Serious Case Review

Overview Report

Child LW

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1. Introduction

This Serious Case Review (SCR) was commissioned by the Lancashire Safeguarding Children Board (LSCB) on 23/05/19. The decision to conduct a SCR was made following a rapid review of the circumstances of the case and advice from the National Child Practice Review Panel that the criteria had been met for a SCR to be commissioned in line with Working Together 2018.

During the course of this SCR, the legal statutory guidance for local safeguarding children arrangements has been revised resulting in the deregulation of Lancashire Safeguarding Children Board and the development of a new partnership in line with Working Together to Safeguarding Children (DfE 2018). The newly formed, Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) will be responsible for considering the learning from this SCR and for considering and implementing any agreed recommendations.

The catalyst for this review was that a 17-year-old child, who will be known as Child LW, who was found unresponsive at home and then tragically died three days later after being taken to the hospital.

Child LW had been diagnosed with Diabetes Mellitus twenty months prior to their death and there had been a number of concerns about the way the child was being cared for and supported by the parents which led to a lack of compliance with the treatment regime required for the child to remain healthy. There were also concerns about the level of family dysfunction in general and Child LW’s exclusion from the safeguarding processes which were already in place to protect the child’s half sibling and step siblings.

The key learning themes identified in this review include**; diabetes mellitus in adolescents; impact of adverse childhood experience and adolescent neglect and safeguarding.**

Whilst this review covers Neglect specifically of an adolescent with Diabetes Mellitus, there is learning for other adolescents with chronic medical conditions such as, Asthma, Epilepsy, Cystic Fibrosis, all forms of Cancer and other less known life-threatening conditions.

2. Methodology

The methodology for this review was carried out using the systems model approach to learning as outlined in the Child Practice Review process provided by “*Protecting Children in Wales Guidance for Arranging Multiagency Practice Reviews”* (Welsh Government 2012).

Local Child Safeguarding Practice Review (LCSPR) (previously known as Serious Case Review) is the mechanism used to review a child death or where a child is seriously harmed and abuse or neglect is suspected. The aim is to consider multiagency working practices and to improve systems to improve outcomes for children.
Local Safeguarding Children Partnership (previously known as Local Safeguarding Children Board) involves three key agencies (Police, NHS and Local Authority) working together as equal partners and with other agencies to ensure that services and professionals work together effectively to safeguard children and to promote their welfare across the local area.
National Practice Review Panel – is the responsible body for overseeing the quality and learning from LCSPRs to influence and promote change to improve outcomes of children. They will also, conduct reviews in cases which are viewed to be of national impotence.

The overall purpose of the SCR model was to consider what happened in this case and explore why services were delivered as they were. Also, to consider how practice can be improved through changes to the system to improve outcomes for children. A Terms of Reference was developed to identify the key lines of enquiry for the review.

2.1. Key Lines of enquiry

- Determine whether decisions and actions in the case comply with the policy and procedures of the named services and the CSAP.
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Examine the effectiveness of the safeguarding arrangements particularly around risk assessment, referral, threshold and escalation of concern.
- Examine the involvement of significant family members in the life of the child, and the impact of family breakdown and having transient living arrangements
- Establish the learning around the impact on adolescent children who have experienced Domestic Abuse.
- Establish the learning from the case about the way in which all forms of neglect in older adolescents is managed including; self, medical, chronic, and adolescent neglect.
- Establish the learning around management of chronic serious diseases in older adolescents who are difficult to engage and support to gain treatment compliance including those with Diabetes Mellitus.
- Identify any actions required by the CSAP to promote learning to support and improve safeguarding systems and practice.

The process for this SCR involved a Review Panel of representatives made up of senior managers and safeguarding leads who were from the organisations involved in providing services for the child and family. The role of the review panel was to provide relevant information and analysis of their organisation's involvement in order to capture service/practice issues and to agree the key learning themes and actions required for multiagency practice improvement.

There was good representation at the panel meetings and participants were knowledgeable about their own areas and the local safeguarding arrangements. They were keen to submit and consider learning issues.

A composite timeline which included all agency interactions between 29/03/17 till 13/03/19 was scrutinised by the Independent Reviewer, Review Panel members and front-line practitioners at the Practitioner Learning Event. The Practitioner Event was well attended and were able to identify the key themes of learning highlighted in this review.

The learning from this review will be reflected throughout the report in a series of **"Practice Learning"** boxes which are intended to reinforce and promote areas of safeguarding practice for frontline professionals. There are also, a number of **"Progress"** boxes which identify areas of practice already addressed by the local area following the onset of this review.

At the end of the report there will be a number of **“Good Practice”** areas identified which reflect where professionals went above and beyond the call of duty. There will also be a number of **“Practice Issues”** identified which are practice areas within and between the agencies which require some single agency focus and improvement at individual practice and organisational level.

There are 4 **Recommendations** for the consideration of CSAP and it is recognised that CSAP have the authority to act (or not) on the recommendations as they feel appropriate in the best interests of children in their local area.

Family involvement in the reviewing process is seen as being key to understanding the nature of services provided to the individual family. Their input can provide an understanding of how helpful practitioners and services were perceived by the family.

Child LW’s mother had agreed to speak with the Independent Reviewer about the agencies involved in the review but has so far been uncontactable. Father has also been uncontactable and therefore their views have not been included in this report.

2.2. The Reviewer had access to a number of documents as follows:

- Initial individual agency rapid response timeline of significant events/analysis.
- Child Safeguarding Practice Review Referral
- Rapid review recommendation and chair’s decision
- Record of strategy discussion on 04/05/17 following incident on 29/03/17
- Composite timeline of significant events/analysis

Research evidence and national statutory guidance was considered and used throughout this review.

3. Family composition and context at the time of the child’s death.

Child LW	White British. Age 17 years. Child LW was found unresponsive on the morning of their 17th birthday. The child was described as being streetwise rather than mature, they took care of their own appearance. Child LW was popular within a large friendship peer group but struggled to engage with professionals. The child lived mainly with father and their relationship was described as being “best mates”. Child LW had a close relationship with their half-sibling who was 6 years younger and cousin who was of a similar age. Child LW developed Type 1 Diabetes Mellitus in adolescence (age 15) and struggled with treatment compliance when at home. Domestic abuse, cannabis, family disruption and a lack of education were key features of the child’s lived experience.
Father	White British. Age 36 years. Working sporadically during the period of the timeline. Concerns by professionals of possible drugs and alcohol misuse. He had an “on and off” relation with his partner who had 3 children all subject to child protection plans for Neglect linked to poor parenting. Both school and health staff found father difficult to contact and engage.

Mother	White British. Age: 34 years. Concerns by professionals of possible drugs and alcohol misuse. Associated with a number of people not conducive to family life. She was the subject of serious domestic abuse with 11 PVP (Protecting Vulnerable People) notifications 2 of which were high risk. 5 PVPs involving mother's partner.
Half Sibling	White British: Age: 9 years. Same mother different fathers. Child lived with mother and mothers' partner. Named as being present during domestic abuse incidents with 11 PVPs between 2011 – 2017. On a child protection plan for emotional abuse and secondary physical abuse. Half -sibling was very fond of Child LW.
Half Sibling – not in contact	White British: Same mother different father. Child lives with father.
Mothers Male Partner (MP)	White British. Lived with mother and half sibling. Unemployed and reported to misuse alcohol and concerns around possible drug use. Associated with a number of people not conducive to family life. 24 convictions for violent offences 2004 – 2015. 12 PVP notifications about his violent behaviour between 2003 – 2017. Poor relationship with Child LW due to violence against mother.
Fathers Female Partner (FP)	White British. On-off relationship with Child LWs father from around 2015. Partner and children often stayed at father's accommodation with her children. Child LW was living with father at the time. Issues around poor parenting and neglect.
Fathers Partner's Children (FPC)	White British. Not blood related to Child LW. 3 children aged 12, 10 and 5 years the father of the youngest child lived in the south of the county where all the children sometimes stayed. The children were on Child Protection Plans for neglect.
Environment	The area where the families lived is a known area of social deprivation. The families lived in relatively close proximity to one another. General health statistics for the area suggests that the health of the residents is generally worse than in the average person in England. (Socio – Economic Statistics and UK census of 2011)

4. Circumstances and significant events (29/03/17 till 13/03/19)

The timeline covered 71 pages with 348 separate entries over a 2-year period.

4.1. Relevant information outside the timeframe

Child LW's parents had separated when the child was around 4 years of age, this was following a number of domestic abuse incidents which often related to alcohol. Mother started a new relationship and in 2010 Child LW's half sibling was born. Child LW appeared to live between both mother and father.

In 2014, mother was subject of serious domestic abuse by her partner. Child LW started to need 1:1 support in school and despite this intervention, further deterioration in behaviour and anger management emerged. Support strategies were implemented by school but the child's ongoing behaviour issues resulted in a permanent exclusion.

Following this Child LW returned to school at an alternative provision and was noted as being a “school refuser” with the school attendance team monitoring on a daily basis and sending texts home. The child (13 - 14 years) did not attend school regularly from October 2016 onwards.

During 2016 Child LW’s fathers’ partners (FP) children became subjects of child protection plans (CPP) due to neglect concerns. At first, FP denied being in a relationship with Child LW’s father. The children remained on a CPP for neglect but Child LW (age 14) was never considered as part of the family group despite FP eventually disclosing that she was in a relationship with Child LW’s father and staying at their property.

4.2. Brief summary of circumstances and events

Just prior to the diagnosis of Diabetes Mellitus Child LW and Half Sibling witnessed serious domestic abuse at mothers’ home which resulted in Half Sibling being subject of a child protection plan for emotional abuse. Around the same time, Child LW alleged being criminally assaulted at fathers’ home but later refused to provide details and the case was closed.

Child LW was 15 years old when diagnosed with Type 1 Insulin Dependent Diabetes Mellitus (IDDM). From the start it was reported that the parents appeared ambivalent about their child’s diagnosis and care. This manifested itself in Child LW not being taken to hospital for essential outpatient appointments to monitor IDDM and to support the child’s mental health.

Child LW was not attending school and later college and therefore was not in receipt of any formal education throughout the timeline. Father was eventually fined for poor school attendance.

There were a number of hospital admissions due to the poor compliance of medical treatment and it was recognition that Child LW was struggling to cope with IDDM management. The level of parental support was not known but professionals were concerned that this was probably poor.

The Diabetic Specialist Nurse (DSN) tried to support Child LW through numerous home visits with no access. School Nurse and College Nurse also tried to make contact with Child LW with little success.

There were a number of referrals made to children social care (CSC) throughout the timeline but with no further action being taken until towards the end of the timeline when father and child were homeless. At this point Child LW was in hospital and there were serious concerns about the child’s poor compliance with medical treatment.

One month after a previous admission, Child LW was again admitted to hospital for 2 days via emergency ambulance. The child had run out of insulin the previous day resulting in high blood sugars and resulted in Child LW becoming unwell. Father stated he did not know Child LW had no insulin because the child had been staying at aunties.

2 weeks following hospital discharge the DSN contacted Child LW who reflected that they were the best they had been and were happy about moving into a new home. The Child Family Support Worker (CFW) had found an address which was accepted by father and white goods including a fridge in which to keep the insulin in was arranged.

4 days before the event the DSN contacted father who reported that Child LW was definitely looking better and was much happier. DSN tried to contact Child LW direct but was unable to make contact.

4.3. The significant event

At 04.55hrs on the morning of the child's 17th birthday a 999 call was received by the local ambulance service who on arrival found the child to be in cardiac arrest. The parents were unaware of the last time the child was seen alive and well. Child LW was found by fathers' friend in an upstairs bedroom, the child was lying on a mattress on the floor with just a duvet (no covers). Police were informed of the situation in line with local sudden unexpected death of a child protocol.

Police information found that neighbours had seen a number of young people at the address the previous evening possibly drinking alcohol. The child's cousin had last seen the child at 01.00hrs when Child LW was seen to be well before the cousin went home.

Sadly, despite every effort made by hospital staff the child never regained consciousness and died 3 days later as a result of poor management of IDDM.

5. Analysis of practice and organisational learning

There were three main learning themes which emerged during the reviewing process as follows:

- **Diabetes mellitus in adolescents.**
- **Impact of adverse childhood experience.**
- **Adolescent neglect and safeguarding.**

6. Diabetes Mellitus (Type 1) in adolescents.

Child LW died as a direct result of having Diabetes Mellitus (Type 1) which had been poorly managed by the adolescent and family.

6.1. Diabetes Mellitus Type 1

Diabetes Mellitus type 1, is a metabolic disorder in which persistent hyperglycaemia (high blood sugar) is caused by a deficiency of the hormone "insulin" which is produced by the pancreas. Insulin deficiency leads to the body being unable to metabolise carbohydrate, fat,

and protein which are needed for the body to produce energy and function normally. (NHS UK website).

The onset of diabetes mellitus in childhood is often linked to adolescence and there is a strong family history associated with this condition. Diabetes mellitus is a serious life limiting condition, unless treatment is well maintained there are fatal consequences. Poor management of diabetes is known to be associated with reduced brain growth affecting memory, cognition and academic performance.

Type 1 diabetes mellitus symptoms can come on quickly, particularly in children/adolescents and include:

- feeling very thirsty and tired
- passing urine more than usual, particularly at night
- losing weight without trying
- blurred vision
- cuts and grazes that aren't healing

Managing diabetes mellitus can be a challenge but the vast majority of adolescents living with the condition go on to have a long and fruitful adult life.

The daily routine includes:

- Checking blood glucose levels - knowing when and how to interpret results
- Injecting insulin – knowing when and calculating dosage prior to administration.
- Recognising and treating hypoglycaemia (low blood sugar)
- Knowing what and when to eat and drink.
- Check-ups and appointments are essential because as the child develops and grows the child's treatment may need amendment to keep pace with the changing physical needs of the child.
- Development and growth in the adolescent stages of life is rapid and requires a proactive response to managing treatment. (NHS UK website)

All these activities are normal everyday activities for an adolescent living with diabetes mellitus. This can be a daunting experience at first, requiring both self-control and family commitment to support the treatment plan. Parents have an important role to play in supporting adolescents to self-manage their disease, but resultant family tensions can be high. (Ashraff A; Siddiqui M. and Carline T. 2013)

During the first few months of having diabetes mellitus there is a "honeymoon period" during which time the body can cope with less than optimal treatment levels of insulin because the pancreas is still winding down its own production of insulin which eventually comes to a halt. Once insulin production stops completely the body can no longer cope without careful and well-maintained insulin treatment. The "honeymoon period" may have been a relevant factor in Child LW's case. (NHS UK website)

There are a number of other adverse situations which may affect an adolescent in relation managing their condition as follows:

- Change in weight and body size as they grow

- Stress
- Use of medications/ recreational drugs/ alcohol
- Exercise and sport.
- Being physically unwell
- Depression and anxiety. (NHS UK website)

Type 1 Diabetes mellitus is known to have a major psychological impact on adolescents with depression and anxiety being a common feature. Different types of therapies to improve mental health have been developed to support the patient as well as their families. These include Behavioural Family Systems Therapy and Cognitive Behavioural Therapy. (Ashraff A; Siddiqui M. and Carline T. 2013)

Psychosocial factors have also, been found to contribute to poorer metabolic control and less than adequate adolescent self-care being associated with lower levels of family functioning, increased adolescent behavioural difficulties and poorer adolescent mental health. This raises the importance of acknowledging the dimension of family functioning and relationships for those adolescents with diabetes mellitus and any other life limiting condition which requires the individual to conform to a strict chronic disease management. (Daneman D. and Daneman M. 2012)

In order to provide the best management possible for supporting children and adolescents with diabetes mellitus the NHS have developed a number of Specialist Diabetes Paediatric Teams across the UK. These teams, which are usually hospital based, are multidisciplinary and include an expert Paediatric Consultant with other medical and nursing staff. Clinical psychologist and emotional well-being workers are usually included as part of the team.

Child LW was cared for by such a team within the child's own local hospital. Whilst hospital in-patient care for the child was important and hospital appointments essential, there was a proactive outreach service working in the community who visited the child at school and at home and tried to maintain contact with the child and family.

6.2. Child LW's journey with Diabetes Mellitus

Child LW was aged 15 years when they were diagnosed with Insulin Dependent Diabetes Mellitus (IDDM) in June 2017. There had been a history of IDDM in mother's family.

At the time of Child LW's initial admission to hospital, the child had experienced a number of social issues which were not known to the specialist diabetes team working with the child and family at the time which included issues such as:

- Witness to regular serious domestic abuse
- Child LW's poor relationship with mother's partner due to domestic abuse
- Recently alleged unsubstantiated criminal assault on Child LW
- Concerns of possible heavy drinking and drug misuse in both mothers' and fathers' respective homes.
- Mothers home unsafe to go to due to criminal violence and activities.
- Half sibling subject of a Child Protection Plan for emotional abuse and secondary physical abuse due to domestic abuse in the home.

- The 3 step siblings living at the home address were subjects of child protection plans for neglect due to poor parenting.
- When the step siblings were resident at fathers' home Child LW slept on the sofa because the bedroom was in use for the other children.
- Not attending school for several months.
- Not receiving any form of education and was viewed as a "school refuser".

CSC were involved with the children living in both mothers' and fathers' separate households due to separate child protection concerns. Child LW was in process of having their needs assessed by CSC but this never came to anything because father withdrew his consent part way through the process. **(*Safeguarding arrangements will be addressed later in this review).***

During the initial admission Child LW had a number of IDDM educational sessions with the Diabetic Specialist Nurse (DSN) which were repeated and reinforced at sporadic points along the timeline. It was planned for this to be on a regular basis but the child was not available to be seen in school and was mostly not in at home when the DSN made a planned visit. However, on the limited occasions Child LW was seen the child was able to demonstrate a good understanding of the disease process including how and when to check blood glucose levels and to administrate insulin.

It was apparent from the beginning that there were concerns amongst some professionals that the parents appeared to be ambivalent towards Child LW's diagnosis of IDDM despite the life-threatening nature of the disease. They were seen to be avoidant in being educated in the diagnosis and treatment of IDDM, with mother rejecting training because the child did not live with her and father did not attend prearranged training sessions as agreed.

The detail of the Child LW's day to day lived experience was unknown but it is feasible that the parent's apparent ambivalence to IDDM could have resulted in the child being left to their own devices in terms of management of the treatment plan. One can presume that for an adolescent this would have been complex, overwhelming and emotionally draining.

Adolescence is a transitional stage of physical and psychological development that generally occurs during the period from puberty to legal adulthood. The diagnosis of IDDM at this stage adds to the already changing world that the adolescent child is trying to make sense of. This, alongside any loss of potential life dreams that have already been set can have a devastating impact on the adolescent and family.

Practice Learning Parental support in situations where an adolescent is dealing with a life-threatening condition is essential. Parents have a responsibility to care for their children until they reach the age of 18 years. (UN Convention Rights of the Child 1989). Medical Neglect should be considered in cases where there are concerns about parental engagement and treatment compliance.

6.3. Follow on care by the Specialist Diabetes Paediatric Team

Child LW had a 20 months journey with Type 1 diabetes mellitus. The specialist team had a number of challenges in trying to engage the child and family and to improve compliance with the treatment plan that was in place to keep the child alive and well.

The main challenges included:

- Poor compliance and engagement with health professionals/ "Was not brought"
- Lack of school attendance in relation to IDDM and healthcare.
- Change of GP
- Mental Health and emotional wellbeing
- Hospital admissions

6.4. Poor compliance and engagement.

Once Child LW was home following the initial admission to hospital, the child had a number of "was not brought" (previously known as "did not attend") episodes for essential hospital appointments. At 15 years of age the child would not be expected to take themselves to the hospital and would not have the resource to do so. Child LW was not brought to the first 3 essential appointments following discharge and this resulted in the Consultant Paediatrician writing to father reminding him that IDDM was as serious as cancer and that it was essential that Child LW attended appointments.

Poor compliance was a feature throughout the timeline with Child LW not being brought to 8 out of a possible 10 essential hospital appointments to monitor the child's condition and for ongoing management of IDDM. Child LW's aunty took the child to the only 2 hospital appointments the child did attend. Poor compliance with treatment was highlighted as a concern at both appointments.

The hospital did have a "was not brought" policy in place for missed hospital appointments at the time, but it was not consistent across all departments.

Practice Learning
"Was not brought" policies should be in place for all health providers with clear guidance around how to respond and when to contact children social care for additional support where medical neglect is suspected.

Progress - There is ongoing work being done to strengthen the hospital "was not brought" policy with a more consistent approach which will be broadly in line with other health providers in the local area to provide consistency.

There were innumerable attempts by the DSN to make regular contact with Child LW and father via telephone, at school and home visits. Home visits were prearranged by the DSN to provide advice and support around IDDM management and on the majority of occasions, the father was not contactable and there was no access to Child LW at home, which presented a worrying picture.

On the occasions that father and Child LW were seen at home the DSN observed that father would leave the room when further useful relevant information about IDDM was being discussed. It would appear that father's avoidant behaviour was not directly challenged or discussed to provide insight into the reason why father appeared to be unable to engage with the professional support on offer.

Chasing up the child and father became the norm for the DSN and school/college nurses and whilst this could be seen as good practice there needed to become a point of realisation that Child LW and family were clearly not engaging with a health plan which was essential to keep Child LW healthy. This should have been viewed as medical neglect and referred to CSC with concerns that the child was at risk of significant harm. ***(Safeguarding arrangements to be discussed later)***

There were occasions when professionals did manage to make contact with father and on these occasions, father was found to be personable and in agreement with the healthcare plan. It was found that father would then fail to follow through on what had been agreed. On reflection at the practitioner learning event it was realised that father used a degree of disguised compliance in order to placate professionals.

Practice Learning Professionals need to be alert to parental disguised compliance. Good record keeping to reflect agreement between professionals and parents is key to providing evidence of neglect.

The lack of attendance at essential health appointments became a grave concern and eventually led to both the DSN and Consultant Paediatrician discussing the level of non-compliance with the Hospital Safeguarding Children Team. Their advice on the first occasion was for the DSN to make an Early Help referral to gain additional support for the child and family but there is no record that this occurred.

A multiagency Early Help Assessment / Common Assessment Framework (CAF) at this stage may have provided the specialist diabetic team with relevant information about the nature of the Child LW's home life. In the event of father withholding his consent for the assessment this may have led to a further risk assessment using the hospital safeguarding team with an escalation of concern to CSC. It was not clear why an Early Help assessment did not happen at this point.

The DSN worked tirelessly to bring about engagement with Child LW and father in partnership with the School, school nurse and later on with the college nurse. An IDDM management plan had been agreed in school but never progressed because Child LW rarely attended school. A home visiting management plan was implemented and supported by the DSN, school nurse and college nurse without success due to the number times Child LW was not at home for appointments.

It would appear that the school and the collective group of nurses involved were constantly sharing information with each other about their concerns regarding treatment compliance by the child and family rather than sharing their safeguarding concerns with CSC.

Whilst sharing information with other professionals working with vulnerable children is best practice it should not replace a referral to CSC. When professionals are unclear around threshold for referring to CSC, they should consult their line manager or safeguarding lead.

Practice Learning
It is important that professionals escalate safeguarding concerns to their line manager or safeguarding lead / Safeguarding Children Team to access objective senior support, supervision and advice. Locally developed mechanisms for convening a multiagency / multidisciplinary professionals meeting to explore areas of welfare concern including non-compliance of essential medical treatment should be available and considered in cases where there is difficulty in getting cases over the CSC threshold for child protection.

6.5. Lack of school attendance in relation to IDDM and healthcare.

The relevance of not attending school in relation to IDDM was that Child LW was not able to receive the full benefit of the agreed health care plan to support the child and maintain the management of IDDM as would have been expected by any other child with IDDM who was attending school.

Children with IDDM who attend school with IDDM have the benefit of:

- Being seen on a regular basis by caring professionals who can identify changes in the child who may become unwell.
- Regular checks with the school nurse and or DSN in school
- Supportive environment in terms of emotional welfare
- Provision of a full regular meal
- Peer support and friendships
- Having a good routine to the day
- Provides daily activities and exercise.
- Encouraged engagement with hospital services

All the above are important to promote the health of children with IDDM or any other long-term life-threatening medical conditions.

Obviously, because Child LW was not attending school there was a huge gap in relation to having all their needs addressed. It was not known what Child LW was doing during school time apart from gaming and sleeping and it was unclear with regards to the level of social isolation being experienced and its impact on the child's mental health.

School were already concerned about Child LW in terms of the child not meeting their educational needs due to the lack of school attendance and had previously made 2 referrals to CSC with no further action.

Early Help Assessment /Common Assessment Framework (CAF) - is a key tool in the early identification of children and young people and families who may experience problems or who are vulnerable to poor outcomes and underpins the work of Early Help. The process identifies unmet needs and works with the family to highlight strengths and protective factors, identifying appropriate actions to address the needs. The voice of the child, young person and family is encouraged throughout the process

Clearly, school became more concerned once Child LW became diagnosed with IDDM which led to them resorting to contacting the DSN for assurance that Child LW had been seen as part of the school's own welfare checks. When it was reported that the DSN had seen the child at home or the child had been in hospital this appears to provide school with a false sense of reassurance for the child's welfare in general.

Practice Learning
Schools should share their welfare concerns about children and their families directly to CSC. They should be clear with CSC about what they are worried about and what they expect to happen. Safeguarding Leads working in schools should be clear of their role in relation to making a professional challenge to CSC decision making when required and have extensive knowledge in the use of the local escalation policy to advocate for the child when there is a difference of opinion between the 2 agencies.

6.6. Change of GP Practice

The DSN tried working with the GP however, there was some confusion around this because at the time the child's GP had written to the family to explain that Child LW did not live in their catchment area and therefore, the parents were given notice that the child would be removed from their register. The parents were advised to register the child at a more local GP Practice.

Owing to a delay in this taking place by the parents there was some confusion around the prescribing of Insulin. It was possible that this confusion led to a delay in insulin being collected by the parents for the child and the child had a hospital admission due to having no insulin and no testing strips for 5 days.

Practice Learning
GP practices should ensure that children are not removed from their practice register until the child is registered with another GP, particularly when children have life threatening conditions and/or there are concerns regarding medical compliance or safeguarding issues.

After several weeks of no access visits at the home and no response to telephone calls the DSN and rest of the Specialist Diabetic Paediatric Team had growing concern for the child's health and wellbeing which resulted in the DSN suggesting to the GP to not hand-over a prescription for insulin until the GP had seen the child. This unusual approach was aimed at getting an urgent review of Child LW by the GP however, this request was overridden by circumstances because the child was admitted to hospital with dangerously high blood sugar levels due to having no available insulin at home.

The GP representative at the learning event confirmed that the GP would not have considered this as a management approach because of the potential risks to the child and continued to prescribe Insulin as normal. However, the parent or child still missed picking up a prescription for Insulin resulting in the child becoming seriously ill and requiring hospital admission where the child was eventually seen.

6.7. Mental Health/Psychological Health

Professionals were unaware that Child LW had experienced domestic abuse throughout their life and the possible impact of this trauma was never considered as part of the mental health service provided. Child LW was seen to struggle with mental health issues early on in the timeline. The trigger was thought to be due to the realisation that the child would not be able to join the Army to pursue a career in engineering as was the plan due to having a diagnosis of IDDM.

On the unusual occasion that the child attended school, the child was found to be low in mood. The DSN was concerned about low mood too and made a referral to the Psychologist from the Specialist Diabetic Paediatric Team who was experienced in working with adolescents with IDDM.

Low mood is often linked to depression and anxiety and can be as a result of a particular trigger, such as was recognised in Child LW case of being diagnosed with a life-threatening illness and not being able to join the Army. Talking therapies such as Counselling and Cognitive Behavioural Therapy are known to be beneficial in these circumstances. However, these types of therapies rely on regular contact with the patient and requires their full participation. (NHS UK Website)

In Child LW's case, attempts to engage the child in any form of helping therapy was to be unsuccessful because firstly, the child "was not brought" to appointments by the parents and secondly, the professionals who could have helped were unable to fully engage the child in regular therapeutic contact in school or at home.

There were 3 "was not brought "essential hospital appointments for the psychologist before Child LW was eventually seen at home on the 4th appointment at which time the child had reported that they were feeling more optimistic because they could be an engineer outside the Army.

On assessment Child LW was found to have a sleep disorder, which entailed the child sleeping during the day and being up most of the night gaming and this was a persistent feature in the child's life. This was not helped by the child sleeping downstairs on the sofa and the family lack of bedtime routine. Advice was given about the importance of good quality sleep at night. The child talked about getting back to education but this never translated into any form of action.

A good night sleep is particularly important during adolescence because it is the time when hormones are released into the body to allow the adolescent to grow and mature. Poor sleep has been linked to depression and anxiety and has also been found to impact on emotional responses to regular daily life challenges. (sleepcouncil.org.uk).

Research into people with diabetes found that if someone with IDDM has blood sugar levels that are either too high or too low overnight, they may find themselves tired through the next day. Lethargy and insomnia can both have their roots in blood sugar control and can be a key in re-establishing a healthy sleep pattern. (Diabetes.co.uk). In other words, poor sleep

can influence blood sugar control in diabetes and visa-versa therefore, the quality of sleep is an important indictor in both diabetes and mental health management.

The non-engagement with the psychology team led to the team resorting to seeing the child on the ward during admissions. It was found that the child appeared to be relaxed and in good mood when on the ward where the child was observed to eat healthy and slept well at night. This was opposite to how the child presented in their own home environment but the reasons for this were not explored further. Professional curiosity and exploration of the home environment may have resulted in the identification of domestic abuse, heavy alcohol use and chaotic home life as possible reasons for Child LW's changes in mood.

It was reflected at the Practitioner Learning Event by professionals who had cared for Child LW on the ward, that Child LW may have flourished within the ward environment because of the presumption that the ward would have provided a warm caring environment with daily routine activities, regular healthy meals, regular sleep times and support around treatment plans.

This observation is important and relevant for all adolescents who have a serious medical condition and are possibly being left to care for themselves when at home or are without the support of a main caregiver. Adolescents (as well as children of all ages) need continued nurturing and support to enable them to remain mentally and emotionally resilient to maintain and sustain adequate levels of wellbeing when coping with a serious medical condition such as IDDM.

Practice Learning

When children / adolescents have contrasting behaviours between hospital and home, with hospital presenting as the most positive environment, this should be viewed as an alert that something negative may be happening in the home. Professional curiosity should be employed to ask relevant questions in order to help to unpick and understand what is causing this variation.

When Child LW was on the ward on the final admission before their death. Child LW was reported by staff on the ward to have an improved mood and was appearing to be more optimistic. According to Child LW this improvement of mood was because father had split from his ex-partner which unbeknown to staff this relationship had been marred with domestic abuse and featured parental neglect.

Two weeks following this conversation the DSN spoke with Child LW on the telephone and was told that they were feeling the best they had ever been and happy to be moving to a new home with father. It was sad to find that just when Child LW appeared to be starting to have improved mental health and looking forward to a new stage in their life that tragedy struck.

An additional issue which may have had a negative impact on Child LW's emotional health became apparent during a review of the timeline which identified that Child LW's step grandfather had died suddenly. The impact of this death is unknown and there is no record

that Child LW spoke to anyone about this. Bereavement is known to have an impact on a person's mood but there was no evidence of this in relation to Child LW.

6.8. Hospital admissions

There were 5 hospital admissions following initial diagnosis all of which related to poor management of IDDM.

On the initial admission Child LW (15 years) was admitted to hospital with diabetic ketoacidosis (DKA) which required a stay in the High Dependency Unit. A diagnosis of Type 1 Insulin Dependent Diabetes Mellitus (IDDM) was made.

There had been a 3-day history of nausea, vomiting, dizziness and lethargy. Child LW was seriously ill on admission and noted to have prominent facial bones (possibly due to weight loss or dehydration) and was wearing "tatty" clothes. There was no exploration around any delay in presentation or about the child's appearance on admission.

Parental poor compliance and engagement was recognised straight away. Whilst the parents were happy to sit on the ward with the child, they were reluctant to engage in appropriate education sessions to support Child LWs diagnosis.

Practice Learning
When children are admitted to hospital appearing unkempt and seriously ill, combined with potential delay in presentation and parental poor engagement, staff should be professionally curious and make robust enquires into the family's social circumstances through a CAF assessment.

It would appear that the child who was only 15 years old at the beginning of the timeline had limited parental support and may have often been left unsupported in managing their own significant medical condition. This is reinforced by the DSN records which demonstrate that Child LW was constantly struggling to cope with the management of IDDM.

There were a further 5 admissions which can be split into 2 main reasons:

- **Acute serious illness** - 3 admissions because the child became seriously ill due to running out of insulin. There was a further occasion when the child ran out of insulin and this was addressed via the OOH service in the community. One these occasions father explained that Child LW had not told him about having no insulin and was possibly suggesting that it was the fault of the child for not having Insulin available.
- **Child LW struggling to cope** - 2 admissions because the child was not coping and was asking the DSN for more support presumably because of a lack of parental support.

Parental support does not appear to have been assessed or addressed in terms of helping Child LW to manage their IDDM. Whilst it is acknowledged that self-care should be encouraged in terms of adolescents moving on to adulthood and independence, there was a sense that the child had been left to cope alone above the levels which would normally be expected.

Practice Learning
Adolescents with life threatening conditions require their parents (who have parental responsibility) to maintain responsibility in helping them to manage complex programmes of treatment and support for the child including providing essential drugs and taking their child to regular essential follow up appointments to ensure the child gets the best care possible. Where this is not happening, professionals need to assess and address the situation in terms of Medical Neglect via the local safeguarding children arrangements in place.

On the final admission prior to the child's death, the admission took place just 1 month after a previous admission demonstrating that Child LW was starting to deteriorate more quickly. This admission may have signified the end of the "honeymoon" period for IDDM. As previously stated, the honeymoon period is the time at the beginning of the process when the body is still managing to produce a little of its own Insulin to support the body. Once this stops the body can no longer function without prescribed Insulin.

Child LW had become critically ill after 1 day without insulin when in the past the child could manage 5 days. Child LW was found to have lost 10 kgs in weight which is a sign found in cases of non-compliance in IDDM treatment. At this point the Consultant Paediatrician recognised the danger signs of possible risk fatality and held a meeting on the ward to try to reason with the child and family to improve their compliance with IDDM treatment management. This was appropriately followed up with a referral to CSC because the seriousness of the situation was so great and father had disclosed some issues at home. ***(Safeguarding arrangements to be discussed later)***

Despite the efforts of the professionals who knew Child LW and were desperately trying to support the child, Child LW was found at home just 1 month later collapsed and unresponsive. The child died in hospital 3 days after being found in cardiac arrest at home. The police rapid response investigation confirmed that the child did have insulin and blood testing equipment available to use but the child had not used them.

Progress – Following the learning from Child LW the Specialist Diabetic Paediatric Team have expanded their clinical pathway to include a robust discussion with all parents of newly diagnosed children with IDDM regarding the management and seriousness of the condition and their expected role in supporting their child. Medical neglect is also to be considered more robustly in case where poor parental compliance exists.

7. Impact of adverse childhood experience.

7.1. The Theory of Adverse Childhood Experiences (ACEs)

ACE's are stressful or traumatic experiences that can have a huge impact on children and young people throughout their lives.

The ten widely recognised ACEs, as identified in a US study from the 1990s, are:
- parents divorcing or separating
- living with a parent who is depressed or suffers mental illness
- living with a parent who is an addict (alcohol, drugs, or otherwise)
- witnessing your mother being abused or mistreated
- verbal abuse/emotional abuse and humiliation
- emotional neglect
- physical neglect
- physical abuse
- sexual abuse
- a family member going to jail.

As well as these 10 ACEs there are a range of other types of childhood adversity that can have similar negative long-term effects. These include bereavement, bullying, poverty and community adversities such as living in a deprived area, neighbourhood violence etc. (Collingwood. S. et. al. 2018)

The impact of ACEs is that it can create harmful levels of stress (toxic stress) which impact on healthy brain development. This can result in long-term effects on learning, behaviour and health. Evidence from ACE surveys in the US, UK and elsewhere demonstrates that ACEs can exert a significant influence throughout a person's life. ACEs have been found to be associated with a range of poorer health and social outcomes and that these risks increase as the number of ACEs increase. (Collingwood. S. et. al. 2018)

Practice Learning
Being aware of parental, children/adolescents ACEs can help professionals to work with children and their parents using a more trauma-informed approach to care which can help to engage people who have experienced toxic stress and reflects an awareness of the harm that has occurred and takes that into account.

7.2. Finding the ACEs

For professionals to be ACE informed on behalf of children / adolescents, particularly those with life limiting conditions where there are concerns around compliance and engagement, professionals need to engage in a robust history taking and information sharing processes which includes information about their home and social life experiences. Parental consent for information sharing with other agencies would need to be addressed early on in the process.

Whilst it may not be possible at the first visit for the Specialist Diabetes Paediatric Team to become aware of all of the child's ACEs and stressors in a child's life, there is a need for ongoing assessment to better understand the lived experience of the child and to consider any areas of personal and family stress which may have an impact on the child's health.

Linking in with other health professionals such as GPs and school nursing can provide an insight into the child's medical and social history because they have possession of primary

health records which usually contain helpful information about the child's early development, social stressors and CSC involvement.

The use of an assessment such as HEADSSS may provide a useful tool. (Royal College of Paediatrics and Child Health, 2003).

HEADSSS is an interview prompt or psychosocial tool to use with adolescents and covers:

- **H**ome
- **E**ducation and Employment
- **A**ctivities
- **D**rugs including alcohol
- **S**ex and relationships
- **S**elf-Harm and Depression
- **S**afety and abuse

Stress has the potential in diabetes to affect metabolic control directly through its impact on cortisol and other hormones that interfere with insulin metabolism. It may also affect metabolic control indirectly, by interfering with the adolescent's ability to complete self-care tasks. (Daneman and Daneman. 2012)

Child LW was presumably trying to manage a number of stressors following the child's experience of living with a number of ACEs. It is not clear if the child suffered from toxic stress as a result of experienced trauma but this would not be surprising given the long history of experiencing domestic abuse, parental drug/alcohol misuse, parental separation, criminality and bereavement during the course of the timeline.

When children are diagnosed with a life-threatening illness, professional teams working with the child, should make an assessment of the child's ACEs and use this information to better understand the needs of the child and family. The needs of the child may require a multiagency response to address those needs in order to gain medical compliance. It should be remembered that good compliance can only come when the child is in an environment which can allow the child to feel safe and to flourish.

Practice Learning Medical teams working with children and adolescents with life threatening conditions should consider the use of a psychosocial model of assessment such as HEADSSS to help identify other stressors which may coexist in the life of the adolescent and may help to identify ACEs and their impact, particularly for adolescents for whom there are concerns.

CSC were aware of the ACE's in this case but these were not shared with hospital health professionals working with the child. There was an opportunity for CSC to share information when the parents told social workers that they were not making progress with child protection plans for the half sibling and the step siblings because Child LW was seriously ill in hospital with newly diagnosed IDDM.

At this time the Child LW was subject of a child and family assessment and there does not appear to be any professional curiosity or consideration by CSC in checking information with the hospital staff with the view of gaining further information for their assessment. A conversation between CSC and hospital staff at this point may have alerted hospital staff that a seriously ill adolescent in their care may need additional support in view of historical and current safeguarding concerns which had already been identified within the family.

Practice Learning
It should be best practice for CSC to check out new information about any child (including adolescents) where there are rising concerns about their health and/or wellbeing when they are part of a family network where their siblings have child protection plans in place.

7.3. Working with ACEs

In response to growing evidence on ACEs Lancashire Constabulary funded a research programme carried out by Public Health at Blackburn with Darwen Council which initially focused on the educational setting. The programme evolved to enable multi-agency programmes to adopt and become trauma-informed. The cultural change programme was called Emotionally and Brain Resilient to ACEs or EmBRACE for short.

The EmBRACE multiagency programme initially ran for 4 years in an area known for poor health and poor social outcomes in adulthood with links to childhood adversity. The results of the programme saw a drop in out of school suspensions, increase graduations and increase number of students going on to post-secondary education.

EmBRACE recognises that individuals impacted by trauma operate at a continual high level of stress which results from living in a high survival mode of "fight", "fright", or "freeze" and find helpful ways to combat these effects. EmBRACE is a vehicle for change, with a focus on relationships as the first principle and then to focus on change in behaviour. (Collingwood. S. et. al.)

Practice Learning
EmBRACE is a trauma informed practice programme which is already available locally and can offer children the best opportunity to flourish through a nurturing and supportive environment. Whilst EmBRACE has been used mainly in education other areas of children services such as healthcare and children social care may benefit from replicating the principles of the model into their own settings.
There are 6 key principles to a trauma informed approach:
Safety/ Trustworthiness and Transparency/ Peer Support/ Collaboration and Mutuality/ Empowerment Voice and Choice/ Culture, Historical and Gender Issues. (MentalHealth.org)

7.4. Impact of the lack of school attendance

As already stated, the lack of school attendance was a huge gap in Child LWs life. Child LW told a variety of professionals that they wanted to be in school and later disclosed to the

Additional Learning Support Team that they were struggling with being in crowded environments which unfortunately are inevitable in both school and college. This inability to cope with crowds could have been a sign consistent with toxic stress. More work needed to be done to understand and support Child LW in getting back into an educational setting.

Practice Learning
It is important for schools to understand the nature of a child's poor school attendance in order to effectively address it. School refusal by a child can be the consequence of a child or adolescent having physical, psychological and emotional distress. A multiagency approach to working with the child and family through Early Help and CAF helps professionals to better understand the child and family situation.

School would have provided a safe environment, social interaction with teachers and peers and health support with IDDM. The child was only 15 years old at the beginning of the IDDM journey and should have been in compulsory full-time education. Despite the school texting the parents daily about non-attendance there was a total disregard by them over a 9-month period, to comply in getting Child LW back to school.

Child LW was at one point labelled as a "school refuser" which may have given a sense that the child was not attending school because they do not want to and it was their own fault, they did not attend school. However, the parents were still being pursued to try to get Child LW to school and later resulted in father being fined £370 for failing to provide an adequate school attendance level.

The label of "school refuser" did not collaborate with what Child LW told professionals, that they wanted to be in education. There needed to be a more robust approach by school and local authority to ensure that Child LW received some form of education as was the child's right to expect. Additional, 1:1 support would have been beneficial and consistent with the principles of trauma informed practice.

Practice Learning
Schools and local authorities should provide and adhere to robust school attendance policy and include the level of intervention to be taken to address parental non-compliance. The rights of children to receive an education should be preserved in the best interest of the child. All parents have a legal duty to ensure that their child receive an education suitable to his/her age, ability and aptitude and any special needs. There are legal processes available such as Education Supervision Orders and School Attendance Orders to support school attendance under the Education Act 2011.

Impact on Child LW

Toxic stress may have played a part in Child LW's lack of school attendance, but we cannot say with any certainty what stress levels Child LW endured because of the lack of a psychosocial and multiagency safeguarding assessment. We do know however, what Child LW told professionals and what was recorded in the record as follows:

The voice of the child….

- At the beginning of the timeline Child LW told mother they wanted to get back into education and the child attended a meeting at school with mother.
- Child LW went to school to see a learning mentor to disclose a criminal incident at home. Child LW then became angry when the police became involved and refused to give an account of the incident.
- Following diabetes diagnosis Child LW told the DSN that they felt down because of not being able to join the Army.
- Child LW told the DSN that they felt they were at risk and wanted to be admitted to hospital.
- Child LW told the emotional wellbeing practitioner that they felt “fed-up” and down and lacked motivation to look after themselves correctly and later that said that “getting sleep in hospital has helped my mood to improve”.
- Child LW also, told the wellbeing practitioner that they had been excluded from school for several months and had returned to school but only attended for 2 days because their sleep pattern at home. Child LW was still keen to go back to school at this time.
- A meeting for a managed move to another education provider took place but Child LW refused to engage at the meeting because he did not want to change placement.
- Child LW told the DSN that they refused to go to school that day and the following day the child was admitted to hospital unwell.
- Child LW told Additional Learning Support Team of being anxious in crowds and not attending school very much but wanted to attend. Crowd issues were not picked up.
- Post 16 college reported that Child LW always looked down and sad. Child LW told the college nurse they felt anxious since commencing on insulin.
- College visited Child LW at home to discuss poor attendance. Child LW said to be in bed and agreed to attend college tomorrow – but did not attend as promised.
- When Child LW was admitted to the hospital ward for the final time the child told staff that they had been staying with aunty and had awoke feeling unwell and had run out of insulin. Homelessness was an issue at the time and Child LW was supposedly staying with father in a B&B.
- The last conversation Child LW had with the DSN, she was told that the child felt happier now that father and his ex-partner had split up and the child and father would be moving into a new home.

There were 4 main areas that Child LW was raising persistently with professionals;

1) Child LW wanted to attended school / college.
2) Child LW felt anxious about being in crowds (raised only once but highly relevant)
3) Child LW felt unable to cope with diabetes and wanted more support.
4) Child LW had improved mood and was more able to cope with IDDM in hospital than the child did at home.

The agencies working with Child LW were not coordinated in terms of being able to jointly respond to the wishes and feelings of the child, had they come together more formally

under the local safeguarding arrangements there would have been a better chance to help Child LW and to make progress.

Practice Learning Hearing the voice of the child when there is so much activity going on around the child and family can be a challenge. However, listening to what they say and taking contemporaneous records can help to drill down and better understand the needs of children. It can also provide evidence for court in cases of neglect. Agencies must plan together and work together to improve the chances of making a difference for vulnerable adolescents and younger children.

Sadly, we shall never know the full extent of the impact that ACEs had on the treatment outcome for Child LW. Professionals at the time were not fully aware of the child's stressors and therefore, unable to fully assist the child in gaining the support they needed.

8. Adolescent neglect and safeguarding

The Children's Society acknowledged that, just like younger children, adolescents (age 11 – 17) are more likely to experience neglect at home than any other form of child maltreatment. There is evidence that professionals struggle to identify adolescent neglect and are unsure what to do when they come across it.

8.1. Recognising Adolescent Neglect

Child LW was exposed to a high number of ACE's and other stressors during the 2-year timeframe as follows

- Regularly witnessing domestic abuse
- Regularly witnessing heavy drinking and drug taking
- Possibly a victim of a criminal assault.
- Not attending school or college and not receiving any other form of education
- Living across two households where there were serious concerns of neglect due to poor parenting
- No bed available. Sleeping all day and up gaming all night.
- Delay in presenting for medical attention when ill.
- Serious weight loss with no parental concern
- Being diagnosed with a life-threatening condition requiring regular hospital appointments and a daily routine of complex monitoring and treatment plan.
- Poor treatment engagement leading to poor health and regular hospitalisation.
- Experience of parental ambivalence
- Suffered depression and anxiety – particularly around the time the child realised they could not join the army.
- A degree of social isolation
- Homelessness
- Living in poverty

The different professionals who came into contact with or were working with Child LW were aware of some of the issues listed above, but not one single professional or agency was aware of all the issues. Each professional had a different piece of Child LW's story which never came together before the child died.

In line with the definition for Neglect in Working Together 2018, Child LW appears to have been at probable risk of significant harm due to neglect because the child was experiencing the following:

a) A 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.
b) A failure to protect a child from physical and emotional harm or danger
c) A failure to ensure adequate supervision
d) A failure to ensure access to appropriate medical care or treatment

Lancashire Multiagency Neglect Strategy 2019 – 2021 was launched on 1 April 2019. The strategy comes with supporting resources such as a quick reference guide and a short clip to summarise the purpose of the strategy and some of the key elements of neglect. Good practice materials have also been collated from national organisations to support practitioners in confidently identifying and assessing neglect appropriately.

The content of the neglect toolkit has been reviewed by the independent reviewer who found that non-compliance in health care was well covered in the toolkit and Child LW would have require a Child Protection Plan as a minimum. The only comment that the reviewer would raise is that the neglect tool is a one size fits all approach and it may be helpful for adolescents to have their own version of the neglect toolkit which could cover more areas of contemporary safeguarding issues relating to young people.

Practitioners at the Learning Event who had all the information in the form of the composite timeline in front of them for the first time, concluded that Child LW was at risk of neglect. Particularly around the area of "appropriate medical care or treatment." Medical neglect is a term often used to represent parental neglect when caring for sick children. The term "medical neglect" is not a category of abuse recognised in the national context and does not have a nationally agreed definition.

It may be helpful in future if a local or nationally agreed definition for medical neglect was agreed for use locally to better promote the safeguarding needs of sick children. A formally recognised category of Medical Neglect may improve the way that healthcare staff currently articulate safeguarding concerns to CSC.

Practice Learning

"Medical neglect" can be defined as a parent's failure to provide adequate medical or dental care for their child, especially when it is needed to treat a serious physical injury or illness. In some cases, this can also include a failure to provide for psychiatric care if the child needs it. (legalmatch.com 2018)

Health professionals do not make a CSC referral for medical neglect lightly, in most cases the medical and nursing team involved with the child will have already tried a number of strategies to try and engage the child and family. A safeguarding referral for a child with a life-threatening illness should alert CSC that they need to be cautious about any decision making and ensure they have all the medical detail required to make a full risk assessment of the situation. The views of the medical specialist involved with the child and/or the area Designated Doctor is essential to enable CSC to understand the complex nature of the medical details prior to any threshold decision being made.

Practice Learning
When a health professional makes a referral to CSC regarding a child for whom there are concerns around medical neglect and/or that the child or adolescent is at significant risk of harm as a result of their health, this should automatically trigger a multiagency strategy discussion/meeting. The purpose of this is to determine the full nature of the concerns and to clarify if there is a role for CSC. Cases of suspected medical neglect cannot be managed by any one agency alone.

8.2. Difficulties in safeguarding adolescents

Whilst medical neglect appeared to be the most pressing of matters for Child LW there were a number of other areas of neglect concerns as previously indicated. Child LW was not receiving an education and was living in a home where the step-siblings were on a Child Protection Plan for neglect and the half sibling living with Child LW's mother was on a Child Protection Plan for emotion abuse in response to domestic abuse which Child LW was witnessing too.

The question was why did Child LW appear to fall between two families with child protection plans in place and why does Child LW not appear to be adequately assessed and have an equal focus as the child's younger siblings. The age of a child should not disadvantage the child in receiving an adequate response by agencies, but in practice it can do. Adolescents can be seen or assumed to be coping within a neglectful family situation because of their age or they may be seen as an adult rather than a child.

Adolescent children such as Child LW who was age 15 -16 can vary in maturity and responsibility, best practice would suggest that CSC should ascertain the child's wishes and feelings as part of their child and family assessment and for these to be taken into consideration when working with adolescents and their sibling groups.

Vulnerabilities such as not being in any form of education and having a life-threatening medical condition should have alerted CSC to the unmet need being experienced by Child LW and these should have been fully assessed and addressed in line with the local safeguarding practice arrangements.

A social worker for the 3 step children had seen Child LW at father's address when visiting the children but did not speak to Child LW or start to include the child in any family work that was taking place and this was less than expected best practice and Child LW should have been included as a member of the household.

Research tells us that local safeguarding arrangements often have a "one size fits all system" and usually designed primarily to meet the needs of younger children maltreated within the family. The problem with adolescents is that they can present as an "imperfect victim" they are often hard to engage, uncooperative and appear ungrateful, which makes addressing their needs a complex business. (Rees and Stein, 1999).

Practice Learning
Any form of neglect during adolescence is a complex area of safeguarding which requires sensitive handling and a fully completed child and family assessment in line with local safeguarding procedures. Adolescent children, as with any other child may need to be removed from a neglectful family situation in the form of an alternative placement either voluntary or through the court in line with legal requirements.

8.3. Research on adolescent neglect

The Children Society 2016 Troubled Teens: A study of the links between parenting and adolescent neglect recommend that:

- Support for neglected adolescents should be available – including online information, advice and forums alongside directly-accessible, flexible services which are non-judgemental and young person-centred in their approach.
- Where neglect is a concern a comprehensive assessment should be conducted which include consultation with the adolescents in a family in order to ensure their perspective is incorporated in planning and decision-making.
- Interventions for adolescent neglect should use a 'whole family approach' to ensure that all family members have a stake in resolving problems. Where appropriate, a 'team around the family' should be deployed to draw in the support required from different services to fully address the factors contributing to parental neglect.

Practitioners at the learning event were not aware of any local solutions for dealing specifically with a situation of adolescent neglect. There was also, a throw away comment mentioned ***"well the child would not be going into care would they"*** but why would this have been so unreasonable?

Just because an adolescent child and their parents do not cooperate with professionals this should not deter multiagency action such as multiagency strategy discussions/meeting taking place in the best interest of the child. Agencies have a range of options for safeguarding adolescents up to and including the accommodation of the child as a place of safety.

It is usually preferable for adolescents to be accommodated voluntary (section 20) with another family member or family friend who can be assessed by CSC to care for the child. Foster care or children residential care can also provide useful therapeutic placements.

Children up to the age of 18 years can be subject of child protection plans in line with statutory guidance and UN Convention on Children's Rights. Adolescents up to the age of their 18th birthday should not be prejudiced because of their age. Their wishes and feelings

are important, but in cases where the child is at risk of serious harm in line with the Children Act 1989 & 2004 then CSC can take the option to accommodate the adolescent in line with legal processes available.

8.4. The legal context includes…

Care Planning, Placement and Case Review Regulations 2010 (amended)	Accommodating a child	(s.20 CA 1989) One of the family support services the local authority must provide is that of accommodating (in a residential or family setting) anyone under 18 in need who requires it as a result of: a) There being no person with parental responsibility for him/her b) S/he being lost or having been abandoned c) The person has been caring for her/him being prevented temporarily or permanently (for whatever reason) from providing suitable care/accommodation. So far as is practical and consistent with welfare, children should be placed with parents/ Someone with parental responsibility/ Relatives/ Friends/ responsibility/ Relatives/ Friends/ Another person connected to the child.
Care Planning, Placement and Case Review Regulations 2010 (amended)	Accommodating a 16 or 17-year-old	(s. 20(3) CA 1989) – A local authority must provide accommodation to a young person in the above age group if s/he in "in need" and her/his welfare would otherwise be "seriously prejudiced".

Practice Learning
It is important that service arrangements for engaging and working with adolescents suffering neglect or other forms of abuse are locally defined and known to professionals working with them. Any form of prejudice based on age should be challenged and avoided.

8.5. Safeguarding referrals and process

Whilst it was agreed that accommodating adolescents age 15 or 16 years can be difficult, particularly if the parents and adolescent do not agree with the plan, there may have been a "window of opportunity" to seriously consider child protection and accommodation for Child LW on the final admission to hospital in the child's best interest.

On the final admission there were serious concerns about poor treatment compliance of a life-threatening condition and lack of parental support. At an arranged ward meeting to discuss treatment compliance, it was found that father and child had no money and were homeless with nowhere to go.

The Specialist Paediatric Diabetic Team made an appropriate child protection referral to CSC with the expectation of a child protection response which did not happen. The referral was downgraded to a single agency Early Help response with the Child and Family Team whose main focus was to get accommodation and finance arranged for the family. Early Help were not aware of the Child LWs past social and medical history and managed the situation as a task-oriented response.

Progress – CSC and Early Help Team now have access to each other's IT systems to ensure that relevant child and family information is readily available to improve risk assessment, information sharing and communication.

The response made by CSC clearly missed the point of the referral which had been mainly focused on the risk to the child's life in relation to the management of IDDM. A Strategy Meeting would have been a more reasonable response. This was a good opportunity to instigate an Initial Child Protection Conference or given the level of medical concern and concerns raised by other agencies with the lack of having anywhere to live, a PLO (Public Law Order) consideration would have been relevant.

The referral which had been made by the Specialist Paediatric Diabetic Team was at first presumed to have been accepted by CSC as a child protection case. Once the specialist team found out that the case had been downgraded to Early Help, there was insufficient professional challenge back to CSC to address the difference of opinion.

Whilst father and Child LW were cooperating with the child and family worker (CFW) around the finance and homelessness issues, this was not addressing the medical neglect and other neglect issues which had been identified in the referral.

When the issue of escalation was being discussed with practitioners at the Practitioner Learning Event, practitioners acknowledged that they were not confident about the escalation of safeguarding concerns processes or around the acceptability of professional challenge. Some professionals were not even aware that there was a local escalation policy.

Lancashire Safeguarding Children Partnership have a Resolving Professionals Disagreements (Escalation and Conflict Resolution) Policy (May 2017) which sits within the main body of the local area policies and procedures. This policy describes the various levels that difference of opinion challenges should go through to acquire resolution on behalf of children and families.

Following a review of this policy the Independent Reviewer would suggest that the policy should simply be called the "escalation policy" and provide a pictorial pathway of what staff can do to resolve differences of safeguarding opinion on behalf of children.

Practice Learning
Training is key to ensure that all front-line workers understand their own safeguarding responsibilities and that of their colleagues in other agencies. Knowledge of the legal framework, escalation policy and the local threshold document is important when making a professional challenge and escalating safeguarding concerns on behalf of children. Front-line staff should be encouraged to contact their organisations safeguarding leads for support in these situations.

Although the full picture of what was happening to Child LW was never drawn together until after the child's death, professionals working with Child LW did recognise possible abuse and neglect issues and did try to raise concern with CSC and other safeguarding agencies as follows:

Nature of concern	Referral by agency	Outcome
Child LW present during domestic abuse with half sibling	Police to CSC	ICPC for half sibling acknowledge that Child LW requires section 17 assessment – not completed due of lack of cooperation from father.
Possible criminal assault	School to CSC	Section 47 enquiry was completed and concluded concerns were not substantiated.
Child LW not attending school and father not engaging	School to CSC	No further action – seen as an attendance issue and responsibility of the school
Poor compliance to IDDM management, was not brought to essential hospital appointments and not attending school	DSN seek advice from hospital safeguarding team	Advised to make a referral to children social care – not clear if a referral took place. Not found in the records.
Concerns of non-compliance to IDDM management and failure to attended essential hospital appointments	Consultant Paediatrician seek advice from hospital safeguarding children team	Advised to contact GP to try to contact child and family and to consider police safe and well check and to make a referral to children social care
Continued as above	DSN contacts children social care on behalf of Consultant Paediatrician	Following checks to Child LW record at CSC the DSN was told that Child LW was not open to them. No further action.
Concern that Child LW and other children were present at fathers address during domestic abuse	Police to CSC	MASH contact and assessment. No further action because the team could not contact father or his partner to gain consent for further assessment.
Concern that Child LW was admitted to hospital and had lost 10kg and was seriously ill in high dependency unit due to poor compliance of IDDM treatment.	DSN seek advice from hospital safeguarding team	Child protection referral made to children social care. This was downgraded to Early Help to address the family issues which included homelessness and no money. Father used the ward for 2 weeks as emergency accommodation for himself and Child LW
Serious concerns about non-compliance and serious condition could be fatal	Ward meeting with Consultant Paediatrician, DSN, father and Child LW	Although there was some improvement with engagement this was not maintained.

Serious concerns about non-compliance and serious condition could be fatal	Hospital safeguarding children team to CSC	Concerns may have been alleviated because father was seen as cooperating with Early Help worker at the time of the call.

Referrals appear to fall into 2 main groups:

- Child LW being present at **Domestic Abuse incidents** involving the parents.
- Child LW and **parents not compliant with lifesaving treatment.**

None of the referrals triggered a multiagency response in terms of a multiagency meeting to consider and address professional concern as would have been expected.

Progress
Local safeguarding arrangements have now been strengthened. The learning and progress for MASH was that now any referral relating to complex health needs is checked by the health professional on MASH before a threshold decision is made.

8.6. Domestic Abuse incidents and safeguarding adolescents

Child LW was present at 4 separate Domestic Abuse incidents during the timeline - 1 involving mother and 3 involving father. Child LW would be asked about events by police but when there was a refusal to provide any information the domestic abuse case was closed. Information was shared by police via a PVP (Protection of Vulnerable People) notification with CSC and Health.

"Health" usually denotes the 0 -19 community children services such as Health Visiting and School Nursing. Other areas of "Health" such as hospitals, GPs and mental health services are usually unaware of the incidents relating to their patients unless they are specifically informed. In this case, the hospital Specialist Paediatric Diabetic Service were unaware of any domestic abuse experience in Child LWs life and therefore not able to consider the impact of this further.

Progress – MASH are conducting a pilot study to try and address the domestic abuse PVP notification gap within health to share information more widely in the best interest of children and adults at risk.
All PVPs that are graded medium are screened in MASH and any graded at high risk by the Police is presented at MARAC which is good practice.

CSC response to the police PVP notifications was to ask parents for consent to undertake an assessment of child and family need to identify areas for support. This resulted with the parent's refusal for any CSC assessment with no further action being taken.

Practice Issue
When parents refuse support from CSC this should be viewed with caution and a risk assessment of no further intervention should be considered taking other agency views into consideration at the time.

Child LW had already been subject to witnessing 11 domestic abuse incidents prior to the timeline raising the total to 15 known domestic abuse incidents. It is known that domestic abuse happens most often "behind closed doors" and therefore, there may have been many other incidents of domestic abuse occurring without the knowledge of any of the agencies.

Whilst the traumatic impact of domestic abuse on Child LW was not assessed there was historical information about Child LW when the child was younger and required anger management and 1:1 support in school which appears to have been linked to domestic abuse. This historical information does appear to be considered alongside new and contemporary concerns for the child.

Practice Learning
Domestic abuse should be considered alongside other forms of risk which coexist with the child and family before referrals to MASH are closed. A multiagency assessment through MASH should be relevant for all children and adolescents and the accumulative impact of persistent ongoing domestic abuse should be viewed as high risk resulting in safeguarding processes being implemented in line with local safeguarding procedures.

8.7. Parental non-compliance with lifesaving treatment - Local reflection on safeguarding

Following a helpful and illuminating presentation on diabetes mellitus which was provided by the Specialist Consultant Paediatrician, CSC professionals reflected that they had not fully understood the seriousness of Child LW's health condition at the time. Alongside this realisation, health professionals recognised that they had not been insistent enough in their explanations about concerns they had about Child LW and had been too willing to accept CSC decision to work with the family under Early Help.

Practice Learning
Professionals need to be confident that when they have serious concerns about a child, they are at liberty to escalate concern (where difference of opinion exists) beyond the first level social worker as relevant. Professionals need to be aware that they can directly contact a social worker manager or IRO (Independent Reviewing Officer) to request a review of the case or in serious situations can request an Initial Child Protection Conference in their own right. Health professionals should use the expertise of their Named and Designated Professionals to provide support and influence on complex cases particularly those which rely on in-depth health explanations.

A further observation of note was that there were 8 occasions during the timeline when professionals contacted CSC with their concerns about the welfare of Child LW but the cumulative effect of this did not result in any further action being taken by CSC as would

have been best practice. Each referral appears to be dealt with in isolation of any other historical information.

Practice Learning
MASH should consider using an alert flag on their record keeping systems to indicate when there have been several contacts or referrals over a short space of time e.g. 3 contacts/referrals in 6 months. This should result in a strategy discussion/meeting depending on the nature of the information available.

Progress – MASH referrals are now responded to within 24 hours with feedback given to the referrer if the threshold for section 47 is not met. This will help professionals to consider and escalate child protection concerns within a reasonable timescale.

The conclusion of the practitioner learning event was that Child LW needed Early Help much sooner. If fact, the child needed a child and family assessment and support throughout the timeline. Multiagency Early Help in the early stages of the child's illness would have provided the opportunity for information from across the agencies to be pulled together to provide the bigger picture on behalf of Child LW and would have helped professionals to work together to protect and promote the welfare of the child.

8.8. Information from the local Child Death Overview Panel (CDOP)

The Independent Reviewer requested data on child deaths reviewed over the past 5 years (2015 – 2020) which relate to features of possible Medical Neglect.

The information relates to Lancashire only cases as follows:

There were 4 cases of children with an age of between 2 – 17 years.

2 cases of Asthma
1 Diabetic Mellitus (Type 1)
1 Metabolic Disorder (since birth)

All child death reviews showed elements of poor parental supervision and poor parental compliance around medical treatment plans. There were 2 cases where the adolescent children had been subject of child protection plans for neglect at some point during their life and 2 cases where a safeguarding referral had been made by Health to CSC because of health care concerns. Adult Mental Health was considered in 2 of the cases and Child Mental Health was considered in one case.

Although the numbers of children dying with a long-term life-threatening condition are small these cases considered alongside the findings in this review provides some reflection for the local area in relation to their safeguarding children arrangements around the management of cases of possible child medical neglect as identified in this report.

Good Practice

There was a number of good practice examples recognised across the time period of this review as follows:

- The tenacity and commitment of school in trying to engage Child LW in education.
- The tenacity, compassion and support provided by the members of the Specialist Diabetic Paediatric Team with good information sharing with other agencies.
- Mental health services quick response to the referral and the child's non-engagement did not result in discharge – the child seen on ward.
- CFW made good progress in getting finances and a new property for Child LW and father.
- DSN worked well with school nurse and college nurse with good information sharing.
- School nurse and college nurse both share information within their relevant educational setting and tried several approaches to engage Child LW.

Practice Issues

A practice issue is one that relates to practice matters for review at local provider practitioner level.

1) There are a number of training areas for consideration for all front-line staff:

*Legal framework
*Escalation Policy
*Threshold Policy
*Roles and responsibilities in safeguarding
*Use of Named and Designated Professionals and other safeguarding leads.
*Professional Challenge
*Voice of the child
*Parental disguised compliance.

2) "Was not brought" and "no access visits" were prevalent across the timeline, Health providers should ensure polices are up to date and staff know what to do to advocate for children when they are aware, they are not receiving adequate healthcare. Parental non-engagement with their child's appointments should be viewed as medical neglect.

3) School attendance policies should be more strictly applied and include a clear plan of action for circumstances involving poor school attendance. Local authorities should never accept a situation when a child under 16 years is not receiving any form of education.

4) GP practices should review the way they administrate patients lists around having automated notices to children patients for deregistration without having due regard for the impact on a child's health or wellbeing.

5) All provider services should consider how Early Help systems and processes can form part of any clinical pathways when working with children with serious health conditions. This may help to normalise the practice of Early Help assessment and promote multiagency working.

6) All providers of Paediatric healthcare who are caring for children with life limiting conditions such as diabetes mellitus should consider the use of a psychosocial model such as HEADSSS for interviewing adolescents they are concerned about so they become better informed about the holistic life challenges of the child.

7) MASH should consider and develop new pathways for Medical Neglect referrals as suggested and consider how it can flag CSC child records to indicate that a child has had a number of contacts/referrals within a specified timeframe.

Conclusion

This SCR provides some insight and reflection around adolescent safeguarding and medical neglect. It also, provides an opportunity to consider the impact of ACEs and how these can be identified and supported by using trauma informed practice.

The partners of the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) should consider learning from this review and note several improvements which have already taken place across their area of responsibility.

This review should be shared to promote learning across the safeguarding partnership.

Recommendations

The following recommendations are for the consideration of CSAP as follows:

Recommendation 1

CSAP should review its Neglect Strategy and safeguarding systems in order to improve:
1. Local arrangements for addressing adolescent neglect and to specifically include the legal framework options available.
2. The multiagency approach to management of concerns pertaining to Medical Neglect.

Intended outcome *– To improve the local response to adolescents experiencing parental neglect and for children where there are concerns about medical neglect.*

Recommendation 2

CSAP should request assurance from partners and review how multiagency local safeguarding working practices are being progressed to:
1. Implement ways of working with children and families to better identify the existence of Adverse Childhood Experiences (ACEs) within the children and families they work with.
2. Apply the principles of trauma informed practice more widely and consistently across the local safeguarding arrangements.

Intended outcome *– To improve the way that practitioners engage and work with children and families who are affected ACEs*

Recommendation 3

CSAP should review and promote its safeguarding “Escalation Policy” and seriously consider how it can instil confidence within their multiagency workforce around cross agency respectful professional challenge where there is a difference of opinion during a child safeguarding case.
Intended outcome *– To promote a culture of professional’s respectful challenge in order for professionals to improve the way they advocate of children and families.*

Recommendation 4

CSAP should request feedback from partners that the “Practice Issues” identified in this review are acted upon within a reasonable timeframe.
Intended outcome *– For CSAP to be assured of service level improvements to improve outcomes for local children and families.*

References

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Statement of Reviewer Independence

The reviewer, Kathy Webster is independent of the case and of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and its partner agencies.

Prior to my involvement with this Serious Case Review:

- I have not been directly concerned with the child or any of the family members or professions involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigours analysis and evaluation of the issues as set out in the Terms of Reference.

Kathy Webster – Independent Reviewer

Date: December 2020