Child S

01 Background

Child S was a 16 year old girl described as bubbly and outgoing. She lived with her parents and siblings. As a young child, Child S experienced a seizure, which appeared to be a one off event. Five years later, Child S presented to the GP with her parents who reported that a number of seizures had taken place over a period of months. Child S was referred for a electroencephalogram (EEG) which showed no definite epileptiform activity but she was diagnosed with epilepsy and prescribed anti-epilepsy medication. As the frequency of reported seizures increased, Child S became withdrawn, and would not engage with services and her father advocated on her behalf. Her attendance at school deteriorated and following a transfer to another school she rarely attended at all. None of the professionals involved had witnessed Child S having a seizure, despite her parents reporting that she had frequent seizures throughout the day. Child S was reported to be self-harming

02 The Incident

On the morning of the incident, Child S was found by her mother to be unresponsive in bed. An ambulance was called; father was attempting to resuscitate, which was taken over by the paramedics. It was noted that Child S had scratch marks on her arms, which her parents attributed to 'stress seizures'. Child S was found with empty packets of medication in the room; she was declared deceased at the home address. A post-mortem found large amounts of morphine in her blood.

03 Safeguarding Issues

- Child S's family reported that epileptic seizures occurred daily but professionals had concerns that the seizure activity was exaggerated.
- Scratches on Child S's arms, which indicated self-harm, were reported by family as happening during seizures but professionals discussed with the family that these would not happen during epileptic seizures.
- After the diagnosis of epilepsy, Child S became increasingly withdrawn and would not engage with services or attend school.
- Parents reported that Child S made statements such as 'you'd be better off without me' and 'I don't want be here anymore'. This led to a referral to CAMHS but was not deemed to meet threshold and did not lead to the provision of any services to address her emotional needs
- The father disclosed that he had given Child S his medication but this information was not acted on or shared. Child S was not referred to Children's Social Care.
- After Child S's death a police investigation led to the prosecution of father for supply of Class A drugs.

04 The Review

The Review looked at:

- Safeguarding policy and practice in relation to assessment and referral.
- How Child S's emotional needs were identified and responded to.
- Management and safety of parent's medication and how this information was shared between professionals.
- Non-engagement and non-compliance.
- The Voice of the Child.
- Professionals understanding of information related to medical conditions.

05 The Findings

- Safeguarding policies and procedures were not used to best effect.
- Child S's emotional needs were not fully considered or assessed. The voice and daily lived experience of Child S was not sought or understood.
- The dynamic within the family, including parental illness and illness behaviour were not fully understood or explored by professionals.
- A CAF completed at Child S's first secondary school was not passed to, or requested by, the new school and a new CAF was started but did not capture historical information.
- Agency responses to non-engagement were variable and did not lead to respectful challenge of parents.
- Professionals found the family had complex needs and were difficult to engage with. Child S was rarely spoken to directly by professionals.

06 Recommendations

The voice of the child and an understanding of their lived experience should be central to safeguarding practice.

Specific responses should be developed for working with young people experiencing chronic medical conditions who are reluctant to engage with professionals. The emotional wellbeing and mental health needs of these children should be addressed.

The CAF process should be robust in relation to engagement of professionals, frequency of meetings and respectful challenge.

All agencies should have a clear understanding of pathways into Early Help Services. Referrals should be completed within agreed timescales.

The impact of chronic medical conditions on family functioning and safeguarding and an understanding of Fabricated and Induced Illness needs to be better understood.

All agencies should understand the response to non-school attendance based on medical grounds.

07 Implementing Change

1. Reflect on the findings and discuss the implications for your service/practice.

2. Outline the steps you and your team will take to improve practice in line with the recommendations.

Tameside Safeguarding Children Board

7 Minute Briefing

Child S - Action Plan

Name of Organisation .....

Team Manager .....

Name of Section & Team .....

Contact Details .....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

Tameside Safeguarding Children Board

Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Board will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

Child S - Action Plan

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

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