



## Case Review Briefing for Child G & Mr D

### Why do case reviews?

Safeguarding Boards have a responsibility to ensure that organisations that work with children and adults at risk have the ability to learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm. The two reviews share similar themes and look at what happened in each of these cases, why this may have happened and what action will be taken by organisations and the Boards to learn from the findings.

### Child G - what were the concerns?

Child G was diagnosed with a degenerative and life limiting condition when he was 7 years old, and as a result he had contact with around 24 agencies/organisations and numerous professionals across these.

Although there was considerable ongoing support and packages of care from health professionals and children's services, there were concerns about neglect and the Mother's ability to meet the care needs of Child G. Of particular concern were poor home conditions and Child G not being taken to health appointments.

Management of Child G's health and care need became increasingly complex over time due to Child G's deteriorating physical condition, complicated by neglect and Mother only partially engaging with support services. This made it harder for professionals to understand cause and effect, predict outcome and orchestrate effective support.

In April 2017, when aged 17 years, Child G became acutely unwell and was thought to be at risk of death due to malnutrition. Child G initially refused to accept any treatment for this and only agreed to a hospital admission after considerable negotiation and persuasion involving several health professionals.

**Mr D - what were the concerns?**

Mr D has a learning disability and at the age of 11 he became a looked after child due to neglect and his parents' inability to support his nutritional needs. He weighed 16 stone 7 lbs and required oxygen at night due to health conditions linked to his obesity. Mr D successfully lost weight and by the age of 17 he was no longer obese and no longer required oxygen at night. As Mr D approached 18, there were instances of unplanned contact with his mother. He showed signs of becoming anxious and distressed and there were instances where he self-harmed and went missing. He remained in foster care until the age of 18 when he was deemed to have the capacity to choose to return to the family home.

Foster carers and professionals expressed concerns about his mother's behaviour and her capacity to change. After returning home, Mr D had a significant number of contacts with the Emergency Department, the 111 service Out of Hours GP and the minor injuries unit. His college attendance reduced and his weight increased significantly. Professionals found it difficult to engage with Mr D and his family, with appointments frequently being missed or cancelled by his mother. Three years after returning home, D was admitted to hospital with back pain. At this time he weighed 29 stone. Pressure areas were noted and Mr D was not complying with advice on eating, drinking and mobilising. His mother continued to intervene in Mr D's health care and provide unsuitable food and drinks. Following Mr D's discharge from hospital professionals remained concerned about the home environment. On some occasions dressings were unavailable and suitable pressure relieving equipment could not be sourced. A number of safeguarding concerns were raised to the Multi-Agency Safeguarding Hub.

Three months later, Mr D was admitted to hospital on an emergency basis, with a grade 4 pressure sore and osteomyelitis. It was deemed by all professionals that it was not safe for Mr D to return home. Mr D was judged to lack capacity to make informed decisions about his health needs and was discharged to a residential placement.

**Findings****Child G**

The threshold for escalating concerns and intervening became confused, in part due to there being an enduring belief about Child G's mental capacity, and right, to make informed choices.

Had it not been for a small number of tenacious and vocal health professionals Child G is likely to have died.

The combination of Child G having complex needs, being over 16 years of age and experiencing neglect, alongside the complexity of working arrangements increased the level of risk, and contributed to problematic situations being created.

Legal frameworks were often seen as a barrier to Child G being safeguarded.

## Findings

### Mr D

Agencies focussed on referring on, while not addressing the causes of the concerns.

Agencies did not help Mr D to express what his desired outcomes were from the support he was offered. He was not empowered to participate in assessments, to make decisions, or to safeguard himself. He was not supported by an advocate at transition or at other times.

There was an apparent lack of recognition of the long-term impact of abuse and neglect on the survivor's physical and mental health and their social functioning. There was no evidence of work being done with Mr D either as a child, during the Transition Process or as an adult to enable him to understand his early experiences of neglect and to be aware of their implications for his future in order to empower him to minimise their impact.

There were obstacles to people with learning disabilities experiencing good health outcomes - the circumstances that led to his removal from his family as a child did not lead to any substantial action when he became an adult, despite a range of agencies being aware of them.

### Relevant to both Child G and Mr D

Despite a perception that there were individual agencies and professionals taking a lead, there was no one single identified lead agency taking a holistic and strategic view about either Child G's or Mr D's circumstances.

There was a culture of 'Professional Optimism' that assumes the best of service users and their families, which led to a lack of challenge to the service users, their families, and also to the professionals involved.

There was a lack of 'Professional Curiosity' to look beyond the presenting issues other than to refer on to another agency.

There was a failure to consider the whole family, and recognise that the parents may well have had care and support needs of their own.

There was a lack of understanding of the implications of the Mental Capacity Act 2005 for young people transitioning from Children's to Adults' Services.

**Useful Resources**

- PSAB and PSCB websites <http://www.portsmouthsab.uk/> and <https://www.portsmouthscb.org.uk/>
- 4LSAB and 4LSCB Family Approach protocol <https://www.hampshiresafeguardingchildrenboard.org.uk/toolkits/adopting-a-family-approach-joint-toolkit/adopting-a-family-approach-joint-toolkit-landing-page/family-approach-protocol/>
- Mental Capacity Act code of practice [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)
- SCIE resources on transition <https://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/>

The PSCB offers a comprehensive range of multi-agency safeguarding training. A full list of both taught and online courses offered by the PSCB and details of how to book on these can be found [here](#).