Herefordshire Safeguarding Children Partnership

Local Child Safeguarding Practice Review

"Child HN"

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Report Author
Sarah Holtom
MSc BA(Hons) DipSW

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1. Introduction

Child HN was diagnosed with type 1 diabetes[1] when he was 11 years old. This Local Child Safeguarding Practice Review (LCSPR) looks at how professionals work with adolescent children and their families to ensure the effective management of a long-term health condition. The trigger for this review was as a result of Child HN being taken to hospital in an ambulance due to concerns of Diabetic Ketoacidosis[2] (DKA). Fortunately, Child HN recovered from this critical episode. Health professionals described it as a "*near miss*" and, whilst in hospital, his condition became critical with death a real possibility.

Following a Rapid Review in April 2023, the Herefordshire Safeguarding Children Partnership (HSCP) decided to undertake an LCSPR as this was a "near miss," and it was felt that there was potential to generate further learning in how agencies worked with the family, and together. The National Panel[3] agreed with this recommendation. The initial scope for the LCSPR identified practice and system issues regarding how agencies had worked together, including across local authority borders when Child HN moved from Worcestershire to Herefordshire.

Type 1 diabetes is a challenging condition to manage, particularly for adolescent children, with only 15% achieving target control. Research[4] shows that adolescents with this condition have five times increased risk of depression, the highest rates of diabetic ketoacidosis admissions and the highest rate of not being brought to appointments. Whilst children with type 1 diabetes will have more school absences, it is not associated with poor educational attainment. However, children with poor diabetes control have been found to attain less than their counter parts with optimal blood glucose levels, although this may be due to family and socioeconomic characteristics.

The key learning themes identified in this review include:

- **Management of type 1 diabetes**
- **Cross-border working together**
- **Understanding an adolescent's world and working effectively with families**
- **Understanding medical neglect**

1.1 What the Review looked at

The review examines a nine-month timeframe from July 2022, when Child HN moved to a refuge in Herefordshire with Ms HN (Child HN's Mum) and his siblings, to March 2023, when he presented at hospital in a critical state due to suspected diabetes mismanagement. There has been a critical eye on the historical contextual factors known by agencies whilst the family lived in Worcestershire from June 2020 (following diagnosis). This was to better understand

[1] If you have Type 1 Diabetes your blood sugar is too high because your body cannot make the hormone insulin. It is a lifelong chronic medical condition.
[2] Diabetic Ketoacidosis is a serious condition. It develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in your body. It can be life threatening and needs urgent treatment in hospital.
[3] The Child Safeguarding Practice Review Panel is an independent panel commissioning reviews of serious child safeguarding cases. They want national and local reviews to focus on improving learning, professional practice, and outcomes for children.
[4] French, R., Kneale, D., Warner, J.T., Robinson, H., Rafferty, J., Sayers, A., Taylor, P., Gregory, J.W. and Dayan, C.M. (2022). Educational Attainment and Childhood-Onset Type 1 Diabetes. *Diabetes Care*, 45(12), pp.2852–2861.

how decisions were reached and why certain actions were or were not taken by Herefordshire agencies. There was significant information submitted for this review from Worcestershire organisations regarding the support and services offered, particularly from education and health agencies. This is not specifically referred to in this report as it was not within the commissioned scope and therefore not relevant to the practice and system recommendations for Herefordshire safeguarding partners.

Through the review process, it has become apparent that additional learning has been identified for Worcestershire agencies. There have been reflections upon the original decision to undertake a LCSPR commissioned solely by Herefordshire, as Worcestershire professionals have been part of the Review Group and have contributed to the reflective learning events. The reasons for the multi-agency decision making to not jointly commission is understood in the context of proportionality when undertaking LCSPRs. Both partnerships have taken on board learning for future rapid reviews and the benefits of joint commissioning when there are cross border issues identified.

Paying attention to the Rapid Review learning, the LCSPR considered four key lines of enquiry, which were agreed by the National Panel and LCSPR Review Panel. These were:

- How Child HN's world was understood.
- How agencies distinguished between the complexities of unintentional errors in management of health conditions and parental medical neglect.
- How information was shared between local authority areas and across agencies to keep Child HN safe and meet his needs.
- How effectively support and services were put in place by agencies to ensure a timely impact on Child HN's day to day life.

1.2 Brief summary of what happened

Child HN is one of a group of siblings. He is described as British/Asian heritage. Child HN is described as looking older than his chronological years and Ms HN's view is his physical characteristics were significant when trying to instil rules and boundaries at home and suggests that possibly professionals, and herself, adopted a lens whereby they saw Child HN as older than his years and therefore more able to do tasks for himself. Ms HN also described how difficult it was to find ways to ensure Child HN followed his daily medication regime when he was "*kicking off*" or wanting time on his own in his bedroom.

Contextual history: Child HN lived in Worcestershire with both parents and his younger siblings from birth until he was a teenager. Professionals at the Learning Event shared how Ms HN "*had a lot on her plate and to juggle.*" It was known during the period prior to the review that the family were living in a home where there was regular emotional and financial coercion and control; paternal Class A drug use; and regular parental conflict described by Ms HN as verbal shouting and swearing, with Ms HN undertaking the majority of childcare responsibilities for Child HN and his siblings. The impact of COVID-19 is also seen as significant in terms of professionals in Worcestershire being able to build relationships when national restrictions were in place. All of this understandably took a toll on Ms HN's ability to cope and there were some concerns about maternal low mood. Worcestershire professionals shared a collective

view of how living in this environment impacted significantly on Ms HN's availability to access professional support. Ms HN found her extended family, who lived locally, a support during times of stress.

There were ongoing concerns from aged six years old that Child HN was not regularly attending school and was showing behavioural difficulties both at home and when Ms HN was able to get him into school. Ms HN reported worries about her son's emotional regulation and wondered whether he had some other learning needs that required further assessment. It is evident from records seen and reflections at the Learning Event that schools in Worcestershire worked hard at trying to support the family and progress the educational concerns. As explained by one education professional "*We tried everything and escalated matters to Worcestershire Children First."*

It is highly probable that Child HN had an underlying learning need that went unassessed. Child HN continued to have increasingly low school attendance and education professionals shared how this prevented formal educational assessment work from being completed. It is thought Child HN had a level of neurodiversity, and this presented increasingly in his behaviours as Child HN matured, by showing regular verbal and physical outbursts that were difficult to manage at home and school.

Worcestershire Children First (WCF) undertook a Strategy Discussion[5] in May 2021 following the concerns raised and the outcome was to offer support to Child HN and his family via child in need of support arrangements[6].

With the benefit of hindsight professionals have reflected during the practitioner event how it would have *"flipped Ms HN over the edge*" to then add in a diagnosis of type 1 diabetes for Child HN in 2020. The family were living in a situation of domestic abuse and felt daily coercion, control and fear. Child HN was already showing some behavioural issues including non-compliance with tasks and routines, and then required daily monitoring and injections for this chronic health condition. Whilst living in Worcestershire, two A&E admissions are seen due to Child HN being generally quite unwell and when the diabetes was then diagnosed.

Period under Review: The situation significantly changed in July 2022. Ms HN asked for support from WCF to move to a refuge due to the unbearable levels of coercion and control she was experiencing from Mr HN. Ms HN and the children then moved to a Refuge in Herefordshire.

The multiagency chronology summarises the key practice events during the period under review as:

- WCF did not notify Herefordshire CSC of a family moving to their area who was open to Child in Need of support plans. WCF continued to visit for two months, with Child HN on a Child in Need Plan, until plans were closed in September 2022.

[5] A Strategy Discussion is a multi-agency meeting that is convened whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. A strategy meeting/discussion is an opportunity to share as much of the available information as possible between agencies to inform the next steps.

[6] A Child in Need of support is defined under the Children Act 1989 (Section 17) as a child who needs additional support to meet their potential.

- From July 2022 – October 2022, Herefordshire Children Social Care (CSC) did not know that the family had moved to their area and therefore did not provide support.
- The Refuge did not initially notify Herefordshire CSC of the family moving into their provision in July 2022. It was standard practice to only notify the Police when families arrive in to their provision.
- When the family moved to Herefordshire, there was delay in Child HN receiving support and help from Herefordshire education services and health providers (GP / Diabetic Team / CAMHS).
- Ms HN reports she contacted Herefordshire CSC to ask for help with Child HN's behaviours/diabetes (with the Refuge's support) on numerous occasions from July 2022. Herefordshire CSC did not have a record of these contacts and there may have been some confusion regarding whether the contacts were made to Herefordshire or Worcestershire.
- Child HN was registered with a GP in Herefordshire from July 2022. Electronic records were transferred but Child HN was not seen by the surgery.
- Ms HN made a 999 call in September 2022 concerned about Child HN's diabetes management. An ambulance responded and no further treatment was deemed necessary in hospital.
- A MASH referral is made to Herefordshire CSC in October 2022 by the Refuge.
- Following CSC statutory assessment, which commenced in October 2022, Child HN became subject to child in need arrangements with Herefordshire CSC.
- Child HN was being educated through provision made available to him through section 19 of the Education Act when the family resided in Worcestershire, which allowed him to study at home. Herefordshire Education was notified by Ms HN of the intention for her son to be Elective Home Educated when he moved areas. Herefordshire Education professionals did not become involved until November 2022.
- A referral was made to CAMHS in November 2022 and Child HN was seen for assessment in December 2022 at home.
- Ms HN calls 999 again in January 2023 due to concerns about Child HN diabetes mismanagement and receives advice.
- Child HN is taken by ambulance to hospital in March 2023 having had a stomach bug and showing signs of suspected diabetes mismanagement. A diabetic ketoacidosis episode is confirmed once in hospital.

1.3 Methodology

The process for this review involved a review panel of representatives made up of senior managers with no direct operational responsibility from the organisations involved in providing services for Child HN and family, both in Herefordshire and Worcestershire. 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 multi-agency 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 multi-agency chronology of all agency interactions was completed, and this included contextual information supplied by Worcestershire agencies. This formed the basis of

reflective discussions at a Practitioner Learning Event. The Event was well attended by all agencies who knew Child HN, including Worcestershire Children First; Herefordshire Children's Social Care; Herefordshire & Worcestershire Health & Care NHS Trust; GP Services; Worcestershire Acute Hospitals NHS Trust; Wye Valley NHS Trust; Herefordshire and Worcestershire education provisions; West Mercia Women's Aid; and a housing provider. The Police played a very minimal role during the period under review and have provided proportionate input. Multi-agency professionals were able to identify the key themes of learning highlighted in this review.

The review has adopted a collaborative style with a range of multi-agency professionals and the family. Their voices and experiences lie at the heart of this report, with direct quotes used. A feedback learning event to discuss the report was held with all professionals involved with Family HN from Worcestershire and Herefordshire. The review process has aimed to identify what happened; to try to make sense of why it happened from a practice and systems perspective; to evaluate current systems and practice; and then to decide an action plan for change.

Ms HN met with the independent reviewer to share the family's reflections on the support and services offered to Child HN. This has proved invaluable to understanding the practice and system barriers, and forms the basis of the key learning. Child HN has been offered the opportunity to share his views and feelings, however unfortunately this did not take place despite attempts by the Independent Reviewer to make arrangements. Given the issues raised in this review concerning Child HN's father, a decision was made to inform Mr HN of the review and seek his views in writing.

The Review focuses upon how agencies understood the apparent barriers to effective diabetes control and how the partnership worked together and with Child HN and family to overcome these to ensure all the child's needs were persistently met. In order to maintain a level of protection and privacy, a limited story is provided. This report has been written with the intention that it will be published, and only contains the information about Child HN and his family that is required to identify the learning from the contextual history and period under review.

The learning from this review will be reflected throughout the report in a series of **"Practice Learning"** briefings, which are intended to reinforce and promote areas of safeguarding practice for frontline professionals. The LCSPR concludes with recommendations for systems change, which if embedded should also strengthen skills and confidence when in day-to-day practice.

This Review appreciates the considerable time and efforts by all agencies involved in preparing written evidence and chronologies and thanks all who contributed to this process.

1.4 Local & National Learning

The review has considered other local[7] and national[8] learning reviews that look at the management of chronic medical issues in children. This is further considered in Section 3.1.

Although Herefordshire CSC has made positive progress in supporting Child HN and his family, this review has considered the inadequate 2022 Ofsted rating[9] of Herefordshire CSC to help understand some of the practice and system issues identified in this LCSPR. The learning themes identified in this review period for Herefordshire Children's Social Care (CSC) and multi-agency partnerships are seen within a wider system context, which Ofsted highlighted as:

- sufficiency and stability of staff across CSC workforce
- CSC lack of effective management oversight and supervision
- insufficient quality assurance tracking and monitoring systems to prevent drift and delay
- poor quality of assessment, plans and lack of purpose to statutory visits which result in children's needs not being understood
- ineffective multi-agency arrangements for children at statutory levels of need and intervention

Although outside of the review timeframe, it is important to highlight whether further checking is required of Herefordshire CSC's correct use of section 20[10] of the Children Act 1989 to accommodate children who require local authority care. Paying attention to a 2018 High Court Judgement[11], the review has found discrepancies in the application of the legislation, which specifically requires a parent to understand and give written consent for this arrangement. This has been highlighted to Herefordshire CSC for further consideration and action as required.

1.5 What the Review Found

This Review found that Child HN experienced significant and serious harm through a mismanagement of his chronic health condition. This was avoidable. The family's contextual history in Worcestershire was significant and was not shared in a timely manner with Herefordshire agencies. The family moved to temporary refuge accommodation in Herefordshire in July 2022 due to concerns for their safety. The children remained the responsibility of WCF and continued to have a Worcestershire allocated social worker upon moving to the temporary refuge accommodation. The move did not trigger conversations between WCF and Herefordshire CSC and WCF closed their involvement under child in need arrangements in September 2022.

The failure of WCF or the Refuge informing Herefordshire CSC of the family's arrival in their area resulted in Herefordshire CSC not being aware of Child HN until October 2022. Once

[7] Pettitt, Nicki (2014) Subject of this serious case review: HH: overview report. Hereford: Herefordshire Safeguarding Children Board.

[8] See Birmingham SCR Hakeem (2022); Lancashire SCR Child LW (2020); East Sussex SCR Child T (2019).

[9] Ofsted (2022) *Inspection of Herefordshire local authority children's services*, Herefordshire, England. Available at: https://reports.ofsted.gov.uk/provider/44/884

[10] Section 20 of the Children Act is a voluntary arrangement with a parent where the local authority accommodates a child as a looked after child. The child may live with family or friends, in foster care or residential care homes. When a child is accommodated by the local authority under Section 20, any person with parental responsibility for the child may remove the child at any time from the accommodation provided.

[11] Herefordshire Council v AB [2018] EWFC 10 (1 February 2018). *Bailli.* Available at: http://www.bailii.org/ew/cases/EWFC/HCJ/2018/10.html

multi-agency work commenced with Child HN from November 2022 it was not provided in a co-ordinated multi-agency way that the family found helpful or ensured effective diabetes management for Child HN. The pace of interventions was too slow to ensure impact for Child HN and his range of needs.

As in line with procedural requirements, a health plan of diabetes monitoring was established (but not always recorded on systems). A professional narrative in some agencies was formed that does not appear to have been shared openly with the family regarding the possible parental barriers to working together. A hypothesis of medical neglect was not considered through any assessment of need undertaken. Although some work was seen, particularly by the Specialist Diabetic Nursing Team in Herefordshire, from November 2022, a fragmented approach persisted across the multi-agency partnership. The review found that information sharing and working together was not coordinated or communicated well, which likely contributed to the ineffective management of Child HN's diabetes and resultant hospital admission in March 2023.

The review highlights how the family's move to temporary accommodation, which was across local authority borders, complicated matters for agencies working together as professionals did not know where the family were moving to initially and for how long. This LCSPR process has identified a weakness in the cross-border transfer of this family by WCF, which has since been rectified with a transfer protocol being reviewed and strengthened.

Professionals have reflected together during this review process, and it is clear that no one agency or local authority set out to fail to work effectively with Child HN and his family. However, collectively and in both areas, Child HN's daily life was not fully seen, fully understood, or responded to effectively to ensure things improved for him. Indeed, Child HN himself told on many occasions that life was not good for him and how he struggled to manage his diabetes, saying "*he would rather be dead.*" Ms HN talks of "*never getting the right help and support when in Worcestershire or Herefordshire*" until after her son's hospital admission in March 2023 and shared how she felt she was "*constantly banging her head against brick walls*" when trying to get her son's needs understood.

Whilst this review covers specifically an adolescent with type 1 diabetes, 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.

The review identified **six findings** and **six key learning points**. These correlate to **nine recommendations** that, if adequately addressed through systems change, will impact and strengthen current professional practice. As agreed within the Terms of Reference, the recommendations apply to Herefordshire only. This Review recommends that Worcestershire consider the recommendations given Child HN's contextual history, as the professional reflections shared in the Learning Events, alongside the family's views, would suggest quality assurance is required. This might shine a light on what further improvements may be required in their own area from a practice and systems perspective.

Finding 1: The previous local learning from Herefordshire SCR HH[12] has had limited long-term impact on system and practice change. Wider learning[13] concerning diabetes management does not appear to be used effectively across the multi-agency network.

Finding 2: There was an inadequate handover of services and support from Worcestershire to Herefordshire partner agencies, which included Children's Social Care, Health Services (GP & Hospital) and Education. This resulted in a full picture not being understood by Herefordshire at the start of the period under review.

Finding 3: Child HN's world was not fully understood and his voice/lived experiences missing from most of the records seen. Child HN's culture and identity needs were not considered, and possibly due to his large stature and physical appearance he was seen as older than his chronological years and assigned more responsibility by his family and professionals. Despite some efforts seen from the Specialist Diabetic Nursing Team to build relationships, there was limited understanding heard at the Learning Event of the daily life of Child HN. The statutory child in need assessment undertaken by Herefordshire CSC was limited in understanding risk, and the actions arising from it were not sufficiently detailed to effect positive change for Child HN.

Finding 4: Ms HN felt she was not given the right support at the right time by some agencies when they moved to Herefordshire. The review finds evidence of attempts by Ms HN to get help and support by calling the GP and 111 for advice from July 2022 when the family moved into temporary housing in a Herefordshire refuge. It would have been stressful for the family moving to a new area and feeling that the help was not available to them. This may have resulted in a loss of trust in certain agencies with a resultant impact on professionals' ability to build relationships. Although no contact records are seen in Herefordshire, Ms HN reports she requested help from CSC from July 2022. She feels the requests were not acted upon quickly enough as the family did not receive any meaningful input until November 2022. This resulted in the family feeling "*let down*" by CSC until later in the period under review.

Finding 5: There was little consideration by professionals around understanding what constitutes significant harm thresholds for medical neglect where a child has a chronic medical condition and concerns about the management of this. There were different professional views regarding how Child HN's diabetes was being managed by Ms HN and regarding whether there was an unintentional neglect of his needs. There was a need for professionals to adopt a more enquiring stance when working with the family to understand the inconsistency seen regarding parental management of medication. Discussions did not consider the parental barriers to ensuring a persistent approach to managing Child HN's diabetes and nor did they raise the issues of medical neglect openly.

Finding 6: Multi-agency Interventions and services to Child HN were far too slow and fragmented. This lack of joined up communication and coordination resulted in delay where no holistic picture of N's range of needs were fully understood by any individual agencies and when working together. This impacted on his educational needs, physical / mental health

[12] Pettitt, Nicki (2014) Subject of this serious case review: HH: overview report. Hereford: Herefordshire Safeguarding Children Board.
[13] See Birmingham SCR Hakeem (2022); Lancashire SCR Child LW (2020); East Sussex Child T (2019).

needs and neurodiversity needs being understood through assessment to ensure he received the right help and support as an adolescent with a chronic medical condition.

1.6 Publication Note

Following an Independent Reviewer being commissioned, the review process started at the end of May 2023. The HSCP acknowledge that this LCSPR is being published just outside of the six-month timeframe set out in the Working Together 2018 Guidance[14]. The partnership considered that a sensitive and balanced approach was needed and wanted to ensure the participation of the family.

2. Child HN and his Family

This section includes Ms HN's perspective on the help and support she received when living in Worcestershire, during the period under review, and since her son's hospital admission in March 2023. It also includes a brief contextual history and story of what happened during the timeframe under review and multi-agency professionals' views on the practice and system barriers and enablers.

Child HN's family involvement in the reviewing process has been key to understanding the nature of support and services provided. Their input provides an understanding of how helpful or not practitioners and services were perceived by the family.

2.1 Family's views

Ms HN has provided a balanced view on the support and help offered by Herefordshire agencies. There are strengths seen from the Herefordshire Specialist Diabetic Nursing Team who provided training on injections and the corrections required when levels indicated this was needed. Ms HN has felt supported by staff in the Women's Refuge and has felt able to confide in them. Ms HN is extremely complimentary of the input from CSC professionals since March 2023 and describes the current team as "*a godsend.*" This is summarised in Practice Learning 3.

However, Ms HN has shared how she has mainly felt "*let down*" by a range of services. Ms HN strongly believes her son has additional learning needs and this has never been fully understood. Ms HN has shown an openness and honesty in the struggles she has faced as a parent in managing her eldest son's range of behaviours and then the diagnosis of type 1 diabetes, whilst also trying to shield her children from living in a controlling and coercive home. She is clear in her view that she wanted help and support, and this was not provided until now in a way that worked for her family.

Ms HN summarised her perspective and the main challenges as:

- Having 3 different social workers in Herefordshire from October 2022 to March 2023 was difficult as "*you just got to know one and then they left, and we had to explain all over again.*"

[14] DFE (2018) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children,* England. Ref: DFE-00195-2018.

- "*Weeks and months went by in Herefordshire, and we were left on our own despite asking for help from children's social care on many occasions.*"
- Feeling "*blamed*" by health and CSC professionals for either not being able to manage her child's behaviours or not being able to safely give him insulin injections.
- Receiving mixed messages from professionals when asking for support regarding how to give injections when Child HN was not able to do it himself or allowing his Mum to administer it, and the situation became very difficult to manage given his adult size.
- Describing how she often felt left *"to my own devices"* to manage her son; his non-compliance with having injections and understanding his range of neurodiversity and educational needs.
- *"I'm damned if I do and damned if I don't."* Ms HN was fearful of insisting on injecting her son without his consent as a CSC professional had told her this would be seen as a safeguarding issue and "*child abuse.*"
- Explaining how she received mixed messages from health professionals and things were not often explained well. Ms HN's says she asked for help from health professionals prior to the hospital admissions as she was worried and says she was given reassurance to monitor Child HN's condition.
- Feeling "*petrified*" her children would be removed from her care if she was seen to do anything "*wrong*" – she knew she was not in a psychologically safe space due to having lived in a world of being controlled and coerced and talked of feeling guilt that her children had always lived in this environment.
- Ms HN said the family have found the unsatisfactory temporary housing situation in Herefordshire, which has lasted over 15 months, to be extremely difficult. Ms HN thinks professionals have underestimated the impact this has had upon her family and her ability to cope as a parent away from her extended family.

3. Key Learning

The purpose of any Child Safeguarding Practice Review is to identify improvements that need to be made locally and nationally to safeguard and promote the welfare of children, and to seek to prevent or reduce the risk of recurrence of similar incidents[15].

This section considers system and practice areas when working with families and children with a complexity of issues and a chronic medical condition to manage. The details of the agency support are not provided at length, but the key learning points are highlighted. The detailed analysis and workings out are held by the Herefordshire Safeguarding Children Partnership. The focus being upon how agencies identify and respond to risks and how professionals work with families. It draws upon analytical, evidence-based work undertaken by the Review Panel, Multi-Agency Learning Events with a group of practitioners and managers, and highlights strengths in practice and systems where seen, alongside areas for further development and actions.

3.1. Embedding local and national learning to strengthen practice & systems

[15] DFE (2018) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, *Chapter 4.* England. Ref: DFE-00195-2018.

This review has analysed the practice and system parallels concerning the mismanagement of chronic conditions in children in previous learning reviews across the country[16]. The 2014 Herefordshire Serious Care Review examining the life and death of Child HH[17], a 17-year-old young person in the care of the local authority who had been diagnosed with type 1 diabetes, was considered to understand how the recommendations for practice and system learning had shown effect locally.

Child HH's review found the psychological impact of type 1 diabetes diagnosis during teenage years, together with the neglect HH had suffered at home, had not been adequately considered by agencies. Like Child HN, Child HH had showed a number of signs of not having fully accepted his diagnosis as he would miss injections and at times would rarely use his blood glucose meter. The Serious Case Review concluded that the seriousness of type 1 diabetes needed to be better understood by the agencies looking after Child HH. Several specific recommendations were aimed at improving the level of care offered to children and preventing similar tragic cases from occurring in the future.

The local and national themes for learning can be summarised as:

- the need to ensure that patterns of missed appointments and issues with medication management for a life-threatening condition receive a robust response
- there is more critical consideration of the risks associated with a sporadic engagement patterns
- the need to consider all domains of a child's daily life when managing a chronic illness
- improving consideration of mental capacity and knowledge of self-neglect in children with diabetes diagnoses
- the need for a written down and reviewed plan, involving the appropriate professionals and the family that identifies the support required.

It is evident from the Learning Event that despite professionals having an awareness of the previous local learning review in Herefordshire[18] regarding diabetes mismanagement, the recommendations and action plan have had limited long-term impact across the multi-agency workforce systems or practice. While recognising that SCR HH was published nine years ago, and that changes in staff have impacted on the continuty of learning, the HSCP acknowledges that partner agencies need to ensure learning and system changes are less vulnerable to changes that come with time. Following the publication of SCR HH, learning was cascaded at various events and through briefings across the partnership, and a SMART action plan was developed and completed. Since 2014, the HSCP has continually worked to improve how learning from case reviews impacts on practice, and has stronger systems now that focus on impact, although there is still work to be done.

[16] Pettitt, Nicki and East Sussex Local Safeguarding Children Board (2019) Serious case review: Child T [full overview report]. East Sussex: East Sussex Local Safeguarding Children Board.
[17] Pettitt, Nicki (2014) Subject of this serious case review: HH: overview report. Hereford: Herefordshire Safeguarding Children Board.
[18] Pettitt, Nicki (2014) Subject of this serious case review: HH: overview report. Hereford: Herefordshire Safeguarding Children Board.

Practice Learning 1: Embedding Learning from Reviews
Professionals need to have time in supervision to ensure transfer of knowledge from learning reviews is considered and then applied, so as to strengthen practice. Managers need to ensure practitioners can attend learning events or information is cascade into teams. It can be helpful to have practice champions with key responsibilities for linking research / learning reviews into day-to-day activities with families.

3.2 Understanding a child's lived experiences and world

It is generally well accepted that enabling children to meaningfully participate and be involved in making decisions that affect their day-to-day life is required to ensure the rights of the child are upheld, with wellbeing and individual safety supported in doing so[19]. However, how a child's views, wishes and feelings are heard and included in day-to-day assessment and planning by agencies remains patchy and tokenistic[20].

There was very little known about Child HN's daily life. It is evident that no one professional built a meaningful relationship with him and was able to understand his world and hear his views, wishes and feelings. There is limited documented evidence seen regarding Child HN's experiences of living within a home where there was regular coercion and control behaviours, and what impact this had upon him, in conjunction with a diagnosis of type 1 diabetes. Child HN's voice was typically not heard during conversations as Mum provided her thoughts on her son and his diabetic condition. Often the records document Child HN as being "*hard to engage*" or "*refused to engage*" by services as opposed to showing curiosity as to why he may find it more difficult to share his thoughts and feelings and what else might lie beneath this behaviour and silence.

There were three social workers allocated within a 6-month period (October 2022– March 2023) and this clearly impacted on relationship building and Child HN feeling comfortable with different people coming to his home. The reason for the changes were due to staff leaving Herefordshire CSC as they were on a temporary contract.

More professional curiosity to understand Child HN's world should have included Child HN being spoken to and seen with his family and on his own. Some expected examples of practice are evidenced, such as sessions undertaken by the Diabetic Nurse and School Nurse in Herefordshire. This should have been regular and routine and not one-off examples of relational practice, as the records illustrate how connection could be built with Child HN with a persistent or creative approach adopted.

There are examples seen where agencies did not ensure Child HN was seen. For example when the Police visited the Refuge following an anonymous welfare concern in August 2022, they received assurance the children were OK by speaking with Refuge staff. The review finds examples during social work visits that Child HN remained in his room with limited attempts or

[19] Holmes, Dez (ed.) (2022) *Safeguarding Young People: Risk, Rights, Resilience and Relationships,* England: Jessica Kingsley Publishers

[20] Warrington C (2017) *Young person-centred approaches in child sexual exploitation*, Research in Practice. Available at: https://www.researchinpractice.org.uk/children/publications/2017/february/young-person-centred-approaches-in-cse-promoting-participation-and-building-self-efficacy-frontline-tool-2017/#:~:text=In%20CSE%20work%20young%20people%27s,resourced%2C%20valued%20and%20has%20influence.

creativity seen to engage with him. During the period under review, it is known that Child HN spent large amounts of time on his own in his bedroom playing on his computer devices and "*gaming*" into the early hours. This would have impacted on Child HN's energy levels in the morning and school attendance or medical appointments. It may have been helpful to have understood this part of Child HN's life further by entering his world and suggesting activities such as joining in with his online activity and this may have ensured a way of making a connection from his world and not the professionals' world.

Research and guidelines[21] show how children and young people with type 1 diabetes have a greater risk of emotional and behavioural difficulties, and their self-esteem can be impacted. Children can experience psychological problems (such as anxiety, depression, behavioural and conduct disorders, and family conflict) or psychosocial difficulties that can impact on the management of diabetes and wellbeing. Child HN needed specific support after diagnosis as he clearly said how he was struggling to accept the diagnosis and would "*rather be dead.*" He regularly showed through his behaviours that he did not want to adhere to his medication regime, and he disliked the daily injections. His refusal to attend appointments and extreme views on not wanting to manage his condition needed unpicking with health professionals and his mum as the barriers to effective diabetes management remained a concern over a considerable amount of time. There are some examples seen towards the end of the review period where conversations were beginning to happen with Child HN and health colleagues, but this was late in the day following diagnosis almost three years prior.

Finding ways to build connection with young people during their teenage years requires a persistent, flexible, and creative approach. Adolescent behaviours can at times present in a way where professionals describe, as in this review, as "*they are often hard to engage,*" "*uncooperative*" and even appear ungrateful. Research shows how addressing adolescent needs is often "*a complex business*"[22]. Ms HN has shared how at times she found it very difficult to manage her son's range of behaviours, describing things at home as a "nightmare" when he refused to adhere to the need for an insulin injection. Health professionals at the Learning Event commented on how often they see adolescent children finding it difficult to accept diagnosis and/or showing a reluctance to comply with health care plans, but in Child HN's situation this was described as "*extreme.*" This needed to be unpicked as to why this was and considered through a lens of adolescent development, additional learning needs and/or neurodiversity.

The health professionals involved in the review shared how, typically, young people with type 1 diabetes can have difficulty with blood glucose management during adolescence, and this may in part be due to non-adherence to therapy. There is then a need to raise the issue of non-adherence to therapy with children and young people with type 1 diabetes and their families or carers in a sensitive manner to understand individual psychological barriers and worries. The NICE Guidelines[23] in fact highlight how professionals need to be aware of the possible negative psychological impact of setting targets that may be difficult for a child or young person with type 1 diabetes to achieve and maintain.

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[21] Duinkerken, E. van, F J Snoek, and M. de Wit (2020) *The cognitive and psychological effects of living with type 1 diabetes: a narrative review,* Diabet Med, 37 (4): 555-563.

[22] Rees, Gwyther and Mike Stein (1999) *The Abuse of Adolescents within the Family,* England: National Society for the Prevention of Cruelty to Children (NSPCC).

[23] National Institute for Health and Care Excellence (2015) Diabetes (type 1 and type 2) in children and young people: diagnosis and management, last updated 11 May 2023. Available at: https://www.nice.org.uk/guidance/ng18

Records show the child and family assessment completed in December 2022 by Herefordshire CSC is based on a single conversation with Child HN and his mum. It is unlikely that one conversation was sufficient to gain insight into Child HN's views, wishes and feelings, including any concerns he had. The assessment does not reflect Child HN's personality or the things he liked to do or was interested in.

The assessment does reference that Child HN's ethnicity is dual heritage and that he has been raised as a Muslim, however the assessment does not offer any support, signposting or actions due to this information. This means that Child HN's religious needs and cultural identity were likely not fully considered and supported following the family's move to Herefordshire. The cultural diversity and populations of Worcestershire to Herefordshire may have felt different to Child HN, having moved to a much smaller county with most residents describe themselves as being white[24] and where 1 in 8 children are living in income deprivation.[25] In line with Herefordshire Children's Services Practice Standards, an assessment should have noted any specific needs arising from a child's ethnicity, culture and faith and should consider what resources are available within the community to meet these needs. This was a practice oversight.

Practice Learning 2: Entering a Child's World

Hearing the voice of the child when there is so much activity going on around the child and family can be a challenge. However, building connection, listening to what they say and observing their world, alongside taking contemporaneous records, can help to drill down and better understand the needs of children. Having a separate space to record a child's lived experiences can ensure this area of practice is prioritised.

It is important that as practitioners we need to; actively hear what the child has to say or communicate; observe what they do in different contexts; hear what family members, significant adults/carers and professionals have said about the child; and consider their history. Ultimately, we need to put ourselves in that child's shoes and think "what is life like for this child right now."

Adolescent children need additional emotional support when faced with a long-term health diagnosis so as to face whatever difficulties they have and hopefully find ways to be helped to find ways through them.

Assessments need to ensure they are culturally sensitive and pay attention to a child's identity needs and how they see themselves in the world.

Assessments need to be based upon several interactions with a child, and ideally in different places and spaces they frequent

[24] Data from the 2021 Census states that 96.9% of Herefordshire residents identified their ethnic group as "White," compared with 90% of residents that identified their ethnic group as "White" in Worcester.
[25] Indices of Deprivation, 2019, Summary for Herefordshire. Available at: https://understanding.herefordshire.gov.uk/inequalities/index-of-multiple-deprivation-imd/income-deprivation-income-deprivation-affecting-children-sub-domain/

3.3 Working effectively with families

Records show that hospital and the diabetic specialist team worked hard at trying to build a connection with Child HN and his family. For example, data shared from the diabetes specialist team in Worcestershire shows how, with a team comprising of two nurses and a total of 150 patients, there were 208 contacts with Child HN and his family between June 2020 to November 2022. This is way above the recommended guidelines for monitoring type 1 diabetes. Ms HN has shared how some of these interactions were helpful in supporting her understanding of the chronic condition. The diabetic specialist team have shared their creativity in trying to ensure a relational approach and also highlighted the system pressures when trying to maintain a persistent approach with families when there are workforce capacity issues and time constraints.

There have been two different narratives seen in this LCSPR by different agencies. The 1st view seen from some agencies with some of the language heard at the practitioner event included "*the family were hard to engage*," "*there were frequent cancelled visits*" along with, "*offers of our support were not taken up.*" The 2nd agency view, also shared by Ms HN and the current social work team, evidence that Ms HN did ask for help and support persistently through the period under review. For example, Ms HN is seen seeking out medical help from the GP and calling 999 on two occasions, and records from Refuge staff consistently show Ms HN asking for help when trying to manage N's range of behaviours. In many records, the review found how "*Ms HN works well with professionals and seeks support*".

It is important to unpick such differences in opinion to inform thresholds of need and plans of work with families. By having open and honest conversations so as to unpick the potential barriers to working together with families, often understanding is strengthened and solutions can be found. Ms HN shared how she was often so stressed by her family situation, living in temporary accommodation with no childcare for her younger children, it made it very difficult to get Child HN to some appointments. She gave the example of the CAMHS assessment being undertaken at her home as being very helpful and this is an excellent example of a creative and family first approach by an agency that can flex its services when required. Practitioners have shared that in a busy, time-limited schedule of appointments, systems are often not designed to allow such responsive approaches.

Child HN received his diagnosis during COVID 19. Health professionals at the Learning Event held the view this was significant upon workers being able to build effective face-to-face relationships with the family at a time of social distancing restrictions.

Some of the early visits to the family from Herefordshire CSC were not effective or helpful to the family and Ms HN has shared these with the Independent Reviewer. Clearly some examples given fell short of what would be expected practice standards. The following are reminders outlined by Ms HN as being her current experience from Herefordshire CSC, and very helpful in making a difference.

Practice Learning 3: The skilled helper

- Practitioners show they care by using kind words and gestures to a family, for example making drinks and sitting to play games.
- Practitioners that listen without judgement.
- Practitioners are honest about what their concerns are, also reminding the family of what things they need to build upon and what the family strengths are, to ensure progress.
- Practitioners show a good knowledge of specialist conditions and if they don't know something are honest about this and "do their homework," involving the child and family so they learn together.
- Practitioners "pull it all together" by working closely with the family and a range of multi-agency professionals.
- Practitioners that advocate on a family's behalf, when the family feel unable to, highlighting gaps in provisions and weaknesses in systems.
- Practitioners do what they say they will, and if they can't they tell you why.

3.4 Assessing medical neglect to inform levels of need and intervention when working with adolescents with chronic conditions

There was poor diabetes management for Child HN. This can be evidenced in three hospital admissions prior to the critical incident in March 2023 and the two 999 calls by Ms HN asking for help. It is evident that Mum struggled, for various reasons, to ensure Child HN received necessary medication to ensure he remained well. One of the overriding questions within this review has centred upon how professionals understand apparent parental barriers and then work out where the line falls between unintentional errors in condition management and medical neglect.

Colleagues in Herefordshire shared how the answer to this practice question was not considered in the way it was needed as there were different professional views regarding how Child HN's diabetes was being managed by Ms HN. Some professionals saw how Ms HN sought support, either from their agency or other agencies, and the other narrative focused upon the missed appointments. This difference of professional opinion was hindered by a lack of historical information from Worcestershire which could have assisted in professional decision making. There was a need for professionals to adopt a more enquiring stance when working with the family to understand the inconsistency seen regarding parental management of medication and the reasons for this, which centred upon Ms HN's ability to manage Child HN's range of complex needs. Discussions did not consider the parental barriers to ensuring a persistent approach to managing Child HN's diabetes and nor did they raise the issues of medical neglect openly.

In trying to understand the reasons for the poor diabetes management, it is clear from discussions with Ms HN during the review that she has a very good understanding of diabetes management, and she can clearly articulate this. The view of CSC towards the conclusion of

this review is that Ms HN is in a better place emotionally, feels safe and professional relationships have been established, so she is more able to take on support and advice and ensure the diabetes is managed more effectively. It is probable that at the time of diagnosis and due to other complicating stress factors within the family that, at times earlier on in the timeline, Ms HN may not have always given the management of Child HN's diabetes the priority that it required. As aforementioned, it is clear that Child HN struggled significantly with his diagnosis.

Health professionals sought to support Child HN and Ms HN with the diabetes, and this is seen in the health records and has also been explained in detail by the specialist diabetic nurse teams both in Worcestershire and Herefordshire. It is evident that a range of verbal and written advice was given, dependent upon Child HN's circumstances and what intervention or treatment was required at the time, ranging from needing to eat a meal and requiring a dose of insulin, to receiving hospital treatment. Questions remain as to whether the type of support offered was communicated in a way that a) was understood by Child HN and his parents and b) ensured Ms HN fully understood the severity of risk, including death if not managed properly. Professionals reported it was, however, Ms HN's feeling that she was not offered the right type of support to ensure medication was taken each day. This nuanced position and difference of family and professional opinion was not unpicked to determine levels of risk and to adjust interventions.

Ms HN has shared in hindsight whether she allowed Child HN to take on too much responsibility for administering his own medication and she has questioned herself whether there should have been a higher level of adult supervision around Child HN's injections, both by herself and the professional network. Given Child HN's large stature for his age, it is possible an unconscious bias also crept into thinking in which it was assumed he could take more responsibility and control of his diabetes care than he should have been allowed. He was still a child, although entering in his adolescent years, and it was known he had levels of self-neglect due to the psychological impact of the diagnosis. Ms HN has shared how the situation today is very different and she undertakes all injections.

Ms HN acted consistently in protecting her children from domestic abuse and maintained their safety by staying in the refuge for over one year. Professionals are generally positive about the relationship between the children and their mother, reporting a close and loving relationship with each other. There were some known tensions between Ms HN and Child HN – these are seen around behavioural support and management. The quality of care of the children is generally described as appropriate: the children being well nourished and well presented. Ms HN made efforts to maintain the education of her younger children and ensured they were enrolled and attended a local school once living in Herefordshire, after the school holidays had concluded.

Any form of parental or self-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. Practitioners from across agencies shared how at times they struggled to understand what neglect might look like when considering a chronic health condition and highlight how more learning is needed in this area to increase confidence.

Practitioners at the Learning Event had varied views regarding whether Child HN 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. "*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.

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 children with chronic illnesses such as type 1 diabetes. A formally recognised category of medical neglect may improve the way that healthcare staff currently articulate safeguarding concerns to CSC. Adolescents with life threatening conditions require their parents 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 and determine via assessment whether it has reached a threshold in terms of medical neglect via the local safeguarding children's arrangements in place.

Herefordshire is currently in the process of launching multi-agency Child Neglect tools to assist professionals in understanding how children's day-to-day care needs are being persistently met by their parent. No specific assessment work was considered or used by any professionals working with the family to determine whether there was some form of parental neglect. In understanding why this might not have been thought about, it is evident that embedding the use of any such assessment tools requires further work in both areas. For example, the Herefordshire & Worcestershire Health and Care NHS Trust undertook a survey in July 2023 to understand workforce use of multiagency neglect guidance in Worcestershire. Out of 57 responses less than a 25% were aware of the local guidance and less than 10% had used it or attended training on it. The common reasons for not using it were not being aware it existed, not having had training, or it was not needed. Actions are needed to improve the use and increase the workforce knowledge of this resource and the benefits of utilising it.

Practice Learning 4: Professional curiosity to consider medical neglect

Children with a life-threatening condition require a robust health and children's social care response to understand the complex area of unintentional errors with condition management versus medical neglect. Any missed appointments with concerns regarding "poor compliance" with medication must be taken seriously and chronologies used to see patterns. Assessments should consider the risks associated with the lack of engagement, and whether this is a safeguarding issue by involving children's social care services. In understanding "poor compliance" an assessment of parental factors, including historical factors, is needed to determine what barriers might be in place and a plan devised with parents to work together and overcome these.

It is vital to assessing risk and providing support to families to unpick when they hypothesis there are parental barriers to working effectively together. This requires an empathetic and authoritative approach where probing questions are used to sit alongside a parent to understand why there may be issues in taking children to appointments or offers of help.

A neglect tool should be used when safeguarding concerns are raised regarding the parenting of children with chronic health conditions, as this will provide a consistent approach to help determine the children's needs, risks and circumstances and the parenting they are receiving within the family and environmental context.

3.5 Multi-agency cross- border information sharing

As aforementioned WCF did not notify Herefordshire CSC of Family HN's move. The rationale for not doing this remains unexplained as there are no records that refer to the transfer. Given the history of domestic abuse, Child HN's long-standing absence from formal education and his diabetes diagnosis, the West Midlands Regional Safeguarding Procedures stipulate that families on a Child in Need Plan should be referred to the receiving authority as part of expected practice. The family continued to receive support from WCF for two months following their move to the Refuge before their involvement ended, with the Child in Need Plan with WCF being closed. The Refuge staff are recorded as asking for support to continue this statutory support, but this was not pursued.

The Refuge staff clearly recognise the need for additional support for Child HN and the family and requested ongoing support from WCF and a higher level of support from Herefordshire (via a statutory plan rather than Early Help) when they became involved. It is possible that the Refuge staff may have been confused about which local authority was responsible for the children, particularly as WCF continued to provide social work support when the family initially moved to Herefordshire.

There was a system-wide ineffective transfer of information from across all agencies who worked with Child HN in Worcestershire. The lack of multi-agency coordination of information being shared shows examples such as the Paediatric Hospital Team sending a transfer letter

to the Paediatric Team in Herefordshire. This was not typical of practice via the diabetic nurse specialists and paediatrician, and the rationale provided related to capacity and workload pressures.

A further example can be seen in the MARAC[26] process. The family were not heard at MARAC in Worcestershire before they moved. Worcestershire MARAC therefore submitted a transfer referral to MARAC in Herefordshire and the family were heard at this MARAC at the end of August 2022. The review has identified system learning regarding ensuring the MARAC processes are strengthened in Herefordshire to ensure timely and effective sharing of information with other agencies when a family moves into their area, and especially if residing in the refuge, and ensuring MARAC records are accurately recorded on all agency systems. At the completion of this LCSPR, additional resource had been sourced by West Mercia Police to ensure that there is a minute-taker for MARAC meetings, which addresses these concerns.

The impact of this lack of multi-agency coordination and information sharing between local areas regarding Child HN resulted in key information either simply not being transferred or being shared single agency to single agency, which then resulted in the family history and its significant being lost. This clearly impacted on understanding levels of need and any possible risks being understood early on by Herefordshire services and in a multi-agency way so that a full picture was known.

This has been acknowledged by WCF about the practice and errors evidenced, and steps have been taken to remedy this with a revised protocol now in place for children subject to child in need plans who move areas.

Practice Learning 5: Effective transfer arrangements between neighbouring authorities

Ensure protocols are in place and used to support practice and ensure information is transferred in a co-ordinated way between areas. In may be helpful to consider the benefits of a multi-agency transfer protocol rather than single agency transfers when children are subject to statutory plans. Children's Social Services should be responsible for managing this and would mitigate against some agencies knowing that a family is living in an area, and others not.

3.6 Ensuring timely intervention and partnership working to effect change for children

A view heard by some at the Practitioner Learning Event described the situation where information became known after a delay following the family's move to Herefordshire, and this feeling like "*an avalanche,*" and clearly showed how they, as a multi-agency partnership, had "*fell down*" when working with Child HN. Health professionals described how it felt overwhelming, as there was a combination of physical health issues, psychosocial issues and possible neurodiversity needs.

Ensuring a persistence and pace to interventions, support, and services so as to have impact upon children's lives, is considered under each agency area. The review finds a dis-jointed

[26] MARAC is a multi-agency meeting that is held to discuss the most high risk cases of domestic abuse and sexual violence, to share information and to safety plan to safeguard a victim.

approach to working together in Herefordshire, despite a Child in Need plan being in place. The need to escalate effectively, either informally or via formal processes, when there are professional concerns about drift and delay are required and were not seen robustly by any agency during the period under review.

This sub-section considers individual service responses and what was provided to Child HN and his family to understand what difference it made to his lived experiences.

3.6.1 CSC Assessment & Planning with adolescents with chronic conditions

The Child & Family Assessment completed in December 2022 shows some reference made to the history of domestic abuse and to Child HN's absence from school over a 4-year period as well as his previous health issues in relation to his diabetes and emotional difficulties. The lack of information being transferred impacted upon understanding the family's life in Worcestershire, the severity of the domestic abuse, and a history of Child HN's previous difficulties, and were therefore insufficiently addressed in the assessment. These gaps are likely to have influenced understanding and appreciation about Child HN's complexity of needs, family vulnerabilities and decision making at this time.

At the referral stage, the MASH Manager recognised that information about Child HN and his family from Worcestershire would be relevant to inform the risk assessment, however there was delay seen, as only when the Child and Family Assessment was nearing completion was telephone contact made with the previous Worcestershire social worker, when a brief conversation took place.

The assessment referred to Child HN being "controlling" but this issue was not explored, or any evidence provided about what this meant. The assessment identified Child HN's behaviours as the issue, principally as he was not attending school and causal factors for these behavioural concerns were not considered in terms of what Child HN might have been trying to communicate about his daily life. The management of his diabetes was also highlighted as a concern. Responsibility for Child HN's circumstances was attributed to him and to his mother's parenting, despite Ms HN repeatedly stating that she needed support. The impact and trauma of the previous domestic abuse were not fully explored, although of course this may have been due in part to the absence of the history of the family in Worcestershire.

The assessment and resulting Child in Need Plan appear to have been completed after a single visit which focused in the main on mother's self-reporting and own judgement of her capability to manage the children's needs. The assessment was not framed in a strengths-based way. It is recognised that Ms HN sought to protect her children by removing them from a domestically abusive situation, but other strengths that may have been present in her parenting are not considered. The relationships between the siblings and any wider family supports are not explored.

The Plan outlined following the assessment lacks the specificity and level of intervention required to effect change for Child HN and improve his day-to-day life. Beyond identifying the risks, the Child in Need Plan is unclear and fails to detail exactly how Child HN and his mum will be supported to improve Child HN's health and education alongside the additional pressures facing Ms HN in relation to her general parenting of him and his siblings. The Plan

does not set any targets nor does it outline any milestones for securing education for Child HN or obtaining suitable housing for the family, which are significant gaps given that the family had been living in overcrowded refuge accommodation for almost five months at the point the plan was produced.

There is limited CSC oversight and direction seen. The first supervision is dated January 2023. The case summary noted that Child HN was not receiving education and was not in contact with the Diabetic Nurses, although the management directive was to step-down to Early Help and sets an action for the next CIN meeting for the Early Help service to be invited. While the step-down to Early Help did not happen prior to the critical health incident, the record that this was the proposal of the social work team following the Child and Family Assessment indicates that Child HN's vulnerabilities were not fully understood. With hindsight, the suggestion to step down to Early Help services at such an early stage seems premature and underplays the risks.

3.6.2 The Specialist Diabetes Paediatric Team

As outlined in the NICE Guidelines[27], children and young people with type 1 diabetes and their families or carers should be offered a continuing programme of education from diagnosis, and this is delivered via the Specialist Diabetic Team. It should include the following core topics:

- insulin therapy (including its aims and how it works), insulin delivery (including rotating injection sites within the same body region), and dosage adjustment
- blood glucose monitoring, including blood glucose and HbA1c targets
- how diet, physical activity and intercurrent illness affect blood glucose levels
- managing intercurrent illness ('sick-day rules', including monitoring of blood ketones [beta-hydroxybutyrate])
- detecting and managing hypoglycaemia, hyperglycaemia and ketosis
- the importance of good oral hygiene and regular oral health reviews for preventing periodontitis.

The guidelines also recommend tailored education programmes to each child or young person with type 1 diabetes and their families or carers, taking account of issues such as:

- personal preferences
- emotional wellbeing
- age and maturity
- cultural considerations
- existing knowledge
- current and future social circumstances
- life goals

Child HN was encouraged to attend clinic four times per year and attempts are seen to have regular contact with the diabetes team with the aim of helping Child HN and his mum maintain optimal blood glucose levels. The specialist team talked of having a number of challenges in

[27] National Institute for Health and Care Excellence (2015) Diabetes (type 1 and type 2) in children and young people: diagnosis and management, last updated 11 May 2023. Available at: https://www.nice.org.uk/guidance/ng18

trying to engage the child and family and to improve compliance with the treatment plan that was in place to keep Child HN well.

Health professionals think the uncertainty and timeliness of the potential move either back to Worcestershire or to Dudley (where N's maternal aunt lived), delayed the transfer of care between diabetic teams to take place in a timelier manner. The transfer of information between the diabetic teams was not managed effectively, with the Herefordshire Diabetic Team only being aware of Child HN living in Hereford in November, four months after the family moved. This meant Child HN had limited health input for his diabetes for several months, which mainly consisted of ensuring Child HN had his medication. Once the Herefordshire Diabetic Specialist Team were aware that Child HN was in their area, they called two multi-agency meetings to discuss his health plan.

There is some confusion in the various recordings seen about who is responsible for Child HN's diabetes management. The Herefordshire CIN Plan suggests that this is Child HN himself, alongside his mother and other professionals. Ms HN reports having had conflicting advice about how to manage Child HN's medication compliance. This may be due to Child HN's age and his assumed competence by professionals. This Plan or Child in Need minutes were not shared with Health Services as they should have been and so the GP and specialist diabetic paedatric team were unable to clarify the health expectations in a multi-agency context.

Ms HN stated she has previously been advised not to force her son to take his insulin. In a case note seen, Child HN is reported as saying that he knows what to do but sometimes finds this overwhelming and this prevents him from acting. The full implication of this may not have been fully understood or appreciated by the professionals working with the family. It is evident that between Child HN, his mum, health professionals (from Worcestershire and Herefordshire) and other professionals, there was a lack of clarity about arrangements to manage Child HN's diabetes. There may also have been an assumption of competence in relation to Child HN and Ms HN's understanding of how to manage the diabetes. This was a clear risk.

Child HN required a coordinated, tailored package of intervention to consider his emotional, social, cultural, and age-dependent needs. There is no evidence from initial health assessments or health care plans in Worcestershire that there was a clear understanding of the emotional and psychological wellbeing of Child HN in the context of his day-to-day home life. Child HN would have benefited from a more detailed psychosocial support plan, which could have included a programme of behavioural interventions and linked with his Child in Need Plan in Herefordshire; with ongoing access to mental health support; and opportunities for mentoring to enjoy social and physical activities.

The Herefordshire School Nurse offered one intervention with Child HN with evidence seen of a good relational connection being made and discussions around Child HN's worries and fears. Child HN started to open up about his chronic health condition and his hopes for education. Unfortunately, the School Nurse was not able to continue the intervention due to resource pressures and, as other health professionals were involved, it was deemed a duplication of services.

3.6.3 Education

Child HN was not regularly attending any formal education setting for five years, despite efforts seen from education provisions when he lived in Worcestershire. The limited written evidence seen from Herefordshire shows how he received Elective Home Education, but no learning is seen to be achieved in any meaningful way as Child HN tended to spend most of the time in his room on his own and gaming. Child HN states that he had a laptop and used to attend on-line classes in Worcestershire, but then had limited opportunities for online learning since moving to Herefordshire.

As Child HN was not attending school there was a huge gap in relation to addressing all of his needs. It was not known what Child HN 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. As heard from Worcestershire education representatives who attended the Learning Event, the schools were already concerned about Child HN in terms of not meeting his educational needs due to the lack of school attendance, and had previously made two referrals to WCF with no further action.

Ms HN described feeling generally '*let down'* by the education system, constantly struggling to get her son to mainstream school and, when there, Child HN struggling to manage being in a classroom situation. Child HN was not subject to any formal assessment of his educational needs. An Education, Health, and Care Plan (EHCP) for Child HN, may have indicated that his special educational needs required more specialist education provision. Legally, if parents think their child needs more help than the school can provide, they can ask for an assessment. In Child HN's circumstances, Ms HN said at the time she did not have the knowledge or experience to push for this.

From the records seen it is difficult to see that an effective handover took place between Worcestershire and Herefordshire education authorities for Child HN. Conversely, Child HN's siblings were quickly transferred into new provisions. The reasons for the gaps seen are explained in terms of it being the summer holidays when the family moved local areas; that authorities were not sure that the family were remaining in Herefordshire and reported issues in terms of professionals being able to get in touch with Ms HN. The Herefordshire Home Education Team were alerted of Child HN's situation, and some limited contact seen, but with little effect.

The impact of non-school attendance in relation to type 1 diabetes was significant. The relevance of not attending school in relation to the diabetes management was that Child HN was not able to receive the full benefit of the agreed health care plan to support him and maintain the management of his health care plan, as would have been expected by any other child with type 1 diabetes who was attending school. A school would have provided a safe environment, social interaction with teachers and peers and health support with type 1 diabetes management. Child HN was only 11 years old at the beginning of his diabetes journey and should have been in compulsory full-time education. Despite schools trying various ways to address non-attendance whilst in Worcestershire, when in Herefordshire Child HN had a disjointed educational experience, which included a period of elected home education and a short period out of county, before being enrolled in the Hospital School (H3).

The lack of school attendance was a huge gap in Child HN's life. The review is reminded of the benefits for children with chronic health conditions who regularly are in school:

- 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 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
- Providing daily activities and exercise
- Encourages engagement with hospital services

3.6.4 Housing

The emergency refuge housing situation in Herefordshire was only ever intended to be a temporary measure to ensure physical and emotional safety of the family. This was always a short-term situation due to the nature of refuge provisions for women and their children. It lasted for 15 months and was far too long to live in over-crowded conditions.

There has been an ongoing issue seen during this review process for the family in securing suitable housing, with challenges identified in bidding for homes due to availability of housing stock and the housing provider only providing "like for like" offers in emergency situations, where the family needed a larger home compared to their previous home in Worcestershire. This was due to the family's size and Child HN's health needs. A satisfactory housing move has only recently been secured, around the time of the conclusion of this review, after considerable time and effort by Ms HN working closely with the social work team and refuge. The family have remained in a refuge with clear impact seen on psychological well-being of each family member.

Ensuring the involvement of housing providers in various meetings and forward planning is highlighted in this LCSPR as they were a key partner agency missing from the table of discussions, including child in need of support meetings when the family were residing in Herefordshire. The lack of availability of housing stock for families is also recognised.

3.6.5 GP Services

Child HN was registered at the GP Practice in Herefordshire in July 2022, via an electronic new patient registration form completed by Ms HN. There was a slow transfer of information from the previous GP surgery in Worcestershire and flags not raised regarding his diabetes diagnosis or concerns regarding management of it. At this time, new patients were not invited for a 'new patient review' and unless a parent contacted the practice to request a GP review, any child, including those with a long-term health condition were not automatically called in for review.

The practice received several notifications from the Worcestershire Specialist Paediatric Diabetic Team to inform them that Child HN '*had not been brought'* to appointments. The Practice Nurse made attempts to contact mother on three occasions as she wanted to ensure

that Child HN was having some contact with either Paediatrics or the Diabetic Specialist Nurses locally. The GP also wrote to the family, reminding them of the importance of Child HN attending hospital appointments and compliance of his diabetic treatment.

There is no evidence in the records to indicate that there were any other concerns regarding Child HN's lived experience and no face-to-face consultations. The practice did not receive any communication regarding Child in Need plans, non-attendance at school, or domestic abuse.

The changes in practice as a result of learning from this serious incident for the registered GP Surgeries in both Herefordshire and Worcestershire are:

- All children that are transferred between surgeries with type 1 diabetes are referred to the local hospital team
- GPs should consider a phone conversation takes place between previous GP and new GP, along with transfer of electronic records
- GP or relevant practice member (e.g. Practice Manager) will ensure the issues relating to parental management (including children who are not brought) of a child with a long-term health condition, where it could be construed as child protection issues, are discussed with the GP safeguarding lead and/or safeguarding care co-ordinator and a plan of action formulated.

3.6.6 Child Mental Health & Psychological Health Services

It is very likely that the previous history of domestic abuse in the relationship had a negative effect on Child HN's emotional health and wellbeing. This is well evidenced in research[28] and is likely to have impacted on the development of all the children in the family. Child HN was a teenager when his family moved into the refuge, and it is thought the experience of emotional abuse was endured for most of his childhood. The duration of the domestic abuse indicates that Child HN has likely therefore known only this level of coercion and control for all of his life.

There is recognition from various professionals and Ms HN that Child HN needed some form of specialist input from CAMHS to understand the trauma he had experienced, alongside any additional learning needs. As part of the Herefordshire Child in Need Plan, CAMHS involvement is recommended although the therapeutic support identified for Child HN was only just commencing ahead of the critical incident in March 2023. It is recorded that he would not be assessed for autism or via a neurodevelopmental pathway as he was only living in Hereford in temporary accommodation.

Records seen from CAMHS show their intervention starts towards the end of the review period. Various creative efforts were undertaken, such as undertaking assessments in the home environment, but this was considered at the learning event by professionals as being "*late in the day.*" The interventions were looking to offer specific family-based behavioural interventions, such as behavioural family systems therapy, which may have addressed difficulties with diabetes-related family conflict.

[28] The Child Safeguarding Practice Review Panel (2022) *Multi-agency safeguarding and domestic abuse*, Available at: https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

Practice Learning 6: Coordinated & timely work

Children's' Social Care: Treatment Plans should be incorporated into Child in Need Plans for children with serious health issues so young people, their parents and other professionals receive clear messages and strategies about where responsibility sits for managing treatment and what responses are required if any risks or concerns are identified, including any non-compliance and plans to address non-compliance.

Child in Need Plans need to ensure SMART actions that are reviewed to evidence positive outcomes for children. If progress is not seen, plans should be adjusted to try something different to ensure children's needs are met.

Child in Need meeting minutes need to be circulated in a timely manner to all professionals working with the child.

Medical teams (Specialist Diabetic Team and GP Surgery) working with children and adolescents with life threatening conditions should consider the usefulness of including other agencies, such as youth workers, to build connection and help to understand and work through the barriers when young people struggle with a diagnosis.

Education: It is important to understand the nature of a child's poor school attendance and reluctance 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 multi-agency approach to working with the child and family helps professionals to better understand the child and family situation and can ensure children are kept safe by being in an education provision where their health, social, and emotional needs can be addressed.

Housing: When families have been living in temporary accomdation, such as refuges, for longer than 6 months, multi-agency discussions should take place, to include housing as the lead agency, to expediate the search for a suitable housing solution to be found. This review reminds all agencies of the importance of escalation procedures to raise matters where there is delay in progressing a solution for families.

Child & Adolescent Mental Health Services should be designed to continue to offer bespoke interventions based upon meeting the child in their own spaces and places if this will assist in building effective connections.

4. Conclusion & Recommendations

This Review concludes with seeing a different practice and system picture of support and help for Child HN and his family. This is largely credited to the tenacity and drive of Herefordshire CSC team who have ensured relationship-based and trauma-informed approaches to their range of interventions. The Review is assured that when Child HN moves back to his original area, there is a planned and coordinated transfer of information and good communication between all agencies involved in his day-to-day care. This is to be commended. It

demonstrates that the learning identified from the Rapid Review onwards has been taken on board by all those involved in this process and is having positive impact on Child HN and his family.

This section provides recommendations to improve safeguarding responses for adolescent children who have chronic illnesses and who may move between areas due to external factors. We can always identify things that could have been done better and in looking at individual situations we can, with the benefit of hindsight, see what else might have been considered, tried, or done differently to protect the child. The HSCP has given a commitment during this process to ensure systems are strengthened where required, to support multi-agency professionals with the knowledge and skills to make a difference to children and families in their local area.

Where practice and system change are needed, the following recommendations are set out under the key learning areas:

Embedding Learning into Practice:

1. The HSCP Independent Scrutineer to write to the National Panel within 1 month of publication to ask them to consider the benefits of producing a national multi-agency guidance on the management of chronic health conditions in children, given the number of national reviews concerning this issue and the serious impact on children. This review recommends paying particular attention to adolescent young people.

2. The HSCP to ensure, within 3 months of publication, that multi-agency key learning regarding diabetes management in children, cross-border issues, and engaging with adolescents, from this LCSPR and other reviews, is cascaded through the partnership via practice briefings and training opportunities.

Working with adolescents with chronic conditions

3. The HSCP to ensure, within 3 months of publication, that the roll-out of recently launched child neglect tools and training is updated and includes guidance on understanding and identifying what constitutes medical neglect.

4. The HSCP to run a series of multi-agency practice learning briefings on direct work and voice of the child, building on the HSCP Voice of the Child Toolkit, to promote a range of ways of listening and building connection with children, and engaging with them, particularly when working with adolescents.

5. Herefordshire Children Social Care to disseminate learning to practitioners, through a variety of means, to strengthen practice when engaging with adolescents with chronic illnesses to understand their needs, particularly when completing assessments. Tools like “pen picture” for a child will be promoted to capture the child’s lived experience and consideration given to understanding children’s online worlds. This should be reinforced through reflective supervision.

6. Herefordshire Children Social Care to address the quality of CIN Plans and communication with partner agencies, including ensuring minutes are circulated to all partner agencies and the family in a timely manner. An action plan to address this issue, including how Herefordshire CSC will be assured of compliance with standards, should be received by the HSCP from Herefordshire Children Social Care within 3 months.

7. In line with NICE Guidelines (Section 1.5 Service Provision), a task and finish group to be formed by Wye Valley NHS Trust (to include WVT, ICB Mental Health Commissioning Team, and H&W Health and Care NHS Trust), within 1 month of publication, to find a solution to ensuring that children and young people with type 1 or type 2 diabetes are able to see a mental health professional who is skilled to understand their issues, including psychological barriers that children with diabetes can have. The mental health professional should be one of the main members of the diabetes team[29]. Consideration to be given by the task and finish group to hearing from other local areas to understand how they adhere with the NICE Guidelines.

Cross Border Protocols

8. The HSCP Business Manager, within 1 month of publication, to request that the West Midlands Regional Safeguarding Procedures Group reviews the Children and Families who Move Across Local Authority Boundaries guidance[30] to ensure that it aligns with the "Protecting children who move across local authority borders" West Midlands Safeguarding Network guidance. In addition, the guidance should include which agency shares what information with CSC when a family move into a refuge and are subject to a statutory plan. The guidance should also strengthen information about cross-border transfer of children with chronic health conditions.

MARAC

9. Records of MARAC meetings – Whilst the absence of minute-taking at MARAC meetings was identified as an issue in this review and was originally identified as a recommendation, at the time of completing this LCSPR, West Mercia Police have confirmed that a minute-taker has now been sourced for MARAC meetings. This is a positive development and addresses the concerns identified in this LCSPR.

[29] National Institute for Health and Care Excellence (2016) *Diabetes in children and young people Quality Standard [QS125], Quality Statement 6*, last updated 31 March 2022. Available at: https://www.nice.org.uk/guidance/qs125

[30] See West Midlands Regional Child Protection Procedures, *Children and families moving across local authority boundaries (1.16)*. Available at: https://westmidlands.procedures.org.uk/ykpzq/statutory-child-protection-procedures/children-and-families-moving-across-local-authority-boundaries