7 - minute Learning Summary

Serious Case Review - Child Frankie

Case Summary

Frankie died aged 3 years in July 2016. The London Ambulance Service (LAS) was called to the family home, resuscitation attempts were made. Frankie was then transferred to hospital where despite ongoing resuscitation attempts Frankie died, cause of death was recorded as an "acute exacerbation of asthma." The toxicology screen was negative.

Frankie had a history of acute episodes of asthma, frequent admissions to hospital with some periods of stability. Frankie required care on the Paediatric High Dependency Unit on a number of occasions and his asthma was considered by health professionals to be life threatening.

Mr and Mrs F moved to the UK in 2009. Frankie was born in November 2012. Frankie had one older sibling. Between two-four months of age, Frankie was taken to the GP with viral illnesses of cough and coryza managed with advice and support. Frankie was seen again at 15 months with a further viral upper respiratory tract infection. The GP was informed that neither Frankie or the older sibling had been immunised due to fears over MMR and links to Autism. Despite reassurances from the GP regarding falsified evidence around MMR and Autism and discussing the risks of not protecting Frankie with immunisations Mr And Mrs F remained fearful of possible side effects. They continued to refuse immunisations offered to Frankie and did not attend a follow up appointment or engage with the Health Visitor .

Mr and Mrs F were both professional, affluent, articulate and willing to challenge the health professionals. They had a nanny caring for their two children and were not known to Police or Children's social care services. Frankie continued to attend the GP with breathing difficulties. There were periods reported by Mr and Mrs F that Frankie was stable at home, and that the asthma generally worsened in the summer.

In June 2014 Frankie, then 18 months old, was taken to the GP by the nanny. This was the first discussion the GP had about wheeze and "distress in breathing" (DIB) The GP advised the nanny to attend the Emergency Department (ED) if Frankie's breathing worsened.

In August 2014, Frankie attended the ED with serious breathing difficulties. Frankie had been seen by the GP 6 days prior and antibiotics had been prescribed. Frankie's parents did not administer the antibiotics, Frankie spent a long period in Hospital 1 with high dependency care. At this point Frankie was referred to the respiratory team led by (Dr C) an experienced Respiratory Consultant based at Hospital 2 who was also a visiting consultant at Hospital 1.

Frankie was diagnosed with infantile brittle asthma with severe wheezing and discharged home on inhaled steroids. Frankie was subsequently seen by Dr C as an out patient. (Hospitals were not located in Wandsworth))

Frankie had twelve hospital admissions to Hospital 1 from the age of 20 months until death, all attendances were associated with severe asthma. On six of these admissions Frankie required admission to the Paediatric High Dependency Unit. Frankie required resuscitation on at least three occasions. Frankie had also previously stopped breathing at home. Frankie's last admission to hospital had been on 3 July 2016 Frankie was acutely unwell having been found limp and foaming at the mouth.

Mr and Mrs F had been informed that Frankie's asthma was a life-threatening condition requiring medication. At the time Frankie died there was no clarity around whether medication was being administered at home or whether alternative therapies were being used. There are numerous instances recorded where the Mr and Mrs F declined, reduced or stopped giving medication to Frankie. The noncompliance of the parents to administer medication as advised did raise concerns ,this was not picked up in a concerted way by professionals and was not referred for any safeguarding consideration in relation to medical neglect.

Recommendations from the SCR

1. All Lead Directors for providers submitting IMR's must have oversight and sign off the reports to ensure that they are of good quality and to enable learning to be taken forward in a timely way.
2. Hospitals to explore how clinical teams manage parent consent for emergency treatment.
3. Hospitals must review how it manages severe illness in children when a parent favours alternative therapy.
4. Hospitals must review how ward staff act when there has been an incident of a parent administering medication, on the ward, to a child outside of the treatment plan.
5. The paediatricians at hospitals must undertake a reflective session to consider in what circumstances they would seek legal advice regarding parents who do not consent, and who would make the decision to escalate.
6. Acute Trust Boards must review how the clinical teams are supported in their decision-making regarding treatment when the parents do not agree with the treatment plan.
7. GPs and Health Visitors must have an agreed plan when following up issues of concern with families.
8. All services must be able to evidence how their workforce participates in reflective safeguarding supervision which supports their

What did we learn ……..

Vulnerabilities

Frankie's parents were both affluent professionals. They employed a nanny to look after their two children. There were no known health or disability concerns for either parent. There is also a paternal grandmother however we do not know how involved she was with the family.

Frankie's parents had been reluctant to fully comply with medical advice and prescribed medication. They had a fear of steroids and declined or reduced various medications over Frankie's numerous admissions to hospital. The health care professional were seriously concerned, however this was not considered a safeguarding issue and was never escalated to Children's Social Care. Much blame was attributed to the parents. The influence of affluence has to be considered, as no questions were asked of the parents in regards to the homeopathic medications they purported to be using on Frankie. The type of challenge that is afforded to families with lower class status, widely differs to the deference given to these parents who were viewed as equals. Frankie was not referred for any safeguarding consideration in relation to medical neglect.

Health

Under the Children Act 1989 as amended, the term "parental responsibility" is defined as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". This is a qualified right and in some instances the courts must intervene to protect a child where parental responsibility is not exercised in a way that meets the best interest of the child and puts them in harm's way. The law is clear that if the child is suffering or likely to suffer significant or serious harm due to acts or omissions of a parent or indeed others all agencies and professionals have a duty to act to protect the child

Multi agency

Initially a Rapid Response meeting was held, the family were not known to Police or Children's Social Care, there were no safeguarding concerns identified. The case was reviewed by the Children's Death Overview Panel (CDOP) following delays, including awaiting a full Post Mortem) Frankie's death was finally reviewed and closed in March 2017. Wandsworth Local Safeguarding Children Board Serious Case and Learning Sub-Committee (SCIL) were recommended to review the case. The WSCB concluded that the case meets the criteria for a Serious Case Review (SCR), as outlined in Working Together to Safeguard Children 2015.

Education, Training, Research Resources

The criteria for SCR/CSPR's are now contained in the updated Working Together to Safeguard Children published in 2018

All equality aspects were reviewed no information or inference indicated that any incidences were motivated by any of the 9 protected characteristics (or other diversity factors)

However, the approach that professionals adopted towards the parents in considering their opinions and position in relation to the treatment of their child's condition was overly deferential and lacked robust challenge.

Working Together Safeguard Children published in 2018

Bernard, C. and Greenwood, T. (2019) Recognising and Addressing Child Neglect Affluent Families, *Child & Family Social Work*, 24 (2): 340-347.

Play interventions to reduce anxiety and negative emotions in hospitalized children • William H. C. L, Joyce Oi Kwan Chung, Ka Yan Ho and Blondi Ming Chau Kwo

A copy of the full report is available from the Wandsworth Safeguarding Children Partnership website.

Voice of the child

Understanding of Frankie's lived experience was limited. Following the Health Visitor visit in December 2012, no other professional observed Frankie in his home setting. Frankie had one older sibling who was home educated at the time. Frankie was very young child who may not have fully understood the illness and the restrictions this placed on Frankie's life, however this impact should not be underestimated. Frankie's condition would have been disruptive to daily routines, early learning and play. Frankie had repeated admissions to hospital as the condition was largely uncontrolled and had a high number of admissions where Frankie's breathing was severely compromised. There is much research documenting the potential negative psychological, physical and emotional impacts of hospitalisation upon a child.

Impact

The following 3 questions are suggested to promote discussion:

1. What are your key thoughts and reflections?

2. How can we ensure the learning is embedded and how will we know this?

3. How can we integrate the learning into team or service improvement plans?

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