Nottinghamshire SAFEGUARDING CHILDREN Board

LEARNING & IMPROVEMENT BULLETIN Serious Case Review LN15

SUMMARY:

This was a young boy who had long history of health involvement in connection with developmental delay. He attended mainstream school and was well supported by staff. Despite extensive investigations medical staff were not able to find a diagnosis for his condition and as he grew older mother disengaged from a number of services. A booking system was introduced at LN15's hospital which required parents to 'opt in' to appointments and this led to contact with the paediatric service coming to an end. His school attendance dropped appreciably in the weeks prior to his death. LN15 died aged 8 years as a result of pyelonephritis (kidney infection), which is normally a treatable condition.

KEY LEARNING:

1. Children with a disability or additional health needs are a particularly vulnerable group as signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.
2. Non-compliance may be a parent's choice, but it is not the child's: 'Any non-engagement with services that are central to a child's welfare should be seen as carrying potential harm for the child.
3. A shift away from the term DNA (did not attend) to WNB (was not brought) would help 'maintain a focus on the child's ongoing vulnerability and dependence, and the carers' responsibilities to prioritise the child's needs'
4. Agencies should give due regard to safeguarding children during organisational change.
5. Specialist health services should have a mechanism for reporting back to the service which made the initial referral
6. There is no legal requirement to register or re-register a child with a General Practitioner. It is therefore important that health organisations make 'routine enquiries' in relation to GP registration in order to identify those children with health needs who are not registered.

IMPROVING PRACTICE

Here are some suggestions for improving practice:-

- Share this bulletin in team meetings and during supervision.
- Watch and share the NCSCB video animation https://Rethinking 'Did Not Attend' which is a powerful reminder that children do not take themselves to appointments.
- The full report regarding this Serious Case Review is available in the Learning from Practice section of the NSCB website. The online NSCB inter agency safeguarding procedures provide detailed guidance across the range of safeguarding issues.