambulance crews attending, especially on the occasion when the Father appeared not to know about medication or not know where it was kept. Given this finding it is arguable that the ambulance crew could have considered making a safeguarding referral as the Father's apparent lack of basic knowledge for such a situation was

worrying. The finding also highlights that currently ambulance crews do not have access to CPIS system nationally. However, and positively, South Central Ambulance Service has been chosen as a pilot site by the Department for Health to have access to it; this pilot has yet to begin.

5.4.6. In January 2018 when further concerns emerged school staff discussed the need to make a MASH referral with Social Worker 1. Social Worker 1 advised that any referral to MASH would be referred back to her as it was an open case; this resulted in all concerns being passed directly to Social Worker 1 by the School. Children's Social Care have agreed that, in this case, '*... the local protocol for the Children with Disabilities Service unhelpfully halted the process from progressing ...*'. School A have reflected considerable frustration, not unreasonably, about the delays in escalating action from Early Help/TAC meetings to Child in Need meetings around December 2017 and then again in January 2018. This episode included concerns being raised by the School, the School Nurse and the Community Paediatric Service to Social Worker 1 with the Head teacher stating '*... this cannot go on for even one more day. I am very concerned that Child H has been persistently absent from school ... [at that point he had been absent for three weeks] ... and evidently not at home. I am also concerned for his health needs. The situation is urgent ...*'. Social Worker 1 was reported as arranging an emergency Strategy discussion with all professionals and an expectation that the School would hear from Social Worker 1 the next day. There is no record that this happened; this was due to the concerns being downgraded by the Children with Disabilities Service and the concerns not being judged as reaching a threshold to warrant a Strategy discussion. This was not communicated back to School A. Records indicate that further concerns were raised with Children's Social Care in February, March and May 2018 by School A and the School Nurse but a Strategy discussion was never held; and a Child in Need meeting was not held until the middle of May 2018. Further to this when the Child in Need meeting was eventually held in May there was agreement that about a section 47 investigation was needed; this did not happen until June during which time there had been 13 further separate concerns raised by the School. During this time the School have reported no communication from the Children with Disabilities Service. Additionally, following the Strategy discussion in June there were a further 10 incidents reported by the School to the Children with Disabilities Service before the ICPC was held. An earlier Strategy discussion could have taken place resulting in an earlier ICPC, resulting in an earlier Plan that would not have been initiated just before the school summer holiday period. The high number of additional concerns referred by School A is likely to reflect a mix of issues a) some genuine concerns that were felt to require action, b) a mismatch in understanding about thresholds, and c) a symptom of the loss of confidence in the response from the Children with Disabilities Service. School A could have considered using the professional challenge & resolution of professional disagreement protocol when they did not hear back from Social Worker 1 and experienced drift with a response to their growing concerns. Other professionals, including the Community Paediatric Service, the Specialist Epilepsy Service and School Nurse could also have used this protocol.

Learning point: Using the professional challenge & resolution of professional disagreement protocol is an acceptable course of action to take if you receive no response to the concerns you raise about a child's safety and welfare. Informal resolution should always be the starting point, however where there is delay or drift using the next stage of escalation is acceptable. By accepting drift you are unwittingly colluding with losing sight of the child's needs and safety. Do not rely on emails to escalate your worries and do not accept an unreasonable amount of drift.

5.4.7. The policy of the Children with Disabilities Service passing safeguarding concerns to the MASH or Locality Team has resulted in a culture whereby the Children with Disability Service views safeguarding as a separate task that they have no responsibility for. In doing this, workers did not develop and practice skills in risk identification and risk management, and became professionally disempowered.

5.5 The effectiveness of professional support and interventions, including any barriers

5.5.1. The Safeguarding Service from Portsmouth Hospital NHS Trust have considered the emergency admissions for Child H '*... whilst it is acknowledged that these admissions may have been preventable ... they did ... provide an*

opportunity for health professionals to fully assess Child H's medical and care needs and his parents ability to care ... These opportunities [were] missed and Child H's needs were not holistically assessed at each admission with only his acute medical needs being treated. Child H was often discharged before he could be reviewed by the Specialist Epilepsy Service. On some of the CAU documentation the Specialist Epilepsy Service and Consultant were listed as professionals involved. ... as the email correspondence between the epilepsy [service] and community paediatric service, school nurses and social worker were not filed in Child H's medical records (but were located and printed following ... death) the ward staff may not have been aware of the struggles with engagement other professionals were having. In fact they may have presumed that Child H was getting ... the specialist support ... needed ...'

5.5.2. Portsmouth Hospital Paediatric Service have reflected that children who have complex needs and developmental delay and who have epilepsy are seen in Community Paediatric Clinics and most children in this category are not seen by a Hospital Paediatric Clinic. If further specialist epilepsy input is required the normal pathway of care is for the Community Paediatric Service to refer the patient to the Paediatric Neurology Team in Southampton. In this case, this is what happened following Child H's multiple emergency attendances; however Child H was not brought to any of the appointments in Southampton. This non-attendance was communicated back to the Community Paediatric Service and School A in late 2017. The reason it was communicated to School A was because at the time they were perceived to be the lead professional under the TAC process. In May 2018 there was an email exchange by the Community Paediatric Service to School A suggesting a need to escalate their concerns to a child protection level due to neglect. There is no indication that this was followed through by the Community Paediatric Service and there is no evidence to suggest safeguarding supervision was sought by any member of the Community Paediatric Service for this case. These issues have been acknowledged and steps are being taken to address the learning points raised.

5.5.3. Solent NHS Trust have noted that the presence of a Children's Community Nurse (from the School Nursing Service) in School A was seen as a positive feature as it resulted in communication between school and health staff, and Social Worker 1. It could be argued that the presence of a Children's Community Nurse as part of the Team around the Child process, distracted the need for other health professionals to step up and consider more authoritative action. Solent NHS Trust's perception was that the network of professionals involved with the family appeared to work effectively together, with examples of school staff seeking advice and liaising with the nurse, physiotherapists, occupational therapists and orthotists who assessed and had contact with Child H on a regular basis. The Trust confirm that the network of professionals were familiar with the Mother's erratic engagement and on occasions when planned home visits were undertaken and there was no response, new appointments were offered promptly. This familiarity appears to have blinded the professional network into not taking child focused action when the parents failed to engage but also blunted their expectations about what might be possible. There is no evidence that the Solent NHS Trust's Safeguarding Team were contacted about the case by any of their services.

5.5.4. The Home to School Transport Service were involved in making safeguarding referrals on two separate occasions, in June and then July 2018. This Service were aware of reports that the Mother had slapped Child H, inappropriate language used by Child H during journeys, reports from Child H about the parents appearing to be under the influence of drugs or alcohol, and the parents being seen buying alcohol early in the day, and unidentified adults in the home.

5.5.5. Child H and sibling attended a voluntary sector holiday play scheme for 27 days over three years. This was funded by the local authority and appears to have been a positive experience. The Mother engaged well with the scheme and provided all the necessary equipment the children needed when dropping them off. From the play scheme's perspective, they had no concerns and were fully aware of social worker involvement.

5.5.6. Offers of short-break respite were not taken up by the parents despite good efforts by Social Worker 1 and the Respite Scheme. Agreement for funding, assessment and care planning was all completed however during April, May, June, July, September and October 2017 introductory visits were cancelled by the Mother. This led to a decision that

the Service would only be offered when the family were ready to engage. A further attempt in April 2018 to re-engage the family was unsuccessful as there was no-one at the home when staff attempted an arranged visit. The family therefore never benefitted from this offer of support. This, in itself, could be viewed as a risk factor.

5.5.7. From the Wheelchair Service perspective there is no record of the case worker meeting with the parents during the timeframe under review. This reflects no opportunity to assess parental wishes and views, nor any opportunity to advise the parents on issues about the wheelchair, or explain the considerable delays in providing a suitable wheelchair.

5.5.8. Professionals from a number of agencies have described having a level of sympathy for the Mother – having to care for two children with disabilities and manage multiple health appointments. Social Worker 1 is reported to have built a good relationship with Child H and family over many years, providing information, advice and sourcing funding for support services, reminding and re-organising missed appointments. Holding meetings at School A was seen as a positive step to reduce the travel burdens for the family. School A have noted that there were multiple attempts to support and engage the parents via the Early Help/TAC reviews yet these were largely ineffective as the Mother was failing to follow through with identified actions. Often the Mother would be heard to contradict herself in meetings leading professionals present to be cautious about her accounts and intentions. The issues persisted and the School have noted ‘... *Child H’s Mother was very agreeable to any actions identified in [meetings] and often would admit she was at fault. Any attempt to comply with action plans however was always short lived and the same issues would crop up again at the next meeting. This was extremely frustrating for school staff ...*’.

Learning point: Research⁴⁶ into other Serious Case Reviews highlights ‘... *the quality of empathy embraces considering both the voice of the child and the needs of the family. It must be grounded in the centrality of the rights and needs of the child, while being sensitive but not colluding with the needs and views of the parents ... it is important that appropriate empathy towards the parents does not cloud professional judgement or challenge ...*’.

5.5.9. The impact of this was that it created a culture of dependency and learned helplessness which failed to sufficiently challenge the parents’ increasingly negligent parenting behaviour. The parents’ ambivalent and passive engagement with the professional network was reflected back by a relatively passive and ambivalent professional response with there being a lack of direction and planning. There is no evidence of authoritative intervention by any one professional until the Initial Child Protection Conference in July 2018 – although section 5.6 below argues that this was somewhat flawed as well. Those professionals have reflected on this emergent practice and acknowledge that this biased thinking may have impaired their judgements and decisions. Calder⁴⁷ refers to this as professional dangerousness citing ‘... *reduced sensitivity ... inadequate reflection ... dangerous decision making ...reframing and minimising the true nature of concern ...*’ as possible features with collusion with the family as being an issue that can arise. Research⁴⁸ confirms inconsistent professional challenge when parents fail to comply and not attending medical appointments as being a contributing risk factor. Additional research⁴⁹ states ‘... *where a child has heightened health needs ... lapses in health care can be dangerous. Children who have disabilities or complex health needs often require added vigilance and arguably a higher standard of parenting. Practitioners readily identify with the challenges and stresses that children’s disability and complex health needs place on parents, but this can also mean that they accept*

⁴⁶ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 202, University of Warwick & University of East Anglia, May 2016

⁴⁷ Calder, M. Contemporary risk assessment in safeguarding children, 2008, p. 64 – 65, Russell House Publishing.

⁴⁸ a) NSPCC Briefing: Learning from case reviews – health, December 2015, [NSPCC – Briefing](#) and b) Ofsted: In the child’s time: professional responses to neglect, March 2014.

⁴⁹ Brandon, M., Glaser, D., Maguire, S., McCrory, E., Lushey, C., Ward, H., Missed opportunities: indicators of neglect – what is ignored, why and what can be done? November 2014, p. 25, Department for Education, HM Government.

a lower standard of care or fail to recognise neglect ...'. Whilst these features occur unwittingly for practitioners engaged in working with children and families, they highlight the importance of regular and effective reflective supervision for individual practitioners but also working in a holistic multi-agency arena to share the human dynamics that naturally occur in such situations. Research⁵⁰ refers to these incidences as *'inescapable errors'* which affect practice over time, often without them being realised.

Learning point: Research⁵¹ refers to supervision as *'a fresh pair of eyes'*; *'... Practitioners who are well supported, receive supervision and have access to training are more likely to think clearly and exercise professional discretion ...'*. Whilst there can be benefits to having the same worker over a period of years, there are disadvantages – namely the potential for bias creeping into how the family is viewed, professional habituation and reduced sensitivity.

5.5.10. From the local authority perspective, the quality and frequency of supervision Social Worker 1 received has been found to be an issue. Management capacity at this time has been reported as problematic. Practice management standards and expectations were not met with supervision being approximately every third month, with one session recorded for October 2015, four sessions for 2016 and four for 2017, and two sessions for 2018 – all sessions being several weeks, or months, apart. This is a stark finding and one that offers some insight into the workings, stresses and challenges for the Children with Disabilities Service over the timeframe under review. The allocated Social Worker's extended periods of sickness may be seen in this context. Management capacity was stretched with role changes, additional responsibilities and further distancing between the Education & Inclusion directorate and Children's Social Care. Line management structures did not provide sufficient challenge and support for the Service to adequately discharge their basic functions as a social work service. In turn, this impacted on social work practice. This situation did not improve until December 2017 when additional management capacity was agreed, however it is clear that the benefits of this were not realised until April and May 2018 when further social work capacity was in place. The lack of management capacity and oversight plus considerably reduced individual supervision was a contributory factor to Child H's case not being managed to the standard expected. From a system thinking perspective this is a further example of emergent practices – not planned for or designed, but simply emerging as a result of local dynamics, action and interactions within the system architecture. Research⁵² describes these situations as a *'toxic duo'* – neglected practitioners working with neglectful families, who then fail to meet the needs of the children they work with due to organisational culture and local expectations.

5.6. Service delivery around the time of Child H's death

5.6.1. During the later timeframe under review (May 2018) when the School noticed an increased level of unexplained injuries on Child H, a section 47 investigation was agreed however there were also delays in this progressing. During this period the School reported a further 10 incidents to the Children with Disabilities Service; and then, between the ICPC and the first Core Group meeting the School raised concerns three more times.

5.6.2. The Community Paediatric Service attended the strategy discussion however the minutes of the strategy discussion make no reference to the high number of emergency admissions Child H had to hospital – instead with the focus being on injuries and marks seen.

5.6.3. The interim safety plan developed following the decision to hold an ICPC and then it actually taking place is weak. It comprises of a set of *'terms'* which *'... will be adhered to ...'*. Some statements have no comments added and

⁵⁰ Farmer, E., & Lutman, E., Working effectively with neglected children and their families – what needs to change? Child Abuse Review, Vol.23, pp262 – 273, 2014, Wiley Online.

⁵¹ Burton, S., The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? Safeguarding Briefing 3, p 9, November 2009, C4EO.

⁵² Horwath, J., The toxic duo: the neglected practitioner and a parent who fails to meet the needs of their child, 2015, pp 1 – 15, British Journal of Social Work.

have been left blank; all terms are fixed, such as ‘... all three children will attend school every day ...’ and ‘... there will be no rough handling of the children and play will be supervised ...’. Whilst the need to provide clear, unambiguous tasks for all concerned has value, it does reflect a rule based style of thinking and did not recognise that, to date, the parents had struggled to adhere to ‘the rules’ i.e. getting the children to school every day. In this case as a strategy for managing the children’s safety it is limited and over-optimistic, especially given the known non-compliant behaviours exhibited by both parents over a sustained period of time.

5.6.4. The Social Work report to the Initial Child Protection Conference clearly articulates the concerns, summarises historical information, and offers a clear recommendation that Child H and Siblings 2 & 3 should be made subjects of Child Protection Plans. However, reference to the emergency admissions and epilepsy management is only briefly made in the analysis and recommendations section – with no specific reference to it being of concern prior to this in the chronology section. The focus of risk appears to be mostly around physical injuries and neglectful parenting. The Conference included a ‘professionals only’ slot during which Police intelligence was appropriately discussed. Reports submitted by attending agencies vary in quality, depth and analysis. The report submitted by the School Nursing Service makes no reference to epilepsy or seizures. The recommendations of all professionals attending was unanimous resulting in the children being made subject to Plans under the category of neglect. The decision-making process appears robust and sound on this basis. The decision of the Conference was appropriate given the known risk factors being considered alongside the criteria for neglect. However, and of particular note, the minutes from the Conference make no reference whatsoever to epilepsy or emergency admissions. In effect, the life-threatening condition is minimised in the social work report to the Conference, and then lost completely in the decision-making process and recommendations from the Conference. On this basis, the decision-making process has to be argued as fundamentally flawed given there were sufficient professionals in the room that had enough knowledge about Child H’s condition, circumstances and emergency admissions. This potentially reflects a lack of understanding about epilepsy as a life-threatening condition if not properly managed.

Learning point: Omitting information about risk factors, or compartmentalising risk, does not allow a thorough and holistic assessment of risks children may face. Ensuring all information is captured, considered and shared with those working with a child is an important step to effective safety planning.

5.6.5. A Core Group was held within expected timeframes. Review of the Plan and first set of Core Group minutes reveal three issues of note;

- The first Core Group took place in the last week of the school term just as the schools broke for a six week holiday period. It was at this first meeting that the detail of the Child Protection Plan was developed and does little to reflect a period of time when, often due to staff absence, there is a reduced level of service. The impact of this for this family was that School A could offer very limited support over the next six weeks, and their monitoring would not be available. The Children’s Community Nursing Team/School Nursing Service provided considerable support to Child H and Sibling 3’s lives, and due to the school holiday period their contact was also reduced.
- Accompanying this first point, is that the driving rationale for holding an ICPC was because of physical injuries, missed health appointments, and concerns about the parents’ failure to engage with health professionals to meet Child H and Sibling 3’s health needs. The Plan fails to reflect any sense of urgency about having Child H’s epilepsy and medicines regime reviewed in order to understand or prevent further seizures. The word ‘epilepsy’ does not appear in the Plan. Getting a priority appointment with the specialist services would have been an obvious and urgent initial task to undertake.
- The Plan refers to the intended use of a neglect tool as a way of assessing parental care. It makes no reference to an assessment of parental capacity to change. Assessing parental capacity to change behaviours – in a timeframe that would be of benefit to the children – can be argued as a core requirement given the history.

Learning point: When a school age child becomes subject to a Child Protection Plan, and professionals based in the school form part of the safety planning but are about to break due to a holiday period, it is important to incorporate contingency plans into the overall Child Protection Plan.

Learning point: In cases where there have been long standing concerns, especially about neglectful parenting, it is always appropriate to undertake an assessment of parental capacity to change.

5.6.6. Children's Social Care, who held overall responsibility to lead on the Child Protection Plan have confirmed that the case was being jointly worked by the Children with Disability Service and the Locality Team and that this was a positive and consistent arrangement. Staffing capacity at this time was not an issue and visits were completed weekly, sometimes twice weekly highlighting a higher than standard expectation than the statutory frequency of every 10 days. This increased visiting frequency does reflect a level of professional anxiety and uncertainty about the effectiveness of the Child Protection Plan. Both Social Workers involved were experienced and knowledgeable about working with children with complex disabilities.

Learning point: When a child becomes subject to a Child Protection Plan and visiting frequency is higher than standard expectation there may be value in questioning the quality of the Plan; considering whether it is realistic to expect the parents to offer the level of safety a child needs and whether increased visiting by professionals is an effective strategy for ensuring safety or whether it is simply providing a false assurance to professionals who are monitoring the situation.

6. Good practice

6.1. 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. The following features have been captured;

- This review has generated a high level of interest and desire by the multi-agency professional network to learn and make improvements; this resulted in very good attendance and engagement by practitioners and managers at workshops.
- Prior to the timeframe under review, it is clear that Neonatal Intensive Care Unit within Portsmouth Hospitals Trust demonstrated very good recognition of concerns about parental engagement, which were appropriately escalated. Following on from this, the ongoing oversight and then correspondence to Children's Social Care is good practice as was the oversight by the Named Nurse for Safeguarding from Portsmouth Hospital NHS Trust.
- Child H and his family was provided consistency by having the same allocated Social Worker for nearly six years.
- Matching social worker experience with case specific issues when allocating the case at the point that Child H became subject to a Child Protection Plan.
- The repeated offers by the short break service in their endeavours to engage with Child H's parents.
- The extended efforts by the Adult Substance Misuse Service to engage the Father back into a treatment programme.
- The consistent and frequent communication by the Adult Substance Misuse Service to Social Worker 1.
- The identification by the GP Practice in March 2018 of medication dosage and potential risks to Child H; including the introduction of an improved check and balance mechanism to flag medicines changes.
- The use of a recording system in School A as a method for tracking child protection concerns.
- The determination by the Designated Safeguarding Lead in School A in maintaining a focus on Child H and attempts to overcome barriers with information sharing and multi-agency working.

7. Conclusion

7.1. This Serious Case Review has examined the circumstance of professional involvement with a child who had complex disabilities and epilepsy and who died in August 2018. The review process has benefitted from the

involvement of practitioners who worked with the child and family plus submission of agency documentation to support analysis. The review did not benefit from the contribution of the child's parents.

7.2. The review has found that a number of risk factors were present and known about by a range of professionals involved however many of these factors were not responded to in a timely or effective way and professional attention was often diverted on to dealing with the child's disability rather than seeing him as a child that was being medically neglected and living in a household where there was a dynamic level of risk due to drug misuse. The situation was compounded by non-engagement by the parents with some professionals, parental deceit and a passive parenting style that went unchallenged by the professional network. The professional response lacked authority, pace and purpose.

7.3. Contributory factors included fragmented information sharing, bias towards the parents which hampered a re-evaluation of risk to the child, and emergent practices within Children's Social Care who held lead responsibility resulting in the overall strength of the safeguarding partnership's response to the concerns being raised being undermined. This final factor was compounded by a lack of knowledge, and expectation, by partner agencies about the child's status as a Child in Need. Professional challenge and escalation on these issues was extremely limited or ineffective.

7.4. The review process has enabled a reflective dialogue across the Safeguarding Partnership and also captured learning points for all professionals working with children and families. Those agencies involved have acknowledged their areas of learning and have subsequently considered improvement activity. The review concludes with recommendations for the Partnership.

8. Recommendations

As a result of this Review agencies that have contributed have been able to identify learning that can be taken forward internally, and as such have submitted single agency action plans reflecting their internal learning and recommendations for improvement. It is the role and responsibility of the Safeguarding Partnership to scrutinise and challenge progress against single agency action plans. The following additional recommendations are made for the Safeguarding Partnership;

1. To ensure the learning from this Review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.
2. To seek assurance that the actions identified by each partner agency, as a result of this Review, have been managed, implemented and embedded in a timely manner.
3. The Safeguarding Partnership to promote and increase knowledge across all services in the Portsmouth area about the different processes through which concerns about a child's welfare might be managed, with clear explanations about the differences between Early Help, Child in Need and Child Protection processes, the potential cross-over points and threshold continuum. This should include a clear outline about what is to be expected from Children's Social Care at every stage. This may require a summary version of the PSCB Threshold Guidance to be produced. Initial efforts should target health and school settings.
4. Children's Social Care local policy for the management and review of Child in Need cases, particularly those cases of children with disabilities, should be reviewed to ensure that it clearly reflects the need to involve partner agencies. Once reviewed it should be communicated to all partner agencies, with training/briefing sessions made available. The policy should make explicit reference to the allocated Social Worker being the named lead professional and that this should be stated at the beginning of every Child in Need review meeting.
5. The Safeguarding Partnership should seek assurance about the use of single agency chronologies to aid assessment and decision making, generally as a tool for all agencies working at Early Help and Child in Need levels. Whilst gaining

this assurance there may be merit in seeking assurance that multi-agency chronologies are also being actively used in families where there are known complexities and multiple risk factors and whether the gaining of consent from parents by the relevant professionals to share chronologies is a barrier to effective joint working.

6. The Safeguarding Partnership to commission a multi-agency audit of Child Protection Plans to gain assurance that information taken in to Initial Child Protection Conferences via single agency reports accurately captures and analyses known and knowable risks to the child, that the record from the ICPC reflect such risks and these are translated in to the Child Protection Plan that is considered at the first Core Group meeting.

7. Solent NHS Trust and Portsmouth Hospitals NHS Trust to review their policy and procedure about recognising and responding to medical neglect. Once reviewed, this should be widely disseminated to all safeguarding partners with training/briefing sessions made available.

8. Given the extensive number of different IT systems in use across the local health economy, local health providers should provide the Safeguarding Partnership with assurance that there are adequate mitigating strategies in place to support effective information sharing between health professionals who work across more than one IT system and that information is not lost when transferring information from one system to another (whether paper or electronic).

9. For children who access both community based paediatric health services and acute paediatric health services care pathways should be put in place and/or be reviewed to highlight any gaps or barriers that exist which may hamper effective safeguarding practices. This should include the pathway for prescribing and dispensing medication between the Acute setting, the Community Paediatric Service and GP, but also consideration of developing a Medicines Advice at Home provision to provide support for parents who have difficulty in managing their children's medicines for reasons such as mental health difficulties, learning difficulties or complexity of arrangements.

10. Solent NHS Trust and Portsmouth Hospitals NHS Trust should review and effectiveness of support and supervision available to all health care professionals to ensure that there is access to regular and scheduled supervision for those practitioners working with children with complex health needs.

11. The Safeguarding Partnership should remind all professionals about the professional challenge and resolution of professional disagreement protocol. Information should be specifically provided to all health care professionals who work in community based settings and paediatric settings and school staff about the use of professional challenge and escalation.

12. The Safeguarding Partnership to review the content of the Designated Safeguarding Lead training materials delivered to all schools to ensure it reflects the findings of this review and that information about the differences between Early Help, Child in Need and child protection pathways is clear and unambiguous.

13. The Police to review and confirm its arrangements to ensure that information and intelligence that is relevant to keeping children safe is always shared with relevant statutory partners in a timely way; this should include when concerns arise about an adult's behaviour or criminality that might lead to concerns about a child's safety and welfare.