Bury Safeguarding Children Board

7 minute briefing Aiden

The Safeguarding Board produces 7 minute briefings on various current safeguarding issues and learning from reviews. They are intended to be simple so that the reader can absorb the information easily and that teams can use them within meetings as a team based learning exercise.

They are based on a technique developed from the FBI. The content of the briefings will be a mixture of new information or a reminder/repeat of basic information which can help teams think about the application to practice.

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1. Background

Aiden was born in 2004 and was the elder of two siblings born to mother and father, Aiden's mother and father separated in 2011. Aiden lived with his mother at first and then went to live with his father around 2015. Mother and Father had children from previous relationships.
This Serious Case Review was commissioned by Bury Safeguarding Children Board (BSCB) as Aiden died of a pulmonary embolism in March 2018 aged 13 years old.

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2. Safeguarding Concern

Aiden's family had minimal contact with children's services, however there were no safeguarding concerns which warranted further intervention.
There were a number of issues relating to Aiden's weight and soiling in his early childhood and the family were receiving a service from the school nursing team. In 2015 Aiden was measured as all children are (as part of the National Weight Measurement Programme), he was recorded as 'very overweight'. The transfer information between primary and high school disclosed that there were concerns around hygiene and looking unkempt. During his first 18 months in high school, the school made referrals to the school nursing service regarding personal hygiene and weight management (parental consent was given). There were no reported issues in 2017. In February 2018 there had been a decline in Aiden's hygiene and a meeting was called in school where a referral to the school nursing service was agreed. It was disclosed that Aiden had an issue with soiling in his early years and this was ongoing.

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3. Incident

One morning in March 2018 Aiden fell in the snow and was not present in school, the next day he attended the GP. Aiden's feet were unhygienic and he was sent home to wash/bathe his feet and return. Once Aiden returned he was examined and diagnosed bilateral foot swelling and prescribed antibiotics and antifungal cream and blood tests were undertaken.
The next day Aiden collapsed outside his home, an ambulance crew found that Aiden had a cardiac arrest.

4. Findings

- Aiden's death was completely unexpected.
- Aiden seemed to be a popular pupil with friends who accepted him.
- Opportunities were missed throughout the period under review, and in Aiden's earlier years, to connect Aiden's weight management, soiling and the break-up of his family as potentially affecting his emotional health and wellbeing, and requiring assessment or referral. This was not viewed holistically as indicators of potential safeguarding.
- Agencies did not have a complete picture of Aiden's daily life and the Interactions with Aiden's family regarding weight management were sporadic and inconsistent.
- Opportunities were not taken to construct a complete picture of the changing circumstances of Aiden's lived experience and did not have an understanding of the exceptionally poor home conditions as no agency had a statutory right to enter the home.

5. Recommendations: Key Areas

- The LSCB should receive assurance that local commissioners and Public Health England, are sighted on the important role played by school nursing services as highlighted in this report. (All TORS)
- The LSCB should receive assurance from local partners that work to develop a whole system response (service pathway) to childhood obesity is commissioned. (All TORS)
- Assurance that protocols are in place for identification and assessment of children who may require support with emotional health and wellbeing (or mental health). This should include a specific child mental health obesity pathway, which takes into consideration other potential wellbeing issues (e.g. soiling). That the role of parents in supporting lifestyle change and engaging with services is made explicit within the local pathway.
- The LSCB should receive assurance that training and support for professionals in relation to childhood obesity are in place and that local safeguarding partners develop guidance that incorporates childhood obesity as a potential safeguarding issue.
- The findings of this report to be shared with the Chair of the Greater Manchester Health and Wellbeing Board to raise the profile of childhood obesity as a potential welfare issue.
- The LSCB should receive assurance that a robust system is in place for the transfer of relevant information across education settings. (NB In this case this involves transition from primary to high school, however the same system should be in place when children and young people move from one setting to another). (All TORS)

Full recommendations are detailed in the final report which can be found on the website.

6. What to do

- Professional curiosity supported by robust tools, policies and guidance for assessing parenting capacity and decision making are crucial to enabling professionals to make the right decisions at the right time.
- A holistic, child-centred approach to significant life events using 'Think Family' and 'Signs of Safety' should be used by practitioners.
- Practitioners should be aware of signs and symptoms when childhood obesity becomes a safeguarding issue. https://www.bmj.com/content/341/bmj.c3074

7. Questions to consider

- Consider if you are familiar with up to date research about obesity and when this becomes a safeguarding issue.
- Use this Review to engage staff in discussion and learning about obesity.
- Reflect on the findings and discuss the implications for your service/practice/school.