EXECUTIVE SUMMARY

OF THE LESSONS LEARNED FROM A REVIEW OF INTER-AGENCY WORKING WITH A CHILD IN ACUTE CARE

September 2015

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1 The review concerns a child who had a brain tumour and underwent surgery to remove the tumour at University Hospital Southampton. There was then some disagreement between hospital clinicians and the parents about further treatment which would include radiotherapy and chemotherapy. The parents wished for the child to receive proton beam therapy, which is not currently available in this country, rather than conventional radiotherapy[1]. On 28th August 2014 the child was unexpectedly taken from the hospital by his parents, without consultation or discussion with hospital staff. At this time the child was receiving all food and liquid via a nasogastric tube and the parents had not received training in its use. There were concerns that the parents were not able to manage the child's care and treatment without the support of hospital staff and his whereabouts were unknown. The child was therefore considered to be at immediate risk of significant harm. As a result, a multi- agency investigation was started. The next day the child was made a Ward of Court[2] following an application to the High Court by Portsmouth Childrens Services. Soon after Hampshire Constabulary made application through the Crown Prosecution Service for European Arrest Warrants against his parents. On 30th August, the family was located in Spain. The child was taken to a local Hospital and his parents were arrested and detained. On 2nd September the Crown Prosecution Service reviewed the case and the European Arrest Warrants were withdrawn and the parents were released and reunited with their son. Following a short series of High Court hearings it was agreed by the court and all parties, including the parents who were represented, that the child could receive proton beam therapy treatment in Prague and as such the court discharged the wardship.

2 The review concluded that in general agencies acted appropriately and that in the context that professionals were working there was little that could have been done differently. There were four main areas of learning identified: -

2.1 <u>Working in partnership with the family</u>

Analysis of records by staff within the Southampton hospital system clearly shows that staff worked hard to achieve a partnership with the parents. Nevertheless there is clear evidence that this relationship deteriorated over time. This resulted in the parents removing their child from hospital, without discussion with medical staff, in

[1] 1 Proton beam therapy is not the nationally recommended treatment for medullablastoma. For those conditions where proton beam therapy is recommended, the NHS arranges for children to travel to the USA for this treatment

[2] 2 In this context wardship means that the child is subject to the protective supervision of a court and to its orders made pursuant to that supervision. It also means that, if the court does not appoint a guardian for the child, the powers of a guardian (i.e., the power to make decisions of major legal importance) are exercised by the court as part of its wardship. [State v. Weidner, 6 Ore. App. 317, 321 (Or. Ct. App. 1971)].

order to take him abroad where they thought they would be able to access the services that they considered best met his needs. This action put him at risk. The question that therefore must be asked is whether there was any way in which the breakdown in trust could have been avoided. One factor that is relevant was a delay in obtaining a second opinion for the parents. Whilst the doctors' view that this was not needed immediately was accurate in terms of the child's clinical needs; this failed to take account of the indirect message that was given to the parents, which was that their wishes and rights were overruled by the professionals. T h ere were also some concerns about the parents' actions in criticising and disregarding nursing advice which needed to be addressed more directly. This should have included, if necessary, a formal meeting with them to discuss directly the worries that health professionals had about their willingness to accept guidance.

2.2 The use of legal powers

The significant experience of this review was the limitation of the current legal processes available to professionals working with children and families in these circumstances. The only legal mechanism available to safeguard a child who has been taken abroad is wardship which has restricted powers. In theory it can have effect in Europe, under The Hague Convention however this requires that the wardship order is served on the parents. This takes time and was not an option in this case, as the perceived immediate risk to the child's life, meant there was a need for urgent action. The other legal option was to request the Spanish Police to intervene and to detain the parents in order to check on the safety of the child. In this case, the Hampshire Constabulary were informally advised by the National Crime Agency that the Spanish Police would not take any action without European Arrest Warrants being in place which provided the Spanish police with a legal authority to detain the parents.. The purpose of the warrants was to arrest the parents for child neglect and technically to secure their extradition to the UK. Once the parents were arrested, the matter was managed by the Spanish judiciary and no UK agency had direct influence on the decision-making. Thus the only mechanism that was speedy enough to respond to the concerns was one where any discretion about the nature of the intervention was passed to a third party, the Spanish Police and Judiciary.

2.3 Partnership governance and media management

Whilst there was evidence of good partnership working to safeguard the child, an area for improvement was the multi-agency governance by senior managers of the management of the media. The safeguarding risks were appropriately managed via the 4LSCB child protection procedures, but these did not address the wider media concerns, and the need for senior management oversight because of the sensitivity of the case work decisions and the probable public interest. There is currently no multi-agency protocol that addresses the issues of risk to public confidence in service provision or considers the specific issues of responding to media concerns and interests. The existence of a multi-agency protocol of this type, had it existed,

could have prompted an appropriately senior, joined up governance. A multi-agency meeting of senior managers would have enabled a better oversight of the developing media interest in the case and could have allowed for earlier discussion of how to manage the negative feedback.

2.4 The child's experience

The breakdown in partnership working between the parents and health professionals resulted in their decision to remove the child, without warning, from the hospital. This journey must have been difficult and if anything had gone wrong the consequences would have been significant. The review provides an opportunity for professionals to reflect on the unintended consequences of decisions including the need for professionals to examine their actions from the point of view of the parent and child. Reassurance of patients and parents is a vital element of care and sometimes it is necessary to spend time enabling parents to get a second opinion even if it will not change the clinical outcome, in order that parents can feel that they have explored all possible avenues. It must also be acknowledged, however, that significant efforts were made to work with these parents. It is very difficult for parents to be sufficiently objective when making clinical decisions about their child and there are occasions when that dispassionate objectivity is best provided by professionals.

3 Conclusions

3.1 This review has identified that medical professionals worked hard to ensure the best outcomes for the child and his family. Unfortunately the parents felt that their wishes and feelings about his treatment were not being given sufficient priority and they chose to disengage from the medical professionals and remove him from the hospital placing him at risk of serious harm if anything untoward had happened with regard to the nasogastric tube. Professionals in the hospital attempted to accommodate the parents' wishes but did not respond speedily to their request for a second opinion. Additionally the parents were not happy with the feedback that they received from the hospital staff that the National Clinical Expert Group would not fund Proton Beam Therapy as it did not meet the criteria for financial support[3].

3.2 Once the parents had removed the child from the hospital there were limited options available to the agencies as there were real concerns that he was at immediate risk of significant harm. These concerns were partly a result of the parents concealing the actions they had taken to ensure his safety and were compounded by them failing to respond to attempts to contact them. The legal options available to agencies were draconian and did not allow for any flexibility in application.

[3] See footnote 1

3.3 It is clear that once the child was located and his parents were arrested senior leaders acted appropriately. However, the multi-agency partnership governance and media management could have been stronger. This was particularly important because of the significant degree of media interest which presented a challenge to most of the agencies involved and risked a loss of public confidence in child safeguarding in circumstances such as this. The review has identified a number of areas where practice by professionals could be improved and these are included in the recommendations listed below.

4 Recommendations.

4.1 That Portsmouth LSCB endorses the recommendations made by agencies with regards to changes within their organisations and receives regular progress reports regarding their implementation (Appendix A).

4.2 That Portsmouth LSCB requests that Government reviews the current civil and criminal legislative and procedural options available for professionals who are concerned about the safety of children taken abroad by parents or carers and about whom there are safeguarding concerns.

4.3 That Portsmouth LSCB in conjunction with Chief Officers from all member agencies reviews protocols to enable multi-agency governance and management of critical incidents involving the safeguarding of children where there are risks to public confidence in any agency and there is likely to be significant public interest.

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Appendix A

University Hospital Southampton

1. Development and implementation of guidelines to formalise the agreed leave of absence from the pediatric wards. These specify arrangements for children to leave the ward area in the company of their parents or an approved adult. Their destination, time of return and contact details must be recorded and signed by the accompanying adult. Written guidelines will be available so that the accompanying adult is aware of their responsibilities and the likely response if the conditions of leave are not complied with
2. Reflective practice. It is recognised that there is also useful personal learning from this incident for individuals involved in the incident; who will be asked to perform personal reflection on it and produce written reflective practice to facilitate personal professional development and consolidation of learning. Specific areas to reflect upon include process of obtaining second opinions and discussing psychological support with patients.
3. University Hospital Southampton needs to continue to provide psychological support to those staff involved in this episode.
4. Referral to Proton Beam Panel should happen routinely for families who request Proton Beam Therapy. It will then be clear that the responsibility for the funding decision does not rest with University Hospital Southampton
5. Reviewing University Hospital Southampton guidance for patient support services with regard to dealing with and sharing confidential or sensitive matters

Portsmouth City Council

1. While Portsmouth City Council's communications team had a clear strategy in relation to managing the media around the child concerned, the strategy was not documented. In future significant media incidents' strategies will be documented to support learning and review.
2. The council's protocol for dealing with serious issues relating to children is being reviewed and will include provision for the inclusion of communications staff in key strategy meetings so potential media handling is considered contemporaneously.

Hampshire Constabulary

1. The senior police commander responsible for an incident should consider appointing a dedicated media lead in cases of complex and protracted critical incidents, in order that he/she is able to focus on the broader strategic governance issues and multi-agency coordination.
2. There is a risk that as a result of the political and media commentary on this case (including personal commentary on both the Senior Investigating Officer and Police Commander) that police services in future may be reluctant to use European Arrest Warrant in these circumstances. Police decision makers utilised the National Decision Making Model and the Association of Chief Police Officers risk based principles throughout this investigation. It is vital that the facts and the rationale around decision making is open to all via the learning review findings.