Learning Circle concerning a child with complex health needs
Published July 2024

7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a review concerning a child with complex health needs who sadly suddenly died in 2023. Given the complexity of the child's health needs and escalation in response to concerns, WSCP determined there was a need to undertake a Learning Circle to reflect on how agencies worked together to understand the safeguarding need of the child and their family, alongside care needs.

The areas the review identified included the following:

1. Recognising and responding to safeguarding risk with children who have complex health needs
2. Communication between services and timeliness of escalation
3. Being professionally curious to understand causes of injury and presentations with children who have complex health needs
4. Ongoing assessment of parenting capacity and capability to provide effective care at home

2 WHO WAS THE CHILD AND THEIR FAMILY?

The child had complex health needs and was open to the Complex Care Needs Team with respite support. The child had a range of health related needs from birth which affected their whole body and had no independent mobility therefore used a wheelchair for all mobility needs. As a result, the child and their family were well known to services and they were in receipt of a package of support from a range of health and care services

Concerns were raised towards the end of 2022 as to the child's family being unable to meet their needs given the acuity of care they required, along with some service concerns in respect of home conditions, pressure sores to their skin, being isolated at home from others and the number of unexplained injuries they were presenting with.

3 KEY POINTS AND ANALYSIS FROM THE REVIEW

- The child had multiple service involvement and there is clear evidence that all had a good long term relationships with them and their family. They were seen almost daily from therapy to community health teams, specialist school nursing teams, respite care and at school. The child's medical needs were always responded to as they arose and this was supported by good two way communication being in place between mum and services. Following the child's death, the communication between family and Wakefield District Housing (WDH) was excellent and the process in which the family have moved to a new property was dealt with sensitively in a supportive manner

- The child had regular instances where they would present with pressure sores to their ear and bottom, skin breakdown, being very stiff, had fractures, and being in discomfort when being moved. Although these presentations were recognised and appropriately treated medically, there were no clear escalation of concerns at the point at which they were identified until the latter part of the child's life. Once escalated, services reflected on the positive impact the increase in provision and support for the child and their family achieved. This included an increase to one night weekly respite care, multiple visits within a week and six weekly reviews via the Complex Care Needs Team, alongside their ongoing package of support from a range of health services and school

- Services recognised there was an absence of professional curiosity and appropriate challenge in attempting to understand what had caused the injuries and the way in which the child was presenting. There appeared to be a sense of inevitability that due to the child's complex health needs these types of injuries and presentations would be experienced. It was recognised it would have been beneficial to question and analyse through a safeguarding lens as to whether the child's home environment and the care he was receiving, despite his family's best efforts, was contributing to this

- There was recognition individual service supervision needs to be effective in providing a space for practitioners to be professionally objective, reflective and analytical about what they are seeing and hearing to support curiosity, especially for those practitioners who have supported a child and their family for a prolonged period such as in the child's case. Along with developing multi-agency group supervision which would enable practitioners to collectively come together, parallel to the meetings ongoing for a child and family, to jointly reflect on practice, on situations which feel complex and how services will work together to effect change. This is ongoing development the Safeguarding Children Partnership is progressing with. In addition to this, the existing Health and Care Provision Panel has extended it's Terms of Reference recently where complex cases can be presented to the panel for discussion

- Along with the concerns for the child's presentation and injuries, there were also records which documented periodically observations in relation to home conditions in respect of the house being cluttered and the child being left on their own in their bedroom. Similarly, to their presentations it was unclear as to how these observations were actioned until concerns were escalated in late 2022. Services reflected on using the neglect toolkit may have supported identifying and formulating an appropriate response at an earlier stage

- There were missed opportunities to share information about the child's needs and some of the concerns in respect of home conditions with services who would have been able to have further supported the child and his family. The 0-19 Service and the sibling's school were two services who prior to his death were not aware as to the extent to which partner services had concerns. Support such as considering sibling's pastoral offer and referring to Young Carers (school) and discussing how family were able to manage with the child's care needs as part of the sibling's universal contacts (0-19 Service) could have been put in place. This was reflective of an absence of a Think Family approach along with some wider system considerations which were discussed in relation to Child In Need plans not including siblings of disabled children. This approach manages the appropriateness in sharing information about a family with wider services who do not have ongoing involvement with the named child, however it was recognised this can place limitations on effective multi-agency working, understanding any impact on siblings, and coordinating support for the whole family

- Throughout service records there was little evidence there had been considerations of the impact of the child's health needs on their siblings and vice-versa. When the youngest sibling was due to be born, there were records referring to mum being unable to move him. However, it was unclear as to the level of understanding in how mum being heavily pregnant and then imminently having a new born baby would impact on her capacity and ability to provide the child with effective care

- Services reflected on the high level of care bearing responsibility placed on mum. It was evident mum was trying to provide the best care she could, but there were recurring statements within service records from mum she was not undertaking physiotherapy, not using the child's sleep system equipment and not repositioning them. It was limited within records as to how these occurrences were explored, understood cumulatively and to what extent this factored into any ongoing assessment as to whether mum was able to manage

- It appeared the child's lived experience was understood by services through their mum. Whilst this is understandable to an extent given the child's disabilities, on reflection there were opportunities which were not captured to understand their lived experience through his presentations, non-verbal cues along with what practitioners were seeing, hearing and questioning

- Services reported there were examples of good communication between one another, but reflected there was an absence in joining up different pieces of information services had which may have helped escalate his needs earlier. There were some required improvements in communication identified in the immediacy of his death, as part of the Sudden Infant Death in Childhood (SUDIC) process and the conclusion of any ongoing investigations

4 QUESTIONS TO CONSIDER

Some of the findings from the learning circle presents wider questions for the partnership to consider, which this review in isolation is unable to answer:

- How can the partnership be assured the delay in escalating safeguarding concerns in this case is not reflective of the wider complex health needs cohort?
- Is there a need to consider how a Think Family approach can be adopted for children who have complex health needs e.g., how siblings are considered as part of a Child In Need plan?
- Along with workforce development, is there a culture shift within services required to ensure the needs of children who have complex health needs are viewed through a safeguarding lens alongside their medical care?

5 WHAT WILL WE DO WITH THESE FINDINGS?

- The review generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families

6 NEXT STEPS

- The findings of the review have been approved by WSCP and work is underway in implementing the learning from the incident
- WSCP will consider holding service challenge events for those services involved in the review to report back on how they have implemented recommendations

7 RESOURCES

There are a range of national and local resources, training and guidance in relation to safeguarding children, all of which can be accessed via the WSCP website

Wakefield Safeguarding Children Partnership