



**East Lothian and Midlothian Public
Protection Committee**

**Significant Case Review Child R
Executive Summary**

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1) Introduction

East Lothian and Midlothian Public Protection Committee (EMPPC) made the decision to conduct a Significant Case Review (SCR) following the emergency admission of a male under 18 years (R) to hospital in 2016 with acute severe nutritional failure which almost resulted in his death. R was diagnosed with a blood disorder due to dietary deficiency.

For the purposes of SCR's, the Scottish Government identifies a child as *"a person under the age of 18"*.

The Initial Case Review (ICR) identified that the main areas of concerns recorded were in regard to R's physical health and the impact this had on his attendance at school. There was concern that these may have been managed in isolation with no holistic assessment of the family and their functioning and their ability to effect change. The ICR meeting on 16th June 2016 concluded that the case met the criteria for a SCR in that R suffered significant harm *"and, in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and / or service involvement or lack of involvement"*.

At the time of the incident, R was not subject to any Statutory Requirements, however following hospital admission R was considered an Adult at Risk of Harm under section 3 of the Adult Support and Protection (Scotland) Act 2007 and referred to Adult Services in April 2016.

2) Purpose

The purpose of the review was to establish whether there were corporate lessons to be learned about how we protect children / adults considered to be at risk of harm. The review was a process for learning and improving services and also a means of recognising good practice.

The review assessed single agency and inter-agency decision making and explored agency involvement with the family and others relevant to the case.

3) Time Period

Initially, the period of time covered by the review was from the start of the final year of primary school to the date of admission to Hospital. However, it became evident that it was necessary to alter the start date to include R's early childhood so that historical family functioning and culture would be included.

R and his parents were advised of the SCR and provided with the contact details of the Lead Officer for Adult Support and Protection and Lead Officer for Child Protection should they have any questions about the process. It was initially deemed unnecessary to interview the

family but as the SCR team assessed the facts, this decision changed and the parents were interviewed.

4) Specific Issues

The specific issues considered in the review were:

- History of agency involvement with the family.
- Support offered by all agencies to the family, and engagement with the family and child / adult.
- Quality of assessments and decision making undertaken regarding planning for the child / adult.
- Identification of areas of practice / service delivery for development, how they will be acted upon and what is expected to change as a result.
- Consideration of whether there are gaps in single agency / multi-agency process / systems and whether services should be reviewed or developed to address those gaps.
- To establish findings which will allow the Public Protection Committee to consider what recommendations need to be made to improve the quality of the services.
- To assess adherence to policies, protocols and practice guidance.

5) Summary

From an early age R presented as a child with difficulties separating from his mother. Even before starting primary school he presented with obesity and urinary wetting. His obesity continued and by the time he attended high school he had additional difficulties with soiling, refusal to attend school and limited engagement with services. His diet was poor and R became increasingly isolated, staying in his bedroom and demanding poor quality foods. His relationship with his mother and her inability to provide boundaries added to his dietary restriction, leading to his acute collapse from dietary deficiency despite being severely obese.

R was involved with various agencies throughout his childhood, including universal health and education services. Additional referrals to school nursing, paediatrics and educational welfare had been made and multi-agency GIRFEC Child Planning meetings were held. R also received additional support from the Family Support Team and Integration Team within Children's Wellbeing (Social Work), Child and Adolescent Mental Health Service and referred to the Children's Reporter. R received input and support from a third sector project and Adult Wellbeing Services. On admission to hospital, the medical team made an Adult Protection Concern referral to Adult Wellbeing.

6) Key Circumstances

The key circumstances of R's case lie within:

1. His **family functioning** and in particular his enmeshed relationship with his mother in his adolescence, which meant, despite the best intentions and efforts of professionals, that supports and interventions were ineffective.
2. **Professional Support and Intervention** did not progress as anticipated, particularly around the use and supervision of the child's plan.
3. The **medical presentation** of blood disorder in a young person with **severe obesity** due to a completely inadequate diet. It was unpredictable that R would present so unwell in this way, and arguably he would not have been brought to the attention of a Significant Case Review in the absence of this medical collapse.

Having gathered all the information around R and his presentation and met with practitioners and parents the following are the headline key issues:

- **Family and Young Person functioning – considering enmeshed relationships which build up to a pattern of emotional abuse or neglect which is characterised by:**
 - Developmentally inappropriate or inconsistent interactions with the child: and in particular over-protection and limitation of exploration and learning.
 - Failure to recognise or acknowledge the child's individuality and psychological boundary and in particular using the child for the fulfilment of the parent's / carer's psychological needs.
 - Failing to promote the child's social adaptation, and in particular failure to provide adequate stimulation and / or opportunities for learning so that the child is deprived of the opportunity to develop peer relationships.
- **Practitioner recognition and understanding of the pattern of enmeshed relationships and how best to break the pattern.** The professionals involved with R had difficulty recognising that this case was perhaps as complex as it turned out to be, and the emotional warmth between the family members did seem to influence how the case was managed. This is not to decry the warmth, but the significant lack of progress should have been a warning sign that something else was not right, that needed considered and then challenged.
- **Obesity and how it relates to the family functioning as above and the key threshold of negative impact on the functioning of the child / young person.** Severe obesity is not easy to manage, and rarely triggers child protection processes, and yet can significantly affect the long term health of a child / young person. It is understandable why this is

the case, as a child may be obese and yet happy and enjoying life. Using significant limitation of the child's / young person's functioning or severe medical complications as a guide, may help focus professionals to consider the issues with clarity.

- **Understanding the rare complications of obesity.** This case was extreme and unusual in its presentation. It is important that all health practitioners consider all possible complications of obesity and poor nutrition from a limited diet and obtain expert opinion if necessary.
- **The importance of medical and dietetic oversight in cases of severe obesity.** The Weight Management service was not available at that time, thus did not have regular dietetic input. This could have clarified the severe limitations of his diet, recognising that the non-compliance of the family may have hidden this.
- **Multi-agency planning and the importance of reviewing the evidence of progress of plans.** SMART planning is good multi-agency practice, but was ultimately missing in this case, impacting on the ability to reflect on lack of progress and the reason why this might be. This is not to underestimate the commitment of professionals to R, but sadly it fed into the difficulties, along with a lack of clear reflection on the problems of the case. The pressure on professionals who are juggling many complex and challenging cases is huge, and R, who was deemed to be below the threshold for Child Protection, was perhaps not recognised for his own complexity. Referrals are not an outcome.
- **Where there is no medical diagnosis of mental illness, family psycho-social therapy / support may be required.** How a child or family functions may still be impacting on a child's / young person's wellbeing and functioning.
- **SCRA referral processes are key opportunities for change.** SCRA and the Children's Hearing process is a vital legal pathway to help improve the wellbeing and protection of children / young people, when there is a need for compulsion. In this case the process was delayed and decisions were made that in hindsight seem irretrievable.

7) Learning Points

Summary of why it happened

The circumstances that led to R's sudden life threatening illness were medically highly unpredictable, but the pattern of severe obesity affecting daily functioning, particularly school attendance, peer relationships, continence and risks of chronic ill health are rare but not unfamiliar. The services that worked with R and his family worked in an intensive multi-agency way from his difficult start at high school.

Why R in particular ended up in hospital at severe risk to his health, does seem to be a "perfect storm" of his diet devoid of essential vitamins, leading to immobility and a lack of

ability of his main caregiver to alter R's environment. The level of his isolation, his entirely limited diet and his deterioration into ill health were not recognised by any services still working with him and he was at a time of transition from children's to adult's services, making him more vulnerable.

Despite the intensive and dedicated multi-agency work around R, agencies were unable to effect change for the better. The team did not recognise the enmeshed relationship or non-compliance, and instead relied on multiple referrals to different services in the hope of either more successful support or a diagnosis that could be treated. The lack of reflection on why the plan was not showing improvement fed into this, along with a lack of professional curiosity around the family functioning. Although there was consideration in retrospect about a child protection referral, this was not recognised during the management of the case, and this would seem to be more about the presentation of R's mother who "seemed to be" cooperative, and less about a clear analysis of the lack of progress in the plan and seeking an understanding of why this was.

Key Learning Points

- Severe obesity (BMI \geq 99.6th centile) affecting functioning, including school attendance needs a multi-agency assessment with a SMART plan.
- Inability or failure to comply as well as enmeshed relationships should be considered if plans are not progressing as expected, and explored with robust and clear timescales.
- The rights and responsibilities of a parent who is not part of the household, but who may have a desire to improve a situation need to be considered – it is important to actively engage this other parent.
- There is an identified gap in the provision of multi-disciplinary intensive family home support which explores and challenges family dynamics
- Social Background Reports submitted to the Reporter need to focus on analysis and evidence of need for legal measures.
- On reflection this child / young person should have been subject to a Hearing
- There is a vulnerability at transition into adulthood, (despite the GIRFEC process applying up to the age of 18 years), especially for those who leave school and / or who have complicated or challenging needs which do not fit into an established medically defined category.

Strengths

- The multi-agency team showed a dedication and clear desire to improve the education and health of R.

- When there were concerns about his health, a specialist holistic assessment was arranged.
- Services which provided practical support were key in showing some limited improvement in R's wellbeing.
- Ongoing commitment to R despite lack of progress.

Good Practice

- The determination of the doctor / nurse involved in supporting the attendance at the VALAC clinic.
- Communication between professionals was good.

Outcome

R was registered as an adult at risk of harm. This action allowed professional input to try to effect change in this young man's life, reflecting the significant difficulties of this case.

8) Recommendations

1. Children with severe obesity (BMI ≥99.6th centile) affecting functioning should be supported via the GIRFEC pathway

- a. Universal school health monitoring should escalate concerns via the GIRFEC pathway when a child / young person is identified as severely obese (BMI ≥99.6th centile).
- b. Severe obesity should act as a trigger to refer to a weight management programme as per guidance.

2. SMART plans should be used for all CYP's plans.

- a. Training on SMART plans should ensure they are outcome focussed with an overall realistic timetable for expected progress and clear contingency planning.
- b. Following training, there should be an audit of the use of SMART child and adult plans.

3. Everyone with parental rights and responsibilities should be consulted with and recorded on all agencies' GIRFEC paperwork.

4. The recognition of inability or failure to comply should be incorporated into all levels of public protection training.

- a. All agencies should ensure robust attendance at training, including Children's Hearing panel members and Reporters.

5. Intensive practical family work supporting functioning is promoted by all agencies where necessary to progress GIRFEC cases that are stuck.
6. Scottish Children’s Reporter Administration (SCRA) will consider / review the key learning point regarding the need for a hearing in this case.
7. The GIRFEC pathway should be followed during transition especially once a YP who has a child’s plan has left school, to ensure ongoing support and planning.

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