7-minute briefing: Rapid Review about Child G

Background

Child G died in June 2020, aged 11, while receiving a service from Havering Children's Social Care under the statutory framework of a child in need (CIN) plan.

Initial concerns about her welfare had focused on the impact of conflict between her parents on her emotional wellbeing and safety. While Child G's case had initially been managed by the Early Help service, in January 2020 it was stepped up to a statutory CIN service in response to increasing concerns about her mental health. This followed a disclosure by Child G to health professionals about historical attempts to self-harm, and her presentation to them of low mood and poor self-esteem. Child G's last known weight, recorded in January 2020, was almost 114kg (almost 18 stone).

On an evening in June 2020, paramedics attended Child G's home in response to a 999 call by her father reporting that she was not breathing. Child G received medical treatment at the scene and after being transferred to hospital, but was pronounced dead in the early hours of the following morning. For some months, the cause of Child G's death was unknown as the initial post-mortem examination had been inconclusive, but it was not treated as suspicious and no safeguarding concerns were noted by the ambulance service, the hospital or the police. When Child G's post mortem was concluded in 2021, the causes of her death were confirmed as hyperglycaemia, diabetes and morbid obesity.

Rapid Review

Child G's case was referred to the National Child Safeguarding Practice Review Panel in June 2020 and, later that month, a multi-agency Rapid Review meeting was held to consider the circumstances surrounding her death and determine whether the following criteria were met for completing a statutory Child Safeguarding Practice Review (CSPR):

a) abuse or neglect or a child is known or suspected;
b) the child has died or been seriously harmed.

Learning

Although the cause of Child G's death was unconfirmed at at the time of the Rapid Review, it was assumed that obesity was at least a contributory factor; and, while the case was not considered to meet the threshold for a statutory CSPR, it did present opportunities for learning. Therefore, in July 2020, a multi-agency learning exercise was undertaken with the purpose of:

- continuing the work of the Rapid Review in establishing the sequence of events leading to Child G's death;
- identifying areas of both good and poor professional practice,

and translating these system learning;

- developing recommendations to ensure that the lessons learnt can lead to improvements.

Recommendations

1. National Child Measurement Programme screening completed by School Nurses in Reception and Year 6 should lead to children identified as severely obese being reviewed by a Dietician or Paediatrician.

2. A weight management programme should be commissioned to create a referral pathway for significantly overweight children in Havering.

3. When providing advice to parents regarding a health issue that may indicate neglect, Health Visitors and School Nurses should routinely follow up on whether the advice has been acted on, and follow child safeguarding procedures if there is evidence of non-compliance.

4. NELFT should produce an accessible guidance document to be disseminated across the multi-agency safeguarding partnership advising on healthy weight for children, and what a professional should do if concerned that a child may fall outside these parameters.

5. When sharing information regarding a child's weight across the multi-agency partnership, professionals should provide narrative detail and state explicitly if they consider a child's weight to be detrimental to their health or welfare.

6. The CCG should seek assurance that local GPs are able to identify serious health issues from information received from various sources and placed on a child's health record.

7. Children's Social Care should actively promote a culture where accepted narratives and established trajectories on cases can be challenged by new information, particularly the voice of the child.

More information on this Rapid Review is available in the Havering Safeguarding Children Partnership Annual Report 2019/20