Child F Deep Dive

BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

1. What is a 'deep dive'?

A 'deep dive is an in-depth investigation or analysis of a topic. It is employed as an audit technique to understand root causes and contributory factors where a person has been harmed or was at risk of significant harm.

In this case it has been used for a young man named F, who died suddenly of medical causes aged 18. This deep dive has reviewed contact records across F's life and considered support needs and service delivery for F and his family, including a focus on concerns that neglect may have been a factor in his life.

2. Background of young person:

F lived with his mother; his father was a regular feature in F's life. Historical Social Care referrals began when F was aged 6, reporting verbal/physical abuse by his mother and father. Later, when he was a teenager, there became counter allegations of fights, and F returning the abuse of his mother. He was in Child in Need planning at ages 9 and 13 – 15 years. He was known to Childrens' Services at 16 – 17 years. There were additional concerns about his health, parents not attending appointments and lack of engagement with professionals. On two occasions he had suffered broken bones through playing but wasn't taken to hospital for over a week after injuries occurred.

F was referred to CAMHS and for Prada Willi tests in 2015. He had moderate LD and was isolated at school with few friends - he related to staff better than children. He raised concerns over his weight and self-harming (picking skin) with the school nurse. Parents did not follow up medical tests or follow health advice for F and failed to engage with CAMHS after first appointment. F was morbidly obese at the time of his death.

3. Family background:

Parents were vulnerable, mum had historically been sexually abused by her uncle. There was a suggestion that both parents had LD, mum refuted this. Both struggled to read or write. Services thought dad was living with F – dad was a fostered child and was still living with his foster family in another town. Dad did not see himself as part of F's immediate family and did not intervene when F looked to him for help.

Mum had health issues and was overweight – F was caring for her during the lockdown. Mum normalised F's obesity. Parents did not support F in attending appointments and were wary around professionals with several occasions of disguised compliance.

4. Emerging Themes:

Family and family support - joining up working.
Harder to reach families.
Parenting capacity.
Neglect and abuse – physical/mental health and emotional wellbeing.
Engagement/disguised compliance.
Education.
Impact of Covid Lockdown.

5. Identified areas of Strength:

• Persistence of services in attempts to secure family's engagement.
• Assessments were appropriate and made in line with thresholds.
• All services responded to the referrals made to them and offered assessments and interventions.
• Some professionals recognised need to build a trusting relationship with F and tenacious efforts were made by individual colleagues to engage with F and the family over a long period of time.

6. Identified areas for Improvement:

• Plan review required in cases where there is lack of progress in support/plans, to reconsider strategy and practice to achieve outcomes.
• Information-sharing/use of family conferences to improve multi-agency oversight and joined up working.
• Learning for Barnsley College about the impact of covid lockdown on isolated students, particularly those without connectivity and positive family support
• Importance of key worker or advocate role in work with young people.
• •Communications between Adults & Childrens services. A joint protocol would support

7. Overall recommendations:

1. Support/plans for cases where there is insufficient movement to be peer reviewed to help progress to effective outcomes.
2. Share best practice strategies to address barriers and encourage family engagement.
3. Outline of the deep dive to be used as case study in Neglect Awareness and Family Engagement skills training.
4. Recording systems and professional curiosity to support information-sharing between services.
5. Audit findings to inform the Neglect Strategy.