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# **CHILD F1**

## **SERIOUS CASE REVIEW**

This report has been commissioned and prepared on behalf of Manchester Safeguarding Children Board and is available for publication on the 15<sup>th</sup> May 2018

Ratified: February 2018

Independent Reviewers:  
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## 1. Introduction

### Why this case is being reviewed

- 1.1 Manchester Safeguarding Children Board (MSCB) commissioned this Serious Case Review (SCR) as a result of the death of Child F1 at age 13. Child F1 died from a heart condition that was exacerbated by their morbid obesity. F1 had been obese for many years prior to the period under review. The summary of the multi-disciplinary team meeting held after F1's death at the Royal Manchester Children's Hospital, organised by the Named Doctor for Safeguarding Children for Central Manchester Foundation Trust (CMFT) and attended by four doctors including the Consultant Cardiologist, states "*Undoubtedly morbid obesity has at least contributed to the worsening of the cardiomyopathy (for Child F1) and may also be contributory in its causation.*" It also states "*F1's morbid obesity is a contraindication to a heart transplant.*"
- 1.2 The Review started in September 2015 and at this time criminal inquiries were also initiated. In some circumstances it is possible to run criminal inquiries alongside the SCR process, but in this case, MSCB made a decision to halt the SCR whilst inquiries were undertaken. The criminal inquiries were extensive, but ended with no action being taken and the SCR restarted in June 2017.

### Background and Summary of the case

- 1.3 This review has focussed primarily on professional practice covering a period of nearly two years, from July 2013, when Child F1 was aged twelve years old until their death aged thirteen years old in April 2015. This section provides information that is known about the family background and a brief summary of the history of professional involvement before the time under review.
- 1.4 Child F1's mother came from Eastern Europe as a refugee, with one child and settled in the UK prior to Child F1's birth. Child F1 is the second of four children and the only sibling of their gender. Little is known about Child F1's mother and sibling F1's life prior to their entry to the UK, but the family moved several times before settling in the Manchester area. By 2010 Child F1's father was no longer living with the family. The family were known to housing services following domestic abuse in 2009 and were in homeless accommodation for a time, but subsequently moved to permanent, privately rented accommodation.
- 1.5 Child F1 was born with mild talipes<sup>1</sup> and had some input from physiotherapy services in the area they were born in, although they were not taken to all of their appointments. At the age of three years old Child F1's weight was 30.25 kg, height 104 cm and BMI above the

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<sup>1</sup> Talipes is a condition where feet turn inwards

99.6<sup>th</sup> centile; F1 was morbidly obese<sup>2</sup>. The health visitor discussed F1's weight with their mother and dietary advice was provided. It is clear from F1's centile chart that this did not result in a reduction in Child F1's weight and they would remain morbidly obese for the next 10 years.

1.6 The family moved to Manchester where the allocated health visitor referred Child F1 to the community paediatrician for obesity, tooth decay, and management of their talipes. F1 was offered a number of appointments between 2005 and 2010, when they were between the ages of 3 and 8; however F1 was not brought to many of them.

1.7 In 2008, when Child F1 was 6 years old, the school nurse commenced a CAF<sup>3</sup>, they were concerned about F1's weight (morbidly obese) and as part of the plan a referral was made to MEND<sup>4</sup> (F1 attended only 2 of the 18 sessions offered). Support was also offered in relation to Child F1's talipes, encouragement to Child F1's mother to allow F1 to participate in physical exercise and help with the family's housing situation. Child F1's mother was pregnant during this period and the CAF appears to have been closed some time towards the end of her pregnancy. At the time of closure Child F1 was continuing to be followed up by the orthopaedic consultant, was participating in sporting activities (the health visitor had clarified with the orthopaedic consultant that Child F1 should be encouraged to complete exercise they were comfortable with) and there was agreement for Child F1 to restart the MEND programme in April 2009 following the baby's birth.

1.8 There was no engagement with MEND following the birth of F1's sibling and no re-assessment of Child F1's needs. In 2010, when Child F1 was aged 10 they were referred to a paediatrician following a multi-agency meeting in school because of continued concerns regarding F1's obesity and because their mother had not brought them to appointments. This did not lead to a plan of action, as would be expected, given how long Child F1 had been obese, and how few services they were supported to attend.

1.9 In the period immediately before the start of the review period, Child F1's mother was deregistered by the family's GP due to her aggression when her requests for treatment for

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<sup>2</sup> The BMI is measured by dividing a child's weight (kilograms) by their height (metres). Children's BMI falls into one of four categories:

1. **underweight:** BMI below the 5th percentile of the childhood population
2. **normal weight:** BMI at the 5th and less than the 85th percentile of the childhood population
3. **overweight:** BMI at the 85th and below 95th percentiles of the childhood population
4. **obese:** BMI at or above 95th percentile of the childhood population

<sup>3</sup> CAF; Common Assessment Framework now called Early Help Framework in Manchester

<sup>4</sup> MEND is a multi-component interventions programme used as first line treatment for obesity by specialist weight management services. It was commissioned by MCC at this time

her children were refused as not being in their best interest. Child F1's mother had a number of health problems of her own for which she did not always attend appointments or take medical advice.

- 1.10 The review period starts in July 2013 when Child F1 was in the first year of secondary school. F1 was a popular student with staff and pupils, doing well academically; but there were concerns about their attendance, which F1's mother said was due to health problems. These concerns were discussed regularly with mother.
- 1.11 In July 2013 mother took Child F1 to the GP because of concerns regarding sleep problems, which was subsequently found to be sleep apnoea caused by F1's obesity and enlarged tonsils. This led to a referral for a tonsillectomy, which occurred in April 2014 and a referral to the Family Weight Management Service (FWMS) to address F1's obesity. The FWMS worked with Child F1 and their family for a period of nine months, and although F1 lost a small amount of weight, this was not maintained; mother did not engage with the advice provided and disengaged with the service in August 2014.
- 1.12 In June 2014 mother took Child F1 to the GP with concerns about F1's experience of chest pains and dizziness, and expressed anxiety about a family history of heart disease. An appointment was made with a paediatrician for eight weeks later, but mother reported she did not receive the letter. A further appointment was made for September 2014 to which mother did not bring Child F1 (aged 12). The GP had further contact with Child F1 in December 2014 when F1 complained of health problems which they thought were due to their obesity. A further appointment was made to explore these issues, to which Child F1 was not brought. The GP made no further referral to the paediatrician because of previous non-attendance.
- 1.13 In October 2014 the school nurse and PE teacher started a Change for Life group at the school and encouraged Child F1 to attend. F1 attended until January 2015. During this time the school nurse became increasingly concerned about F1 and following discussion with the nutritionist the school nurse contacted F1's mother and a CAF meeting was arranged for the 3<sup>rd</sup> February. This was cancelled because mother said she could not attend. A further meeting was arranged but postponed because of Child F1's hospitalisation.
- 1.14 In February 2015 Child F1 was admitted to hospital with possible cardiomyopathy, a blood clot and obesity. F1 had continued to gain weight. F1 was discharged home with a plan of care, but readmitted almost immediately to Paediatric Intensive Care (PICU) and was found to be extremely unwell. Treatment options were complex, and although a heart transplant was considered it was ruled out because of F1's obesity and deteriorating heart condition. This meant F1's condition was critical and they were terminally ill. An end of life care plan

was put in place, with full consultation with Child F1 and this was handled thoughtfully and sensitively by the ward staff.

- 1.15 During the hospital admission there were concerns regarding mother's behaviour and attitude, she brought inappropriate food into the unit, was seen to be hostile and aggressive and there was evidence of emotional abuse to child F1. A multi-agency meeting was held – the first one – and a referral made to Children's Social Care. It was agreed that assessments of the siblings would take place after child F1's death and these assessments led to the siblings being subject to child protection plans.
- 1.16 Child F1 died four weeks after admittance to PICU from a heart condition that was exacerbated by their morbid obesity.

### Summary of the Review Methodology

- 1.17 The expectations of a Serious Case Review as contained in Working Together 2015<sup>i</sup> is that they are conducted using a systems approach, but no specific methodology is prescribed. This review has been undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence and more details about this can be found at [www.scie.org.uk/publications/guides/guide24](http://www.scie.org.uk/publications/guides/guide24). SCIE provided quality assurance supervision at key points in the data analysis process and at the end when the final report was in draft form.
- 1.18 Information is provided in Appendix 1 about the methodology, the authors and the process of this review.

### Family Composition

Family member	Relationship to Subject	Ethnicity
Sibling F1	Sibling to Child F1	Eastern European
Child F1	Subject	Eastern European
Sibling F2	Sibling to Child F1	Eastern European
Sibling F3	Half-sibling to Child F1	Mixed Heritage
Mother F1	Mother to Child F1 and siblings	Eastern European
Father F1	Father to Child F1	Eastern European
Father F3	Father to half-sibling F3	Iranian

### Family Involvement

- 1.19 Child F1's mother was made aware of the review by MSCB and invited to meet with the independent reviewers. She did not feel able to do so and therefore her views and the views of Child F1's family were not able to be incorporated into this review.



## 2. Appraisal of Professional Practice in this case

2.1 This section provides a summary chronology and appraisal of practice. This sets out the view of the Review Team and Case group about how effective the professional response was to this family, in the time under review. Where possible, it provides explanations for the practice seen and indicates where these issues will be discussed more fully in the detailed findings. Section 3 then discusses in detail the priority findings that have emerged from this Serious Case Review (SCR).

### Appraisal of Practice

2.2 At the heart of this SCR is evidence of professional uncertainty and hesitancy about addressing childhood obesity and considering it as a possible indicator of abuse and neglect. There were indications here of professional paralysis in the face of a serious issue which had the capacity to impact negatively on many aspects of a child's development. For this reason, much of the learning, or findings relate to the understanding and management of childhood obesity in a holistic way. The review highlights that childhood obesity impacts negatively in the short and long term and is a concern which requires serious thought, assessment, analysis and action and professionals need to be equipped to provide an appropriate response.

2.3 At the start of the review period Child F1 (aged 12 years old) remained morbidly obese and sibling F3 (aged 4 years old) was also obese; this was already a chronic problem which no professional or agency had been able to effectively help to address. Over the next 21 months Child F1 was seen by a number of health professionals with evidence that their morbid obesity was causing them problems. There were also some worries about F1 at secondary school (despite their sunny and friendly disposition). Although professionals were concerned, limited action was taken and the lack of success was not acknowledged. Professionals worked in isolation from each other, information was not always shared, and meetings were not held; and no holistic assessment undertaken. The complexity of the situation was not recognised and the longer the lack of serious action continued, the harder it was for professionals to consider or name this as a case of childhood neglect.

**See Finding 1.**

2.4 Child F1 was liked at school by staff and pupils and they had many friends. Apart from this information, very little was known about what Child F1 thought about their circumstances. With the exception of expressing a desire for change at times and acknowledging how difficult they found it to address their obesity day to day, almost nothing is recorded about F1's views and there is no professional analysis of what the likely impact would be of their current circumstances, both in the present and in the future. This "invisibility" is discussed further in **Finding 5** which addresses professionals understanding of, and response to, children's help-seeking behaviour.

- 2.5 There was also a clearly documented history of mother's poor engagement with health services for herself and for her children, particularly Child F1 who was not taken too many important health appointments. This was not challenged by any professional or seen as an indicator of neglect. Mother was also seen as challenging and when she did not agree with any professional advice offered, she disregarded it or sought another opinion. This led to her children's needs not always being met. There was little understanding of the meaning of this or why she behaved as she did, and she was not challenged regarding the implications for the needs and circumstances for her children. The potential negative implications for the children were not explicitly discussed or connected to the management of the childhood obesity discussed in **Finding 2** or as an indicator of neglect discussed in **Finding 1**.
- 2.6 Little was known about the cultural or ethnic heritage of the family. Professionals were aware that mother had been a refugee and her first language was not English. She was fluent in her first language and English at this time, as was Child F1. The lack of a plan or formal assessment during the timeframe of the review meant that there was no in-depth opportunity to explore the cultural heritage and beliefs of the family, but given that some professionals believed that cultural attitudes might lay beneath mother's attitude to professionals and Child F's obesity, this was an important issue to explore. This is discussed further in **Finding 4** on understanding obesity as a psychosocial issue.

**Referral to the ENT Department in July 2013 up until the GP referral to the weight management service in October 2013**

- 2.7 At this time Child F1 was in full time school. F1 was a popular young person with both staff and pupils and was doing well academically. There were concerns about their attendance because of reported health issues. These were being addressed by the attendance officer with mother, but led to little change and no further action.
- 2.8 Mother took Child F1 to the GP in July 2013 because of her concerns that F1 could not sleep, and had enlarged tonsils. A referral was made to the ENT department for assessment in relation to sleep apnoea and F1's enlarged tonsils.
- 2.9 The GP was aware that Child F1 was morbidly obese, but it is not clear whether this was raised explicitly with mother or with Child F1; and no plan of action was made to address this; for example, a referral to the Family Weight Management Service (FWMS) or endocrinology<sup>5</sup>. It is also not clear whether an explicit connection was made regarding the obesity being a likely cause for the sleep apnoea, and therefore whether mother was informed that she needed to support and enable Child F1 to lose weight for both their

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<sup>5</sup> Endocrinology is a specialty service that sees patients with a range of hormonal diseases which will need to be checked to exclude a hormonal cause for obesity. The use of hormones can also help as part of a weight management process.

health and wellbeing. It is clear from the conversations held during this review that professionals expressed both an uncomfortableness and hesitancy in raising childhood obesity with parents and this is discussed in **Finding 2**.

- 2.10 This GP visit was one of many occasions when Child F1 was seen by professionals where their obesity was obvious, and of long standing, but led to no reflection of the meaning for a teenager and led to no plan of action. The management of obesity is discussed in **Finding 2**. The lack of action here was a pattern that had developed over time by many agencies, and given the chronicity of the problem, the obvious impact on a child's health and wellbeing, a history of missed health appointments, aggressiveness and attitude of mother alongside a lack of change this was an opportunity to consider whether Child F1's obesity indicated childhood neglect. This is discussed further in **Finding 1**.
- 2.11 Child F1 was seen by the ENT<sup>6</sup> department in July 2013 and reviewed in October 2013 with the results of a sleep study. The sleep study confirmed moderate obstructive sleep apnoea. It was acknowledged there were two reasons for F1's sleep apnoea which were "*morbid obesity, weight 116kgs and Grade 4 tonsillomegaly*<sup>7</sup>". It is unclear whether mother was asked to take some action, nor what Child F1 thought about their obesity and the obvious impact on them. The ENT department asked the GP to make a referral to the FWMS and to provide treatment for blood pressure which was moderately raised, but there is no evidence that the chronicity of the situation was discussed, that a referral to endocrinology was considered, or the need to agree a management plan with the GP. This lack of joined up working between health professionals is discussed in **Finding 2**.
- 2.12 A referral was made by the GP to the Family Weight Management Service (FWMS) in October 2013. This referral needed to be clearer about:
- how long Child F1 had been obese;
  - that it was a chronic and pervasive situation for which previous solutions had not been successful;
  - that mother was often reluctant to accept professional advice and could be challenging at times.

This would have provided them with a more holistic understanding of the family and children's circumstances.

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<sup>6</sup> Ear Nose and Throat

<sup>7</sup> Enlarged tonsils caused by infection

**Home Visit from the Family Weight Management Service (FWMS) December 2013 to a referral to the paediatric clinic by the GP in March 2014.**

- 2.13 The first visit to the family by the FWMS was in December 2013 and was an introductory visit to assess the family's attitude to diet and exercise. Child F1 had gained weight since the referral and now had a BMI over the 99<sup>th</sup> centile. Child F1 said that their obesity was due to them overeating and that they got hungry at night; F1 said they liked PE at school. F1's mother told the nutritionist that F1 was "lazy" and a "donut"; this was an indication that mother did not accept or understand her role in enabling Child F1 to lose weight, which should have been addressed directly and this blaming and negativity regarding a young person who was sensitive regarding their weight should have been seen as a potential indicator of neglect (see **Finding 1**). Dietary advice was given including reducing portion size and not having takeaways. This was in line with established practice where cultural and psychosocial reasons for obesity were not routinely discussed. This lack of consideration of the psychosocial factors in weight management is discussed in **Finding 4**. The nutritionist was new to working in the community and was not aware of the role of the school nurse or of other community services, and therefore made no connections with other professionals working with Child F1, leading to this plan of action being in isolation from other health plans regarding sleep apnoea. In addition, the service at the time had no clear protocols in place which supported referral onto other specialist services to carry out more in-depth assessments and support (CAMHS, Psychology services etc.).
- 2.14 At the second visit, two weeks later, the nutritionist was made aware that Child F1's younger sibling had also been referred to the FWMS and therefore provided support in relation to F1's sibling in addition to Child F1. Child F1's sibling had been referred separately by another GP in the practice as they were also overweight. This lack of joined up working is discussed further in **Finding 2**.
- 2.15 In January 2014 when Child F1 was twelve years old their PE teacher raised concerns about Child F1's obesity with the school nurse. The PE teacher was aware that Child F1 liked PE and used the opportunity to exercise. The school were concerned that mother did not provide Child F1 with a PE kit, and would say that Child F1 could not attend PE because of health problems and their disabilities. This information was not true and although the school provided Child F1 with a PE kit, they found it difficult to challenge mother about putting obstacles in the way of Child F1 taking part in something they enjoyed and which was beneficial for their wellbeing. The school addressed this problem by providing F1 with a school PE kit and by encouraging Child F1's mother to allow F1 to walk to school with their friends. They mapped out a route to school so F1 could meet friends along the way and avoid reported bullying. Mother was unhappy with school's interference and undermined their approach by continuing to bring F1 to school by car. Both these issues indicated likely concerns about neglectful care which should have been discussed further and commencement of a CAF considered.

- 2.16 The school nurse agreed to follow up Child F1's obesity with the GP, however there is no evidence that this occurred. Had this been done, the school nurse would have been aware that there were other health professionals involved in Child F1's care who were concerned about F1 and a co-ordinated approach could have taken place. Equally the GP could have liaised with the school nurse and the importance of this coordinated response is discussed in **Finding 2**.
- 2.17 Child F1 continued to be seen by the FWMS and lost a small amount of weight. Child F1's sibling had also been referred but Child F1's mother refused to accept that Child F1's sibling was overweight and after two contacts disengaged from the service for Child F1's sibling. Mother continued to blame Child F1 for not losing weight, saying they were lazy and did not like PE. This should have been checked with the school, who would have provided a different picture which might have enabled a picture of child neglect to emerge and this is discussed in **Finding 1**.
- 2.18 A further contradiction emerged at this time. Mother was diagnosed with cardiomyopathy<sup>8</sup> in December 2013, was advised to lose weight and managed to lose a considerable amount. This demonstrated that she had an understanding of the dietary and lifestyle changes required to get to a healthier weight and was able to do this for herself. Mother had been asked to leave the GP practice where the children were registered, because of her hostility and poor compliance with appointments; this meant the information about mother's weight loss was held at another GP surgery who were not aware that she had children. This further impacted on professional's ability to have a joined up approach to the whole family and was therefore an ineffective strategy. See footnotes for current changes to practice<sup>9</sup>.
- 2.19 The nutritionist was concerned about the children, but they did not discuss either child with the GP or school nurse. Sharing these concerns and discussing the chronic and serious nature of the obesity would have been an opportunity to think about a multi-agency plan and what further action needed to be taken.
- 2.20 No professional considered whether the threshold had been met for a CAF or a referral to Children's Social Care regarding potential neglect. This was in part caused by a narrow focus

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<sup>8</sup> Cardiomyopathy is a progressive disease of the myocardium, or heart muscle. In most cases, the heart muscle weakens and is unable to pump blood to the rest of the body as well as it should.

<sup>9</sup> A Manchester citywide piece of work is being undertaken by the Named GP Safeguarding to review and develop a citywide new patient registration template for children and adults as best practice guidance. In addition, GP practices will be advised to review records whereby an adult patient leaves a practice and the children remain registered at the same practice as noted within this case. Because of the ongoing work to address the issue no finding has been made about this gap in capacity for information sharing.

across all agencies, that childhood obesity is just a health issue, not a psychosocial or neglect concern as discussed in the findings. This belief was reinforced by professionals experience of finding it difficult to get referrals regarding morbid obesity accepted as a serious concern which needed addressing across the safeguarding continuum. It is clear, also that not all professionals are confident in providing information that would enable a safeguarding response. This is anecdotal information that has influenced practice. There is further anecdotal information that this is changing since the time under review, but the importance of ensuring that all professionals are clear when obesity is a safeguarding concern remains and is addressed in in **Finding 1**.

- 2.21 In March 2014 Child F1 was taken to the GP by their mother. The GP appropriately made an onward referral to a paediatrician because Child F1 was reported to be suffering from dizziness, breathlessness on exercise and chest pains. It was noted that Child F1 was “overweight” in fact the weight measurements clearly indicated that F1 was morbidly obese. Mother was said to be anxious and a family history of heart disease was described, about which Child F1 was also said to be anxious. The referral was made and an appointment offered in May, however Child F1 was not taken to the appointment (see section 2.26 and 2.27).

#### **Tonsillectomy April 2014 to September 2014 Disengagement with Family Weight Management Service September 2014**

- 2.22 Child F1 was admitted to hospital for a tonsillectomy in April 2014 and was again noted to be morbidly obese; however there was no plan of action formulated to address this and no liaison with any other health professional regarding the obesity or its management. Once again something that was a complex issue was not addressed.
- 2.23 Child F1’s mother took F1 to the GP following their tonsillectomy requesting painkillers. The GP wished to refer back to the ENT department but Child F1’s mother was not prepared to wait and after discussion with another GP painkillers were prescribed. This was one of many examples of Child F1’s mother not being prepared to accept medical advice about the best interests of her children without challenge is discussed in **Finding 1**. The issue of obesity remained unaddressed and it is clear that Child F1 was not at the forefront of thinking.
- 2.24 There were ongoing meetings with Child F1’s mother and Child F1’s school between 2013 and Child F1’s admission to hospital in February 2015 regarding F1’s poor school attendance, mainly caused by minor ailments. Child F1’s mother was not prepared to accept that any of this was related to Child F’s weight and was observed to be annoyed when this was discussed. Mother said she provided a healthy diet to the children, but the problem was that Child F1 would overeat. The attendance officer tried, without success, to negotiate with mother about Child F1 doing more exercise. The contradictions here between mother’s views and actions was not noted or addressed.

- 2.25 In June 2014 the school attendance officer referred Child F1 to the school nurse reporting that Child F1's mother was concerned about F1's weight gain and lifestyle and how this was affecting their attendance. The meaning of this change of attitude was not explored. At this time Child F1 was seeing the nutritionist but gaining weight. No action was taken by the school nurse in relation to contacting the GP or nutritionist which would again have provided the opportunity to share information and the discrepancies as reported by Child F1's mother. The school nurse reported that this would not be their normal practice but their heavy workload at the time meant they were working in a re-active rather than a pro-active way. This is not included as a finding as school health services have been re-organised since this time. However, the impact of this lack of liaison was that there was no opportunity to consider a co-ordinated response to manage Child F1's morbid obesity (**Finding 2**). Whilst there was a weight management pathway for obesity in place at this time neither the school nurse nor any other professional in this case appeared to be aware of it and it was therefore not followed, which further compounded the issue.
- 2.26 In June 2014 Child F1's mother took F1 to the GP with chest pain. Mother reported that she had not received an appointment (there is no evidence of this) with the paediatrician (referral made in March) and she requested this be followed up. The GP did this which was appropriate practice.
- 2.27 Another paediatric appointment was made for Child F1 for the 5th September 2014 to which they were not taken. Child F1 was referred back to the GP for follow-up. The impact on this for Child F1 was that six months had passed since they had expressed anxiety about their health, and this remained unaddressed. Child F1's anxieties were not addressed because F1's mother did not take F1 to the appointment (F1 would have been 11 years old). This should have been addressed with F1's mother and a plan of action formulated to ensure that Child F1's health needs were addressed. There is now increased emphasis on understanding that all professionals need to be aware of Children not being brought for health appointments and changing the language from Did Not Attend (DNA) to Was Not Brought (WNB)<sup>ii</sup>. The CCG Designated Safeguarding Team have now developed a practice template for Guidance on Children and Young People who are not Brought for Healthcare Appointments in Primary Care which has been disseminated widely. A finding relating to this has therefore not been made.
- 2.28 Child F1's mother also disengaged from the Family Weight Management Service at this time and the absence of any coordinated plan meant that no one was aware of this lack of compliance by mother with services designed to improve her children's circumstances. Additionally, Child F1 had been seen by a number of different GPs with no clear plan regarding management or who was taking responsibility for F1's care within the GP practice. This was reflected in the way health professionals were working together (**Finding 2**).

**Commencement of Change for Life Group October 2014 to the commencement of a CAF in January 2015**

- 2.29 Child F1 (aged 12) was invited to attend the Change for Life Group at school, which had recently been set up by the PE teacher, supported by the school nurse. The group's aim was to include those young people who found PE difficult for whatever reason, provide light exercise, dietary advice, 1-1 support and increase self-confidence. The rationale behind setting up the group was sound and Child F1 appeared to engage well, and used the opportunity to discuss some of their concerns with the school nurse and PE teacher. When discussing their diet, it was clear that F1 was having over 2000 calories before lunch including a high calorie takeaway as a second breakfast; given their morbid obesity this should have caused more concern and action.
- 2.30 Child F1 told the school nurse that they wanted to lose weight but that they found it hard. This was further evidence that F1 wanted help and the whole issue of supporting children's help seeking behaviour by validation and motivational approaches is addressed in **Finding 5**. Child F1 told the school nurse that they did not want their mother to know that they were attending the group as they didn't think she would want them to. This confidentiality was respected because of F1's age and the belief that this would best support them; Child F1 was helped through the group to make changes to their lifestyle, but the lack of support at home suggested that the psychosocial circumstances were not in place. The lack of information sharing with any other professional and the opportunity to contextualise this information alongside other concerns was lost. This was a continuation of the silo working of all professionals and meant that there was no bringing together information which would have formed a growing picture of child neglect which urgently needed assessing and addressing for the whole family.
- 2.31 In December 2014 Child F1 went to the GP with a scalp problem and F1 asked if it was caused by their obesity. F1 also expressed concern about their legs (joint pains) and whether this was because of their weight (evidence of a co-morbid problem with obesity which should have been picked up and is discussed further in **Finding 4**). The GP made another appointment to discuss this with Child F1 in more detail in January 2015. This was effective practice; however, Child F1 was not brought to this appointment. Had F1 attended it would have been an opportunity to explore in depth with Child F1 what was really happening in their life and how it could be improved. Child F1 had gained 18 kg over the previous nine months. The GP referred F1 back to the FWMS, but the situation for Child F1 was clearly getting more serious and this should have prompted a clear plan of action and a mechanism for assessment of what the nature of the problem was and what could be done to address it. The overall lack of knowledge by professionals of the pathway for addressing obesity in children is discussed in **Finding 2**



- 2.32 The GP did not make a further referral to the paediatrician because Child F1 had not been facilitated to attend (non-attendance) and therefore the ongoing health needs of Child F1 remained unaddressed. This lack of compliance with essential health appointments should have been addressed in a child focussed way. Exploring this issue with parents is a way of making sense of whether this is neglect and what action needs to be taken. This is discussed further in **Finding 1**.
- 2.33 Following this attendance at the GP, Child F1 told the school nurse of their referral back to the FWMS. The school nurse contacted the nutritionist which was good practice; they were both concerned and recognised likely neglect and they agreed to commence a CAF. This was more collective action than had been taken for many years for Child F1, but it is the view of the Review Team that there was enough available to make a referral to CSC. The importance of focussing on the necessary evidence to enable any agency to make a decision about the best course of action for chronic obesity is discussed in **Finding 1**.

#### **Child F1's admission to hospital in February 2015 until their death in April 2015**

- 2.34 At the beginning of February 2015 Child F1 was admitted to hospital and found to have dilated cardiomyopathy, a blood clot and a long history of morbid obesity. F1 had continued to gain weight (an increase of 20kgs since their tonsillectomy April 2014). F1 was provided with full medical care, and seen by a variety of hospital consultants. However, there was no discussion regarding whether a multi-agency meeting was needed to discuss the obesity or whether the longevity and worsening of the situation for Child F1 indicated safeguarding concerns. This is discussed further in **Finding 1**. Child F1 was medically fit for discharge and went home mid-February 2015 with an appropriate treatment plan.
- 2.35 Child F1's mother told the school that she could not attend the CAF meeting, but did not mention that Child F1 was in hospital. The meeting was cancelled. It is best practice to involve parents in all meetings, and for professionals to reflect on whether a parents/carer has been enabled to attend. However, a view needs to be taken by all about whether a meeting needs to go ahead when any member of the group cannot attend because of the seriousness of the circumstances facing the child. In this case the school nurse had tried hard to engage mother. Professionals did not evaluate all the available information and take a considered decision regarding whether the meeting should go ahead for Child F1. There currently appears to be confusion about when it is appropriate to continue with meetings when parents do not attend or refuse to engage when all action has been taken to ensure attendance is possible. Current guidance from MSCB would appear to suggest that this should never happen. In the professional view of the SCR reviewers to have guidance which does not allow professionals to use their own professional judgement based on the available evidence and with full transparency to all can lead to unintended consequences<sup>10</sup>.

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<sup>10</sup> MSCB have recently discussed the concept of professionals meetings in cases where there are concerns regarding the welfare of children and young people. It has been agreed that these meetings cannot be supported and the procedure has been

- 2.36 After the discharge home from hospital Child F1 became increasingly unwell and five days later following attendance at the Emergency Department, F1 was admitted to a paediatric ward and transferred to Paediatric Intensive Care Unit (PICU) on the 26<sup>th</sup> February 2015. Child F1's health deteriorated significantly and there were significant concerns about them. Specialist advice was sought to address the deterioration of F1's heart and F1 was transferred to a specialist hospital to be assessed for a heart transplant. F1 was assessed as not fit enough for a transplant because of their obesity and deteriorating heart condition and F1 returned to hospital where it was clear that they were now terminally ill and had a short time to live. The hospital put in place an end of life plan for Child F1 which was discussed with F1 and carried out with considerable care and thoughtfulness.
- 2.37 During this time there were increasing concerns that mother refused to accept current dietary advice from the relevant hospital consultants, brought in take away food, was aggressive to staff and emotionally abusive to Child F1. In mid-March 2015 a safeguarding meeting was held. A referral was made to Children's Social Care (CSC) for an assessment of the impact of neglect on the remaining siblings to be carried out after Child F1's death. This was appropriate practice and showed a consideration and understanding of the situation at that time. This assessment took place and child protection plans were put in place for the siblings.
- 2.38 Child F1 died at the beginning of April 2014 from a heart condition that was exacerbated by their morbid obesity. This was distressing and sad for all who knew Child F1.

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removed from the MSCB website with immediate effect. It is vital that individual practitioners and agencies work openly and in partnership with parents and carers, and concerns should generally be discussed openly and transparently together in meetings where parents and carers are present and able to contribute

### 3. The Findings of this SCR

#### Introduction

3.1 This section contains five priority Findings that have emerged from this SCR. The findings explain why professional practice was not more effective in protecting the siblings in this case. Each Finding also lays out the evidence, identified by the Review Team and Case group, that indicates that these are not one-off issues, but are matters that if not addressed could cause risks to other Children and families in future cases, because they undermine the reliability with which professionals can do their jobs. Recommendations relating to these findings are identified in section 4 of this report.

#### Summary of findings

3.2 The Review Team have prioritised five findings for the MSCB to consider as listed below.

	<b>Finding</b>	<b>Category</b>
1.	<b>There is a lack of professional clarity about when childhood obesity should be considered as a child neglect concern which, if not addressed, leaves children at risk of continued harm.</b>	Professional norms/cultures around communication and collaboration – longer term work
2.	<b>The lack of professional knowledge about the multi-agency obesity pathway, coupled with the way services are currently delivered does not support professionals in the management of obesity.</b>	Management systems
3.	<b>Professional sensitivities to “naming the problem” in relation to obesity is unduly driving practice. This will be compounded when a parent is seen as challenging.</b>	Professional norms/cultures around communication and collaboration – longer term work
4.	<b>Professionals are not supported to take a psycho-social approach to obesity, whereby the wellbeing of children and their parents are linked and worked with as such.</b>	Management systems
5.	<b>Children’s help-seeking behaviour is insufficiently recognized and responded to by professionals, leaving them unsupported in the short term and potentially less likely to ask for help in the future.</b>	Patterns of interaction with families

**Finding 1: There is a lack of professional clarity about when childhood obesity should be considered as a child neglect concern, which, if not addressed, leaves children at risk of continued harm.**

- 3.3 Childhood obesity is a significant national public health issue. It has long term negative consequences across all domains and with significant impact into adulthood<sup>iii</sup>. The impact of obesity on children can be profound. It can lead to bullying, poor friendship networks and isolation. As with all Childhood neglect, the experience of knowing your parents are either unable or unwilling to enable change to happen can cause feelings of low self-worth, poor self-esteem and depression.
- 3.4 This means establishing the cause of the obesity and doing something about it is imperative. One aspect of this is establishing whether childhood obesity should be considered as a safeguarding concern. This is a question that all professionals in contact with childhood obesity, and particularly morbid obesity, should ask themselves. This requires careful assessment, weighing up of the available evidence and a clear analysis. For some children, their obesity is one aspect of widespread concerns about neglect in a number of different areas and requires good assessment using one of the established structured judgement tools for neglect. There are cases where childhood obesity is caused by abuse, physical, sexual and emotional and is part of a response to these traumatic events. This requires addressing alongside other trauma related concerns.
- 3.5 The focus of this Finding is on those children where their obesity is directly caused by and maintained by, parental neglect. Researchers at the Institute of Child Health<sup>iv</sup> provide a helpful framework to evaluate this which has at its heart an assessment of a parents' ability to respond to the child's needs. The framework suggests a safeguarding referral should be made where:
- There is a consistent failure on the part of a parent to change lifestyle and to address the concerns regarding a pattern of behaviour which is underpinning the obesity;
  - A lack of acceptance of professional advice;
  - Complete parental inability to take responsibility for their part in the problem and willingness to create change; the extreme end of this is where the parent blames the child completely for the problem, and is negative and denigrating of the child (this factor was not included in the original framework but seems relevant here as a key aspect of the research regarding neglect<sup>v</sup>);
  - Lack of attendance of appointments, poor compliance with treatment regimens and lack of engagement/hostility to professionals;

- The existence of co-morbidity Factors<sup>11</sup> such as asthma, sleep apnoea, joint problems, weight related injuries (sprains, breaks etc.), incontinence, skin conditions and diabetes;
- The child's outcomes are compromised by the obesity, e.g. social presentation/interaction with peers/educational attainment;
- Concerns are escalating over time (specify time period).

3.6 Implicit in this framework is the need for professionals to evaluate whether they have been clear with parents, over time, their expectations and concerns, and have enabled them to understand the need for professionals help and support.

3.7 The Norfolk LSCB<sup>vi</sup> have taken this framework and produced an assessment screening tools for health and all professionals to help aid professional judgement about when obesity is a concern across the safeguarding continuum from an early help response to a child protection concern and that at whatever stage the needs are evaluated a robust plan is put in place.

#### **How did the issue feature in this case?**

3.8 Although all professionals in contact with Child F1 were aware of their morbid obesity, there was never a clear plan of action and neither an early help response (with the exception of the CAF when F1 was admitted to hospital); or an analysis of whether this was a safeguarding concern. The issue was consistently treated as primarily a health concern and as such referrals were made to the FWMS to address the obesity, and to other health professionals for the co-morbid symptomology, without the two ever being connected together.

3.9 There was no evidence of an evaluation of the available information mother did not always enable Child F1 to attend appointments. Mother was described as difficult with professionals and often did not follow medical advice. She was able to change her own lifestyle and successfully lost a large amount of weight because of her own health problems, but she was not able/willing to do this for Child F1. The reasons for this are unclear as this was not explored with her. She found it difficult to accept her own responsibility for addressing Child F1's obesity and often blamed and belittled F1 to professionals.

3.10 There was also evidence of comorbid symptoms of sleep apnoea and skin conditions. Significantly over time there was either little change to F1's weight, or more latterly it began to increase.

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<sup>11</sup> **comorbidity** is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder

- 3.11 Professionals were not clear enough with mother about either her responsibility to take action for Child F1, or the impact on F1 of the obesity now and in the future. **Finding 3** focusses on professional reluctance to name obesity and discuss it openly with parents because they are either offended or embarrassed, compounded by difficulties with parents who are challenging. This was the case here.
- 3.12 There was evidence that this situation was a safeguarding concern which indicated a primary cause of neglect for the obesity. There was evidence of some professional anxiety more broadly about whether a safeguarding referral regarding childhood obesity would be taken seriously and accepted. The experience of the professionals was that it would not be. When establishing the right pathway to address childhood obesity professionals need to evaluate and analyse the available information from a psychosocial perspective and to be clear about what their concerns are. If a referral is to be made regarding safeguarding concerns this must be clear about the risks using the framework outlined above. It is also the responsibility of those receiving the referrals being clear about why thresholds have not been met and to clarify what information is required where there are serious concerns about a child. This was identified as not routinely happening in 2015 and although the situation has improved as part of the Ofsted improvement plan and the MASH there are still times when this is not happening consistently in Manchester.

**What makes this an underlying issue and how do we know it is not something unique to this case?**

- 3.13 The practitioners who were seen as part of this review believed that in Manchester it was difficult to get concerns regarding child obesity taken seriously as a safeguarding concern. This impacted on their response to Child F1. It is of note that when Child F1 died and F1's siblings became subject to child protection plans, the issue of mother's approach to the obesity in the context of neglectful care was still not sufficiently acknowledged. Obesity is also not explicitly covered in the recent MSCB guidance regarding addressing neglect. Nor is it considered adequately within the obesity strategy and the FWMS Service specification.

**How widespread is this pattern?**

- 3.14 A national review<sup>vii</sup> of the research suggests that there is considerable debate and polarisation regarding whether childhood obesity should be considered a safeguarding concern, with many professionals believing that it is unnecessarily stigmatising and blaming of parents. This research review concluded that not all cases of obesity should be a safeguarding concern but safeguarding should always be a consideration, particularly in the context of morbid obesity, which by its nature is a chronic condition and there should be an analysis of the available information, using the questions in a framework that they provide and which is summarised at the beginning of this Finding.

### **Why does it matter? What are the implications for the reliability of the multi-agency Child protection system?**

- 3.15 The neglect of children is a serious and complex issue, which casts a long shadow over child and adult lives. If these concerns are left unaddressed, childhood neglect has the capacity to have a negative impact on all aspects a child's life and to last into adulthood, where there are also serious consequences such as depression, poor life chances, difficult relationships and difficulties with being a parent. The added issue of morbid obesity, which brings with it psychological, social and health consequences, means if this is not addressed children's needs remain unmet, their adult lives will be impacted upon, there will be cumulative cost to public services, and there may well be a consequence for the next generation of children.

**Finding 2: The lack of professional knowledge about the multi-agency obesity pathway in Manchester, coupled with the way services are currently delivered does not support professionals in the management of obesity.**

- 3.16 An obesity pathway was introduced by Manchester Public Health department in 2013 and implemented. There was training provided, but it is unclear for which staff and how many. The pathway identified an overly simplistic process which started with early identification, provision of advice and support, commencement of a CAF and continues through to a consideration of possible neglect and a referral to CSC. Whilst professionals in this case appeared to follow certain aspects of the pathway when providing input to Child F1 and their family, they did not seem to be aware of the fact that it was in place and therefore did not follow it in its entirety. This contributed to the professionals not being clear as to how to manage Child F1's weight effectively when there was non-compliance from F1's mother.

### **How did the issue feature in this case?**

- 3.17 Both Child F1 and their sibling were identified by the GP as being morbidly obese in 2013 (concerns had been raised by health professionals in relation to Child F1's weight since F1 was 3 years old) and referrals were made to the FWMS in October 2013. These referrals were made by different GPs within the practice and sent as two separate referrals with no linkage between the two children resulting in them for a while being seen by different parts of the FWMS.
- 3.18 When Child F1 was seen by hospital services in 2013 there was no liaison with the GP or the FWMS in relation to how Child F1's obesity was being managed and what if anything further needed to be done, despite there being information relating to previous community involvement and commencement of a CAF in 2009.

- 3.19 The school nurse was working with Child F1 in relation to F1's obesity but not aware of the FWMS input to either Child F1 or their sibling until January 2015 when information was shared and a decision made to commence a CAF.
- 3.20 Professionals in this case when providing input to Child F1 and their family, did not seem to be aware of the fact that the pathway was in place and therefore did not follow it in its entirety. This contributed to the professionals not being clear as to how to manage Child F1's weight effectively when there was non-compliance from their mother.

**What makes this an underlying issue and how do we know it is not something unique to this case?**

- 3.21 The practitioners involved in this case highlighted that there was not always sufficient multi-agency intervention for children who are obese. They believed that obesity, and morbid obesity was treated as a health problem, with routine health solutions, and that there remained barriers to professional action for either an early help response, child in need response or particularly a child protection response. The lack of use of the existing pathway for action was not picked up through any management oversight process or supervision and indicates widespread lack of knowledge of both the reason for the pathway, that obesity is a very serious issue for children, and knowledge of how it can help. Whilst the review team felt that the situation had improved since that time, with work being carried out with GPs, schools and communities as well as staff education, there were still concerns that there is not always a consistent multi-agency response to childhood obesity in Manchester.

**How widespread is this pattern?**

- 3.22 In England 2015/16, over 20% of children in Reception class and over 33% of children in Year 6 were measured as obese or overweight<sup>viii</sup>. Latest figures show that in Manchester more children and young people in this region are overweight than elsewhere in the country. These figures highlight that 11.7% of five year olds were obese (compared to 11.4% in 2015/16) and 25.4% of Children aged 10- 11 years are classified as obese or overweight (up from 25.1% 2015/16 )<sup>x</sup>. Examination of the Manchester statistics also shows that, along with the rest of the country, children in the most deprived areas are twice as likely to be obese than children in the least deprived areas<sup>x</sup>.
- 3.23 Public Health England has identified the need to reduce obesity within the population in England and Wales and it is a high priority within the public health agenda. In addition, there is a clear national obesity strategy in place which if implemented effectively should provide the tools for professionals to reduce childhood obesity. Childhood obesity can occur in early childhood, sometimes before the age of two years, and longitudinal studies show that this will continue into adulthood<sup>xi</sup>. Childhood obesity can lead to bullying, low self-esteem, cardiac and respiratory problems, sleep apnoea etc.



### **Why does it matter? What are the implications for the reliability of the multi-agency child protection system?**

- 3.24 Research shows that the older a child is the more difficult it is to reduce and sustain any weight loss<sup>xii</sup>. This means that the earlier the problem is identified and a plan put in place the more likely changes will be made, and action taken of change does not occur. A clear pathway of action is essential which does not shy away from the fact that at times childhood obesity is a safeguarding concern. This remains something that professionals in Manchester seem uncertain about.
- 3.25 Without having a clear multi-agency understanding of the impact of obesity on a child's health and development, both physically and emotionally the implementation of any pathway however good is unlikely to be successful. The implementation of a pathway in the future will therefore need to take this into account. Having a process in place which both identifies how the obesity should be managed as well as the responsibilities of individual professionals in providing appropriate management, advice and support including effective escalation is vital in reducing the risks of obesity at the earliest possible time. Without this co-ordinated multi-agency working Manchester's obese children will not have their needs met appropriately and their outcomes in the short and long term will be impaired.

**Finding 3: Professional sensitivities to “naming the problem” in relation to obesity is unduly driving practice. This will be compounded when a parent is seen as challenging.**

- 3.26 All professionals who come into contact with obese children can find raising concerns with a parent that their child is overweight or obese difficult and therefore obesity is not always raised as a problem until it is chronic and impacting on the child's health and development. This may not be until the child is a teenager and makes dealing with the weight loss harder for both the child and family to achieve. Obesity can be a very sensitive subject to raise with varying negative responses to the subject being well documented and not everyone sharing the view that it is harmful or can cause problems in later life.

### **How did the issue feature in this case?**

- 3.27 Child F1 was seen by a number of professionals, and although the GP identified with Child F1's mother that F1 was overweight and referred F1 to the FWMS the level of obesity and the lateness of the referral were indicative of the difficulty health professionals have in discussing obesity and its implications with parents. The level of risk to Child F1's health was not fully explored by any of the health professionals involved (during the period of this review) until the hospital admission prior to F1's death. Child F1's mother was reported to be challenging towards professionals and had been deregistered by the GP because of her forceful behaviour, disagreeing with medical advice and insisting on specific treatments in relation to her children. This meant that the professionals working with the family skirted

around difficult discussions with Child F1's mother, trying to get her to work with them and not disengaging further from services.

**What makes this an underlying issue and how do we know it is not something unique to this case?**

- 3.28 A number of professionals spoken to as part of this review identified talking to parents about their child's obesity was one of the major causes of complaint by patients/service users. This resulted in them being anxious about raising the issue of obesity and risking them not being able to engage with the families concerned. Where the families were known to be challenging they were even less likely to raise the issue for fear of the family disengaging totally.

**How widespread and prevalent is this pattern?**

- 3.29 Childhood obesity in Manchester is higher than national and north-west averages and the percentage of obese children is increasing year on year. Finding it difficult to discuss perceived sensitive issues relating to obesity has been identified as an issue in research carried out by Edmunds et al 2007<sup>xiii</sup>. Even when health professionals did discuss obesity they did not consider that discussion to be effective<sup>xiv</sup>. The impact of the difficulty identified by this research<sup>xv</sup> and reflected by the professionals involved in this case will clearly be significant when considering how to reduce childhood obesity in Manchester particularly when the research also identifies that when professionals were themselves having difficulty with weight management they were less likely to raise the subject with their patients/clients making the situation even more complex.
- 3.30 This was not felt by the practitioners or the review team to be an isolated case, and is a finding reflected national research into obesity<sup>xvi</sup>. It is therefore important that whatever training and intervention is provided in relation to obesity the management of those "challenging behaviours" is incorporated to ensure that the focus remains on the child. In this instance an overweight or obese child.

**Why does it matter? What are the implications for the reliability of the multi-agency child protection system?**

- 3.31 Research<sup>xvii</sup> into obesity and its long-term effects is well known, as is the fact that the older a child is the harder it becomes for them to lose weight. It is therefore really important for professionals working with a family to raise their concerns about an overweight child with the family as soon as they identify it as a problem; and to explore with them what the issues may be that have led to the child gaining weight. To do this effectively, as discussed above, they need to feel confident in raising their concern, as well as being knowledgeable and confident in exploring the multi-faceted issues that can contribute to a child becoming overweight. Some parents will find it difficult to accept initially that their child is overweight, particularly when the child is young, there being the false assumption that the child will lose

the weight once they start running around<sup>xviii</sup>. This needs careful management to engage rather than disengage the family. Where parents are already known to be challenging the introduction of obesity is likely to be even more problematic, likely to cause complaint and can lead to refusal of services. Failure then to consider their non-compliance should be assessed as a potential safeguarding concern.

- 3.32 Early intervention is imperative in empowering parents to make changes to their and their child's lifestyle and whether they are challenging or not the obesity has to be named as part of any intervention offered and training and supervision put in place to ensure they are fully equipped to undertake that discussion in a way that will engage the parents, and when they are aggrieved that the professional is supported in ensuring that this does not impact on the child's needs being met. This early assessment and intervention will also enable the professionals working with the family to assess, in cases where weight loss is not achieved whether there is any evidence of neglect (are other areas of the child's health and development being appropriately provided for) and/or is additional support required to support the family (e.g. housing, mental health, disability, domestic violence). Where a family fails to engage either actively or passively further multi-agency assessment is required to identify whether the child's health is being affected and whether the child/ren meet the criteria for a child protection referral for neglect.

**Finding 4: Professionals are not supported to take a psychosocial approach to obesity, whereby the wellbeing of children and their parents are linked and worked with as such.**

- 3.33 Traditionally the management of obesity has focused on dietary advice and exercise. There is growing evidence that failure to address obesity can be because of other issues in the individual or family's life and that these need to be addressed before effective weight loss can be achieved. More recent research suggests that social deprivation and disadvantage along with other psychosocial factors will have an impact on a parent's ability to change behaviour. They include such factors as low self-esteem, domestic abuse, depression and anxiety and lack of family or community support<sup>xix</sup>.
- 3.34 There is also evidence that family relationships, attitude to parenting and parenting style play a part in this complex issue<sup>xx</sup>. Part of this will be an understanding of the cultural or ethnic identity of the family. This will enable a discussion of health beliefs, attitudes to professionals and attitude to family relationships. Alongside this it is important to explore a family's experience of racism and discrimination and consider its impact on family life, access to services and opportunities, alongside further exploration of the role of professionals. The culturagram tool<sup>xxi</sup> can be a helpful too in exploring these issues.

- 3.35 As with all issues effecting the well-being of children, obesity needs to be understood as a complex interplay of psychosocial factors which are likely to interact negatively and therefore a comprehensive psychosocial or holistic assessment is needed to have any chance of effectively managing obesity.

**How did the issue feature in this case?**

- 3.36 As part of the assessment relating to the management of Child F1's obesity there was no recorded evidence to show that a psychosocial assessment was carried out in relation to family functioning during the period under review. This meant that professionals did not know what psychosocial factors were impacting on attempts to address Child F1's morbid obesity and were therefore unable to provide an effective plan to meet Child F1's needs.
- 3.37 Child F1's mother was a refugee from Eastern Europe, and had moved several times since coming to the UK. She had little contact with the two older children's father after 2010, and had experienced domestic abuse at the hands of both him and her current partner. There was no assessment on the impact any of this had on her, either as an individual or as a parent; nor was there any discussion as to her support networks or family beliefs. Whilst Child F1's mother appeared to be financially solvent, her financial situation was not explored either in relation to her outgoings or in relation to her views on what constituted a healthy diet and how she could provide it. Nor was her attitude towards exercise explored, or the contradictions between what she said and her actions around exercise relating to Child F1.
- 3.38 Child F1's mother's attitude to Child F1's obesity was known and there were some hypotheses that these were related to her own cultural norms, but these were never explored and remained as potential cultural stereotypes. These notions needed to be explored as part of the complex interplay of factors that might be maintaining the obesity. There was also no evidence that mother or Child F1 were asked about their experience of racism and discrimination. Given their BME status this was an important issue about which nothing was known.
- 3.39 The connection between parenting, feelings towards children, expressions of love and attachment were also not explored. Although research regarding the cause of children's obesity is limited, as with the management of other childhood illnesses, there is a connection between management and parenting style which should have formed part of a holistic, family focussed assessment.

**What makes this an underlying issue and how do we know it is not something unique to this case?**

- 3.40 Both the practitioner and review team reported that whilst there was an awareness of the impact of low self-esteem, depression and anxiety as well as the impact of social

deprivation, poor housing and inadequate income on obesity, this was not formally assessed and few (health visitors and school nurses) used any formal assessment tool. Practitioners also reported that they did not have access to support services such as CBT and psychology which they felt would have affected the outcome when working with some of the families as they did not meet the threshold for referral. Practitioners also highlighted that in depth knowledge of a family's cultural context, including issues of racism was not currently routine practice. Work with families therefore concentrated on diet, behaviour change and exercise.

### **How widespread is this pattern?**

- 3.41 Until recently this would have appeared to be accepted practice, with weight management services providing one to one support either in clinic or home-based for "hard to reach families". Referral to the service was often when a child was already extremely overweight or obese and therefore more intransigent<sup>xxii</sup>. The need therefore to properly understand the underlying cause of the obesity through a psychosocial assessment was even more necessary.
- 3.42 Since Child F1's death Manchester City Council have re-commissioned their Tier Two Weight Management Service<sup>xxiii</sup>. This includes providing a psychosocial assessment and services to refer to; however those families who have the most complex needs such as Child F1 are unable to access a tier three service<sup>xxiv</sup> (with access to psychology services). They will receive 1-1 support but cannot be provided with psychological therapy which often leads to them not losing weight or dropping out of provision as in this case. This is a gap not just across Greater Manchester but nationally. Additionally, Health Education England have funded a programme in Manchester to reduce childhood obesity. This has included data collection, testing interventions to identify which are effective, research in partnership with the University of Manchester, staff education and work with GPs, schools and communities. This work will inform future commissioning in relation to weight management.

### **Why does it matter? What are the implications for the reliability of the multi-agency child protection system?**

- 3.43 Working Together 2015<sup>xxv</sup> identifies the need for comprehensive assessments to enable appropriate services to be provided for the child and family "*High quality assessments: are child centred... rooted in child development and informed by evidence*".

It identifies the need to assess all aspects of a family and each child individually. Research has shown that a good assessment is one which investigates the following three domains:

- *the child's developmental needs, including whether they are suffering, or likely to suffer, significant harm;*
- *parents' or carers' capacity to respond to those needs*

- *the impact and influence of wider family, community and environmental circumstances.*

Working Together identifies the aim of any assessment being to analyse the information provided and come to a judgement about the nature and level of needs and/or risks that the child may be facing within their family.

- 3.44 If consideration is not given to all the aspects of the assessment process then the psychosocial aspects of managing obesity will not be identified and an effective outcome less likely. This would appear to be supported by the anecdotal evidence from the practitioner group who reported that any weight loss that occurred as a result of safeguarding intervention was not sustained following the child returning to universal services. Until there is a clear understanding of the need for full psychosocial assessment to be undertaken and the length of time it takes to change behaviour and provide long-term support then the number of children at risk of obesity is likely to remain the same or increase.

**Finding 5: Children's help-seeking behaviour is insufficiently recognised and responded to by professionals, leaving them unsupported in the short term and potentially less likely to ask for help in the future.**

*The Child is a person not an object of concern.* Baroness Butler-Schloss 1987<sup>xxvi</sup>

- 3.45 This Finding explores the importance of professionals recognising, responding to and validating the help seeking behaviour of children and young people. Public inquiries<sup>xxvii</sup>, research<sup>xxviii</sup>, inspections and SCRs have highlighted the way in which children can become invisible to professionals in their work across the safeguarding continuum. This is despite a legislative framework which make it clear that children should be fully involved in decisions about their lives and that their views should routinely be sought regarding their own understanding of their circumstances (Children Act 1989<sup>xxix</sup> and the United Nations Convention on the Rights of the Child (UNCRC<sup>xxx</sup>)).
- 3.46 This is not just about best practice. The way that professionals engage with children and young people is important; it can help promote self-esteem, resilience and coping skills. Developing resilience enables children and young people to cope with adversity and therefore improve their outcomes. Of particular importance within this is the development of help seeking behaviour. This is something children and young people learn through their early attachment relationships and through their contact with adults over time. It is a developmental skill that needs support to develop and early experience of adversity, abuse and can have a negative effect. Research highlights that there are many barriers for children

and young people in asking professionals for help and to talking about their worries and concerns so they can be addressed. Children and young people also report that when they do ask for help they are often not heard or their worries not acted upon<sup>xxxii</sup>. The consequence of this is that a recent report by the Children’s Commissioner has found that only 1 in 8 victims of abuse<sup>xxxiii</sup> felt able to ask for help.

- 3.47 Research<sup>xxxiii</sup> suggests that children and young people test out what kind of professional response they will get by seeking help with small concerns. It is how these small concerns are responded to that will encourage them to ask for help or talk about serious concerns in the future. This in turn also promotes help seeking behaviour.

#### **How did the issue feature in this case?**

- 3.48 Child F1 was morbidly obese for much of their childhood, and there was significant evidence that this was impacting on their health and well-being. There is little information available about what F1 thought about their life and their circumstances. F1's mother did not enable F1 to attend important health appointments, or engage with the FWMS to address their obesity. It is recorded that mother talked negatively about F1, calling them “donut” and suggesting that despite her provision of healthy food, it was F1's fault that they were overweight because they chose to overeat. The evidence was contrary to this, but mother was not challenged about not facilitating appointments nor for blaming Child F1. This must have been difficult for F1 and would certainly not have helped F1 develop appropriate self-esteem or self-efficacy.
- 3.49 F1 was given time to talk about their worries by the school nurse and on occasion by the GP. This was important, but there was little action to support what was essentially F1's help seeking behaviour. For example, F1 visited the GP to discuss their worries about various health issues and the link to their morbid obesity. This must have been difficult for a child of 12 to do. It suggests that F1 was worried and wanted help. Appropriately a further appointment was offered, but F1 was not brought to it by F1's mother. This was not followed up and F1 did not speak about their worries with the GP again. When F1 was in hospital, and the ward staff were planning F1's care, and eventually their end of life care, F1 was engaged, thoughtful and aware of their own needs. This demonstrated that F1 had the capacity to make use of professional help.

#### **What makes this an underlying issue and how do we know it is not something unique to this case?**

- 3.50 There have been a number of local SCRs which have highlighted that there is a tendency for children to become invisible in professional practice across the safeguarding continuum, particularly where the needs of a parent dominate. The Review Team for this SCR noted that from their experience of the management of cases, supervision and audit that more work is

needed to ensure that children and young people's help seeking behaviour is recognised and acknowledged.

**How widespread is this pattern?**

3.51 There is significant evidence nationally from SCRs, inspections and research that children are not always fully engaged with by professionals and that their needs can be masked by those of the adults around them. There is less information which focusses explicitly on children's help seeking behaviour and the needs to validate it and promote it to improve children's ability to talk about worries and disclose harm.

**Why does it matter? What are the implications for the reliability of the multi-agency child protection system?**

3.52 Help seeking behaviour is a fundamental skill for all children, but particularly those who experience adversity, abuse and neglect. If children are not responded to appropriately by professionals, their concerns not listened to or addressed, this is likely to impact on their self-esteem and resilience and therefore their short and long term developmental outcomes. The fundamental reason for the safeguarding system is to keep children safe, prevent harm and abuse and promote children's wellbeing into their future. If children do not feel confident that their concerns and disclosures will be appropriately heard and responded to they will not be effectively safeguarded.



4. Recommendations for MSCB to consider	
1.	<p>This review highlights the need for the development of a strength-based psychosocial approach to the identification and management of childhood obesity. The MSCB may wish to do this within its multi-agency programme by:</p> <ul style="list-style-type: none"> <li>• Ensuring Manchester’s Obesity Strategy is updated to take account of current research the need for psycho-social assessments and a multi-agency approach to tackle the problem.</li> <li>• Exploring the best approach to implementing the strategy.</li> <li>• Including in Manchester’s Neglect Strategy and its associated tools a specific focus on obesity as either a cause or symptom of neglect.</li> <li>• Providing specific guidance to enable all professionals to be able to evaluate when obesity should be considered a safeguarding concern.</li> <li>• Updating the current obesity protocol to ensure it includes the multi-agency management of obesity, use of a lead professional, the cultural and psychosocial aspects of obesity and the management of non-engagement with services.</li> <li>• Providing research based training as part of the management of obesity to support staff in how to manage “difficult conversations”.</li> <li>• Considering how training might be most effectively targeted and evaluated in relation to short and longer-term learning.</li> </ul>
2.	<p>The MSCB may wish to consider undertaking work around the effectiveness of the current approach taken by their partner agencies and staff in facilitating child focused practice, exploring known barriers and build on this work to support future child centred practice responses.</p>

## Appendix 1: Methodology, Authors and Process

This review has used the SCIE Learning Together model – a ‘systems’ approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective support and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in health agencies, and from 2006 was developed for use in case reviews of multi-agency safeguarding and child protection work (Munro, 2005; Fish et al, 2009).

The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit. The basic principles – the ‘methodological heart’ of the Learning Together model – are in line with the systems principles outlined in Working Together 2013:

- Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the ‘view from the tunnel’). What was influencing and guiding their work?
- Provide adequate explanations – appraise and explain decisions, action and inaction in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.
- Move from individual instance to the general significance – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency safeguarding system.
- Produce findings and questions for the Board to consider.
- Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

### Typology of underlying patterns

To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local systems are functioning. They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems.

Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

### **Anatomy of a finding**

For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency local safeguarding children board?

### **The Reviewers/ Authors**

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