BSCB Bristol Safeguarding Children Board

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Child Protection Incident Review

2018

Case: Tia

1. Introduction

1.1 On 31/03/2017, the Bristol Safeguarding Children Board (BSCB) received a referral for a Child Protection Incident Review (CPIR) from Barnardo's. The request was to consider the management of Tia's situation where there were grave concerns for her mismanagement and lack of support around her diabetes. She has been dangerously unwell on multiple occasions; she has been hospitalised and suffered from ketoacidosis (a life threatening condition), and she has developed chronic nerve damage which resulted in the loss of feeling and movement in her foot for approximately six months.

1.2 Tia has had a disrupted home life throughout childhood with a significant lack of stability; multiple moves both between family members and placements provided by the Local Authority (Foster Care placements, a Residential Children's Unit, and hostels).

1.3 This referral was considered by the multi-agency Serious Case Review Sub Group of the Board on 12/05/2017 and was agreed by Sally Lewis, Independent Chair on 16/05/2017.

1.4 There are three purposes to be fulfilled by a Child Protection Incident Review. They are:

a. To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard a child.
b. To establish what those lessons are, how they will be acted upon, and what is expected to change as a result.
c. To improve inter-agency working and better safeguarding of children; including the review of procedures where there may have been failures.

1.5 The Quality and Performance sub-group nominated the Designated Doctor for Safeguarding Children from the Community Children's Health Partnership and a Team Manager from Bristol City Council Children's Social Care to undertake the review. At a meeting on 12/07/2017, the terms of reference were drawn up. There were many aspects of concern in Tia's life and there were two overriding issues that led to there being a narrower focus for this CPIR: not to replicate learning from other reviews, and to protect Tia's anonymity.

1.6 Agencies were first asked to review their records to answer the following questions, from the period from April 2012 until March 2017.

d. What was professionals' understanding of the risks associated with Tia's diabetes? How was this understood within the safeguarding framework?

e. How effectively did professionals recognise and respond to the links between Tia's diabetes management and wider safeguarding concerns such as CSE and neglect within the family?

f. How was mental capacity understood and assessed in the decision-making related to Tia's use of medication?

g. Was legal advice ever sought in relation to safeguarding Tia? If not, should it have been?

h. How effectively were periods of transitions between services managed?

i. How effectively did professionals engage with Tia and her family around issues relating to her diabetes?

j. What barriers can you identify for professionals in your agency engaging effectively with adolescents around life-saving medical treatment?

2. Methodology

2.1 Letters were sent to agencies on 31/07/2017 asking that an independent representative from the agency who was not involved in Tia's care, review the case files and provide the following on behalf of the agency:

- A chronology of the agency involvement with Tia
- A report answering the areas for consideration as per the questions above

2.2 The reviewers met with Tia on the 01/09/2017 and her views are recorded below under Voice of the Child.

2.3 A learning event was held on 09/11/2017 with professionals and authors of the agency reports to look at what lessons could be learned.

2.4 A follow up meeting with some of the Children's Social Care staff who worked with Tia was held on 29/01/2018 and follow up conversations were held with individuals who were unable to attend the meetings.

2.5 Unfortunately the reports from the Police, Children and Family Court Advisory and Support Service (CAFCASS) and Tia's school were not received prior to the learning events and therefore only seen by the reviewing team. All single agency recommendations are attached as an appendix to the report.

3. Voice of the Child

Tia was spoken to with the support of her Barnardo's Against Sexual Exploitation (BASE) worker to understand her views.

1.1 Regarding her diabetes Tia stated that when she was first diagnosed "everything felt fine, I felt in control." She clearly recognises that her diabetes control is poor and understands the risks associated with this. Tia was open about the fact that she has struggled with the management of her diabetes "I don't want to inject myself." Tia recognises that at times she used her diabetes to demonstrate her feelings "when they took my independence away I used my diabetes to retaliate. I pushed everyone away when things were bad".

Tia was positive about some of the support she received from the Paediatric Diabetes team. She described finding the more assertive outreach approach from the nurses, when they would visit her in the community and at school, helpful. However she felt they focused too much on her condition, rather than on her as a person.

1.2 Tia felt that she had taken a lead on the timing of the transition of her care to the Adult Diabetes team managed by another NHS Trust "I thought I could get more help. At the time I thought I was able to take the responsibility but that was not the case".

1.3 Tia was generally negative about her experiences with Children's Social Care "nothing social services has done has helped me - I felt they were trying to isolate me – I didn't belong." Tia was very negative about her time in foster care and the children's home when she was aged 13 years. "They treated me like a child. I didn't like anyone to take away my independence". She didn't understand why she was in care and felt her relationship with her Social Worker was poor.

Tia recognises that when she returned to her family her home situation could be very chaotic. Her main carer developed dementia which went unrecognised for a period of time "nan had dementia and Social Services didn't spot it – they [family] put the blame on me. I got blamed for lots of things – [Children's Social Care] believed the adult and not me. Life felt so erratic. I told people what things were like but they didn't listen."

Regarding the Children's Social Care decision to close the case Tia stated "I think in the end Social Services had had enough. At the time I'm glad they had enough but looking back on it I think it would have been helpful if things had been done differently."

1.4 Tia feels she would have benefited from more support moving to independent living. She continues to be negative about her experience of professionals "I don't have a lot of trust in any professionals."

3.5 Tia was positive about her experiences with BASE "they opened my eyes to stuff. [They] always stuck with me, she listened to me".

1.5 When asked what would she would change Tia stated "I needed my family and a settled environment – I feel Social Services prevented this." She was not able to identify anything specific that may have been able to improve the situation.

4. Learning Points from Questions Posed

4.1 What was professionals' understanding of the risks associated with Tia's diabetes? How was this understood within the safeguarding framework?

What worked well?

- The majority of professionals felt they had a good understanding of risks of diabetes.
- Evidence of excellent communication between Paediatric Diabetes nurses and Children's Social Care and Tia's school regarding diabetes management and potential risks to Tia.
- GP team were very aware of Tia's vulnerability and her records were flagged to highlight this.
- GP practice worked very hard to ensure Tia had access to support and treatment. The practice responded in a flexible way in how they communicated with Tia with frequent phone calls as well as face to face consultations.
- The Paediatric Diabetes team offered to see Tia outside normal working hours and at school to support her engagement.
- GP's were well informed of Paediatric Diabetes team involvement.
- Professionals working with Tia were aware that the risks to Tia's physical health were a significant safeguarding risk and that information was shared both timely and appropriately, as well as referrals being made to Children's Social Care.
- Police records demonstrate that diabetes was always an indicator of risk during any contact and/or investigation and was shared between agencies on numerous occasions.
- Care proceedings were very appropriately initiated in December 2013.
- The medical report prepared for court highlighted the significant potential risks.
- The case conference minutes clearly demonstrate understanding that this was potentially life threatening.

What are we worried about?

- GP practice did not really consider diabetes management as a safeguarding issue as they believed she was receiving the right care. The term "neglect" was not formally used in the records although the GPs were clear that this was one of their concerns.
- Children's Social Care records lacked in-depth analysis about Tia's diabetes, including the impact that the diagnosis had on her, what barriers there were to managing it effectively and how this would be best tackled.

- Children's Social Care records indicate that diabetes was a higher concern when Tia was younger, but became diluted in the light of other concerns.
- The Foster Carer was not aware of Tia's diabetes and stated that they would not have accepted the placement if they had been.
- Were the risks of diabetes lost in the Court Proceedings? The children's Guardian's position statement seemed to overly rely on Tia's ability to take responsibility for managing her diabetes despite medical advice given by the Diabetes Consultant being contrary to this. The children's Guardian did have information from the Diabetic Nurse establishing that there was a plan involving the family, school and Health Services to manage the diabetes given her age and this would involve some age-appropriate management of her condition by Tia. However the Guardian's conclusion is at odds with the views shared by professionals in the learning event.
- Social Workers felt to 'back off' after failing to proceed at court.
- Referrals to Children's Social Care, when assessed, were closed due to an over-reliance on Tia's ability to self-care and because things had not worked with the family in the past.
- There is no clear record of the decision making behind Children's Social Care closing the case in September 2014 despite the continuing concerns and fragility of the placement with family members.
- There is limited evidence of risk management meetings being undertaken involving all relevant professionals.
- Supported Housing did not appear to be aware of risks related to diabetes. The risk system is based on young person's self-scoring and Tia was positive about her ability to manage her condition.

What needs to be considered?

- For young people with a complex medical condition and safeguarding concerns, all agencies need to be aware of the potential medical complications and undertake a risk assessment regarding these.
- For adolescents with chronic health conditions all professionals working need to be aware of the significant challenges for the young person to manage this themselves in a safe, effective manner. Work needs to be undertaken in supporting the young person to take ownership of the management of their condition, whilst recognising that they will require a high level of support to do

this, quite possibly for many years and certainly whilst under the age of 18.

- For adolescents who are known to be at significant risk of harm yet the child protection system appears to have been ineffective in reducing this, consideration of alternative methods of engaging and working with that young person and their family should be considered.
- When professional reports and opinions appear to be contrary to the expert medical advice given by a Specialist in a chronic health condition, professionals should be encouraged to challenge this.

4.2 How effectively did professionals recognise and respond to the links between Tia's diabetes management and wider safeguarding concerns such as CSE and neglect within the family?

What worked well?

- Professionals were aware that diabetes management may be used as a form of self-harm and the potential increased risks related to this.
- BASE had a clear understanding of the family circumstances and provided excellent support in terms of Tia's wider risk taking behaviours and vulnerability.
- BASE used the escalation policy to challenge the decision of Children's Social Care to not allocate the case following referral.

What are we worried about?

- GP practice did not receive communications from Children's Social Care or BASE, and while they understood Tia's medical needs well, they felt they did not understand her overarching risks.
- Concerns regarding communication from Children's Social Care to GP practice regarding changes in placement, etc.
- GP practice was not aware of concerns around CSE until a multi-agency audit reviewed her records.
- Tia not taking medication was seen as an 'unwise choice' rather than a possible result of early life experiences or neglect.
- Adult Diabetes team hospital records did not contain information regarding social concerns and vulnerability. Electronic records do not provide clear summary of risks as documents are scanned in and not highlighted.

- Neglect terminology was not consistently used in either assessments or multi-agency discussions. Labelling the concerns may have influenced decision making.
- Too much reliance was placed on Tia to manage herself without credence for her age, her life experience, lack of parenting/care and positive and consistent role modelling. She is often described as mature. This presentation, rather than being an indication of resilience and ability to self-care, may actually be an indication of pathological over self-reliance, which can be very harmful as it reduces the young person's ability to seek and engage with support.
- From the CAFCASS report, Tia's perceived level of maturity and being "streetwise" informed the Guardian's thinking and recommendations. The Guardian's recommendations appeared to be "child led" rather than "child focused".
- The Children's Social Care assessments do not sufficiently consider the impact of Tia's carer's age related health issues and whether she could adequately cope with a teenager.
- No evidence of the outcome following BASE's escalation of the decision to not re-open the case.

<u>What needs to be considered?</u>

- Hospital trusts to review their record keeping systems to ensure that information regarding significant areas of risk for a patient is easily identifiable and accessible to every practitioner providing care for that patient.
- Neglect in adolescents needs to be formally acknowledged and documented.
- Training to all staff to include the impact of chronic neglect on how a young person may present as mature and self-reliant which may mask their ability to seek and engage with support.
- Outcomes of escalation must be fully recorded and shared with appropriate agencies.

4.3 How was mental capacity understood and assessed in the decision-making related to Tia's use of medication?

<u>What worked well?</u>

- Practitioners were aware that capacity would not generally be considered in a formal way for a child as it is not applicable until 16 years of age.

- Professional awareness and recognition that young people with chronic health conditions generally require high levels support.
- Referrals were made to Child and Adolescent Mental Health Services (CAMHS), Clinical Psychologist and BASE mental health worker to support Tia with mood and her Insulin-Dependent Diabetes Mellitus (IDDM) management. However Tia disengaged with these services relatively quickly.

What are we worried about?

- Mental Capacity was assumed rather than formally assessed in all agencies once Tia was 16 years old.
- CAFCASS' position statement (25/3/13) put too much responsibility for diabetes management on Tia when aged 13. The Guardian's view was informed by information from the Diabetic Nurse which led them to believe that it would be in Tia's long-term interests to start to take some responsibility for managing her own condition. Health professionals, including the Diabetic Nurses, disagreed with the Guardian's conclusion.
- Perception of Tia's maturity to make decisions concerning her own care may have been over-estimated.
- How can mental health services support young people who disengage? There is evidence to suggest that this may have not been effectively challenged or alternative options looked at.
- Lack of sufficient knowledge and professional inquiry at an early stage to enable exploration into the reasons Tia continued to mis-manage her diabetes and establish if this was a form of self-harm.

What needs to be considered?

- Practitioners to consider whether the decisions that young people are being asked to make are appropriate considering their context and situation, as well as age.
- Mental Capacity should be assessed and documented for young people over the age of 16 years who are felt to be making "unwise" choices by health, and care professionals should do so similarly.
- If a young person is referred to a service with a history of non-engagement, referral needs to include information about techniques for engagement that have worked for that young person. Agencies need to consider alternative strategies to support engagement.

4.4 Was legal advice ever sought in relation to safeguarding Tia? If not, should it have been?

What worked well?

- Social Workers did use all the legal options available to try and effect change.
- Care Proceedings were initiated at appropriate times. Tia feels that proceedings made her life worse but may have felt the same whenever they were made.

What are we worried about?

- If more robust intervention was made (eg Care Order) would this have enabled agencies to support Tia's diabetes management more effectively?
- Did unsuccessful previous care applications prevent further consideration?
- Issue of whether Health trust or other agencies could have considered taking legal advice in their own right (especially in cases where the family situation is deemed supportive).

What needs to be considered?

- A multi-agency risk management meeting was not held prior to the first care application. This would have bolstered the Local Authority care application. A Child Protection conference was held after the situation deteriorated at home following the conclusion of the first hearing.

4.5 How effectively were periods of transitions between services managed?

What worked well?

- Transition between Paediatric Diabetes and Adult Diabetes hospital teams were planned and managed well with the joint clinic. However Tia said she remembers that all support dropped off.
- A formal handover letter written by the Paediatric Consultant summarised both medical and social concerns.
- GP practice took a very protective decision to retain Tia as a patient even when she was moving areas frequently.
- BASE supported Tia at multiple appointments with different agencies.

What are we worried about?

- The handover medical report was not found in the Adult Diabetes team NHS Trust records so no professional would have been able to access this.
- Tia accessed a number of different health services which all have separate record systems and may have no awareness of other teams' involvement. This is a well-recognised issue within health and could impact on the quality of care a young person receives.
- The case appeared to be abruptly closed by Children's Social Care in September 2014, despite the fact the Tia had only been removed and placed in Foster Care for a week the month before. No professional meeting was held to put a safety support plan in place for Tia following Children's Social Care's withdrawal of involvement.
- No transition to Adult Social Care was considered.
- Tia was given an opportunity to present as homeless under Section 20. Given her history this could have been presented more forcefully. This would not necessarily have changed where she was placed, but would have led to having a social worker followed by post-18 support.
- Tia's housing application did not evidence the extent of her need.

What needs to be considered?

- Handover medical reports for young people transitioning to Adult health services to be clearly identifiable and accessible in medical records. These should include details of any social or safeguarding concerns.
- When Children's Social Care close a complex case with on-going identified concerns there should be a multi-agency planning meeting to ensure all agencies are aware of current concerns, plans to support the young person and identify what should trigger a re-referral.
- Consideration of developing a system of multi-agency planning meetings to review support for young people with complex health and safeguarding concerns transitioning to independent living/adulthood.
- Staff working with young people in Supported Accommodation with chronic health problems to have access to medical advice regarding specific risks that may be related to that condition.

4.6 How effectively did professionals engage with Tia and her family around issues relating to her diabetes?

What worked well?

- A number of agencies have gone above and beyond their roles in their care of Tia.
- The Paediatric Diabetes team worked with a number of family members to ensure they understood the management and associated risks of Tia’s diabetes.
- The GP practice has had a longstanding relationship with Tia and her family, and has seen her with different family members at different times.
- BASE involvement with Tia included liaising with medical professionals and attending appointments with her.

What are we worried about?

- During review meetings it was identified that the family may need support in how they could help Tia manage her diabetes. There was an absence of evidence of how the Social Workers engaged the family in building up their skill base to care more effectively for Tia in terms of managing her condition.
- Staff from a number of agencies report family members to have been aggressive and difficult to work with at times and that this affected their working relationship with them. Social Workers report that relationships had broken down with most of the family and that they had been threatened by family members therefore preventing focus on concerns.

What needs to be considered?

- Assessments need to include ways to support and engage family members, with focused outcomes on the expectations of their involvement in the care of the young person. The Signs of Safety child protection approach will hopefully equip professionals to concentrate on real risks and not be distracted by other welfare issues.
- All staff need additional supervision and support when working with challenging and avoidant families. Multi-agency risk management meetings may be appropriate in recording these issues and planning how professionals can best work with the family in a safe, effective way.

4.7 **What barriers can you identify for professionals in your agency engaging effectively with adolescents around life-saving medical treatment?**

- Balance between maintaining engagement with young person and challenging risk taking behaviours.
- Health services are not commissioned to provide more assertive outreach for young people, particularly once transitioned to Adult care.
- Health services see young people over the age of 16 years as adults despite research evidence to show their brains are not mature until 25 years of age. There is limited ability to tailor transition appropriately.
- Children's Social Care is set up for short interventions - some cases require long term engagement.
- Lack of services for young adults to provide holistic overview and support.

5. Conclusions

5.1 The reviewers need to thank all those who contributed and participated in the learning events with openness and willingness to reflect on whether practice could be improved.

Adolescents with diabetes are a particularly vulnerable group with barely 30% (we heard) managing it routinely and satisfactorily despite every support and encouragement. The role of parents and carers during this time would be to provide persistent, supportive, flexible care and boundaries to reduce the risk (whilst accepting that it will not be possible to completely remove risk) and to support the young person in developing their independence. Parents provide the "safety net" for the young person and professional expectation is that parents or carers do not turn their back on their child, however challenging or ineffective their interventions appear to be.

With a young person who has complex health needs and has been neglected, whose family are not available or are not capable of providing this support, it may be the role of agencies to fulfil this "safety net". Over-stretched services often react to poor engagement by closing the case, which can increase the young person's belief that no one cares and that no one is able to help, increasing their pathological self-reliance. Professionals become disillusioned when their interventions seem ineffective, particularly when they feel they have done their best but systems, e.g, the court process, have gone against them.

This was not a case that lacked effort from agencies and indeed we heard that professionals tried many times to take action to improve the situation. Given Tia's earlier life history, the reviewers could not state with any certainty that any other course of action would have made her management any safer, something Tia herself also commented on.

5.2 Professionals felt the period of time that Tia had spent in the children's home had been the most positive period for Tia's diabetes management although this is contrary to her own views. Tia felt that she was being treated like a child but she was being given the appropriate care that a person of 13 should receive.

5.3 Although there are no definite answers to what may have improved the outcomes for Tia, there are always learning points from such an exercise and these are highlighted below.

- Maintaining a relationship with adolescents even when they are hostile and seemingly rejecting. If not immediate then an opportunity for them to come back to that service or professional.
- Maintaining a child focus without being child led. Tia's behaviour belied her years and that self-reliance can be seen as a worry or complicating factor rather than as a mitigating safety.
- Involving the GP when there are health issues. They are central points of contact for health professionals and can be useful knowledge bases for other professionals where there are safeguarding concerns.
- Recognising the significant risks at times of transition. All agencies need to ensure communication of relevant medical information, social issues and safeguarding concerns to enable appropriate risk assessments and management plans to be created.
- If files are to be closed, there should be resilient risk management plans that are understood and disseminated so that professionals are clear as to what is expected of them and what would trigger further action/referrals elsewhere.