Child C

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

The child tragically died from hypoxic brain injury due to a severe asthma attack which resulted in cardiac arrest. The child was the eldest of five children. The child's mother has issues with alcohol and has experienced domestic violence. The child was on the Child Protection Register twice. The second time was due to the mother's misuse of alcohol and failure to meet the health needs of the child.

Circumstances of, and challenges faced by the individual

Throughout the child's short life, the child witnessed domestic violence, did not receive stable parental care and was being neglected and did not receive appropriate nurture and care. The child's asthma was not under control and the child missed some medical appointments. There was some improvement with the child's home environment and school attendance improved but this was not constant.

What happened?

- The information from the mother was inconsistent, which meant that the medical staff had to rely on younger siblings to provide information (at this point the mother smelled of alcohol).
- The child was unwell for six days prior to admission and the family did not seek medical advice.
- The case was closed by social service .
- Risk assessments and sources did not specify risks to the child's health.
- The final review conference did not acknowledge that the child's on-going poor health was from poor compliance and failure to administer medications as required.
- The main theme is that the implications of the child's asthma were not managed properly as it seems they were underestimated.
- Stress (the child witnessing domestic violence etc) was not considered as one of the contributing factors making the child's asthma worse.

Why it happened?

- It was not clear if there was a clear agreement amongst the professionals about the seriousness of the child missing health appointments or using preventative medication.
- There was no evidence of any checks on the child to see if they are using the medication as required nor was this shared with other professionals.
- The family issues overshadowed the child's medical condition which meant that it was missed.
- The concerns around asthma medication not being given were not thought through as fully as they should have been.
- The report did not have any information about the medication attached. This would have given professionals a clear picture that the child was not receiving the appropriate medication.
- The appointment for child to see a respiratory specialist should have been within two to four weeks but an appointment was not given until three months later.
- The hospital should have been more proactive in following up missed appointments according to guidelines for children who are known to be at risk in relation to safeguarding.
- The child was discharged due to missed appointments and had to go through the system again and no individual practitioner took overall responsibility for monitoring the child's well-being.
- The failure to attend appointments and poor compliance with treatment were never seen as a standalone issue.
- It was not clear how the child's views were considered as part of care planning.
- There was no evidence in the social work files of any follow-up to see if any of child's concerns had been shared, and to see if things had changed for the child and their siblings.
- The child indicated, through diagrams of faces, that they were feeling 'ill', however no one checked to see if this meant that the child was ill or if this was just a general feeling the child was experiencing. This meant that there were missed opportunities to explore how the child was feeling and to address issues around their medication not being used.
- Not all professionals received a full picture of what was happening with the child.
- Some of the paperwork (assessments) was not updated regularly.
- Some key staff were too optimistic about changes within the family when in fact these were only minor changes. Practitioners did not look for signs that the changes were both genuine and long-lasting.
- Team leaders had high workloads and struggled to provide consistent supervision to their staff.

Report recommendations

The serious case review makes 13 recommendations:

1. We recommend that all agencies should review current practice in order to ensure that the wishes and feelings of children are addressed.

2. We recommend that local authority take a clear management stance on Public Law Outline activity with agreed standards for letters and decisions. All written statements of consequences to parents must be followed through and acted upon.

3. We recommend that a multi-agency Public Law Outline Protocol be developed to include a training programme. We recommend that in order to ensure that consultation with children is at the forefront of all practitioners mindset.

4. We recommend that all conferences follow a signs of safety approach to specifying risk, detailing protective factors and clarifying complicating factors and grey areas. A training plan should be developed in relation to this.

5. We recommend the health board assure themselves that their staff apply their policies correctly.

6. We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, they should have an individual health plan that is integrated into the social work assessments and the child protection plan.

7. We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, a medical practitioner must attend all initial case conferences and reviews.

8. We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, a named health professional should be identified at the earliest opportunity to take overall responsibility for ensuring that the health needs of the child are being met.

9. We recommend that all agencies reconsider their position in relation to standing members only attending initial case conferences

10. We recommend that multi-agency training courses should be put in place to ensure that the importance of strict compliance with conference directives are understood and are fully monitored

11. We recommend that the recent good practice instigated by the child's GP surgery, whereby all children on the child protection register are electronically reviewed monthly by their GP to ensure compliance with medication, is disseminated across the region.

12. We recommend that all agencies review their staff support systems to ensure that staff are appropriately supported and fully briefed of the process, when they become involved in a child practice review.

13. We recommend a comprehensive review of all team leaders' workloads in social services to ensure that they have sufficient time set aside to provide consistent supervision to their staff when dealing with complex cases.

Citation

Williams S. and Salem F. (2016) re:ECPR Gwynedd 1 2015

www.safeguardingboard.wales/2018/06/17/case-reference-north-wales-gwynedd