Bury Safeguarding Children Board

Serious Case Review in Relation to Aiden

Final Report

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1st March 2019

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1 Introduction

The Review Panel offers condolences to Aiden's family and friends on his tragic death and thanks them for their participation in the review.

This Serious Case Review is conducted under guidance set out in Working Together to Safeguard Children (2018) and relates to agency involvement with Aiden, who died in March 2018. Aiden was 13 years old at the time of his tragic death.

1.1 Incident Leading to the Review

On a day in March 2018 Aiden collapsed outside his home. An emergency ambulance was called to Aiden's home by his father.

Father reported that he and Aiden were going out and he had gone to bring the car round to the front of the property. Father later told paramedics that in the previous few days Aiden's feet had been swollen and he was having some difficulty walking.

When father returned in the car, he found Aiden outside the house and on his knees, (father thought Aiden may have fallen down a couple of stairs as, because of his swollen feet, he was wearing father's slippers at the time).

Father asked Aiden if he was OK and he said yes. Aiden then said 'I'm not sure'. Father became concerned and rang for an ambulance. Whilst father was on the phone Aiden collapsed and appeared to stop breathing. The emergency ambulance call taker advised father to attempt to resuscitate Aiden and a passer-by also assisted, until paramedics arrived at the scene.

On arrival the ambulance crew found Aiden in cardiac arrest. Aiden was immediately transported to hospital by emergency ambulance. Attempts to resuscitate Aiden were made by paramedics on route to the hospital, however tragically these attempts were unsuccessful. On arrival at the hospital further attempts were made to resuscitate Aiden, however these were also unsuccessful and Aiden was sadly pronounced dead at hospital.

Following Aiden's tragic death, police visited father at home. The home conditions were observed to be exceptionally poor. Father told police both that he and Aiden had been sleeping in the living room and that Aiden slept in a reclining chair. The room in which they had slept was heavily cluttered with cardboard, paper and food cartons. There were also signs of faeces in the room and in other rooms in the property and it was observed there was a noticeably strong smell in the room.

1.2. Sudden Unexplained Death of a Child (SUDC) Meeting following Aiden's death

As is usual practice in cases of sudden unexplained death of a child, a SUDC meeting took place to review Aiden's death. The Serious Case Review has seen minutes of the SUDC meeting which detail the examination of Aiden's body following death.

Within the minutes of the SUDC meeting, observations are made regarding Aiden's physical condition after his death, which include Aiden's weight and body mass index. Aiden was noted to be significantly above the weight range for his age which placed Aiden in the category of severely obese.

The report from the SUDC meeting makes reference to information being provided by father which indicated that Aiden had experienced difficulty with soiling (encopresis) from around age 6 (the review has seen other information that suggests the issue had been ongoing from an earlier age). Father indicated that the family had initially sought help, and had been referred by the GP to a Paediatrician, who had advised on a management programme. Two follow-up appointments were offered, however Aiden was not taken to these, resulting in no further contact with the service.

A brief social history was included in the notes of the SUDC meeting which confirm that the family did not have contact with Children's Social Care (CSC). The report noted that safeguarding enquiries were being made in relation to Aiden's younger sibling, which is usual in such circumstances. The report also notes the exceptionally poor conditions in the home conditions, which were described as squalid.

2 SCR Methodology and Parallel Processes

2.1. Decision to undertake a Serious Case Review

At a meeting of the Bury Serious Incident Review Panel following referral of Aiden's death, the decision was taken to undertake a serious case review.

In September 2018 the LSCB Chair wrote to the National Panel for Serious Case Reviews to inform them that a review was taking place. The National Panel indicated that the review would be of national interest and asked to be kept informed of progress.

2.2. Period under review

The review focuses on the period from Aiden's transition to high school in September 2014 until his tragic death. Historical events are included in the chronology where they have specific relevance to the terms of reference.

2.3. Terms of Reference

A scoping meeting took place in October 2018 where the following terms of reference were discussed. These TORs were agreed at the first meeting of the SCR panel in October 2018.

- Did agencies have a complete picture of Aiden's daily lived experience? Was Aiden spoken to about his daily lived experience? Did agencies understand what Aiden wanted?

- How could the 'voice of the child' have been strengthened in this case?

- Were agencies sighted on any issues within Aiden's home environment and family life that may have raised safeguarding concerns?

- How did agencies work with Aiden's family to address his presenting needs?

- How might this be done differently in future?

- Did agencies respond appropriately to issues of weight management, including speaking to the child and family regarding potential associated medical problems?

- If not, why might this be and what could be done differently in future?

- Did agencies give appropriate consideration to Aiden's emotional health and wellbeing? If so, what actions were taken in this regard? If not, what could be done differently in the future?

- Did agencies give consideration to wider safeguarding issues including neglect?

- What multi-agency working took place? Was this robust and of a good quality?

- What is the role of school nursing in co-ordinating care for children such as Aiden?

- How can pathways of care be strengthened to respond to the needs of children such as Aiden?

- Are there any other aspects of agency involvement with Aiden that offer learning for the future?

2.3. Methodology

The review used a blend of systems review methodology developed by the Social Care Institute for Excellence (SCIE) and the Welsh Model for Child Practice Reviews[1].

An integrated chronology of significant events was compiled from agency records, and a key events timeline was agreed.

[1] http://cysur.wales/home/child-practice-reviews/

Two practitioner learning events were held, in December 2018 and February 2019 which brought together professionals who had involvement with Aiden and his family. Both sessions were well attended and practitioners made valuable contributions to the review.

The Lead Reviewer and LSCB Business Manager met with Aiden's father in January 2019. Aiden's mother had also attempted to participate in the review but found this too upsetting. Aiden's mother was offered a further opportunity to participate, either through a one to one meeting or by writing her thoughts down for inclusion in the review. At the time of writing mother has not yet participated in the review. Father's views are summarised at section 2.6 below and included throughout the report as appropriate.

A meeting will be arranged with family members before publication of the report.

2.4 Sources of information to the review

The following agencies provided information to the review:

- General Practitioner for Aiden (chronology report and participation in practitioner events), NHS Bury Clinical Commissioning Group
- Primary School (written information and participation in practitioner events)
- High School (chronology and participation in practitioner events)
- Pennine Care Foundation Trust (chronology and participation in practitioner events)
- Pennine Acute Foundation Trust (chronology and participation in practitioner events)
- Greater Manchester Police (written information regarding home visit)
- North West Ambulance Service (NWAS – chronology)

2.5 Parallel Processes

2.5.1. Post Mortem

A post-mortem was conducted which concluded that the cause of Aiden's death was 'embolus' as the primary cause of death, with obesity as a secondary factor.

2.5.2. Coronial Matters

Aiden's death was referred to the local Coroner. Based on the available information the Coroner decided not to conduct an inquest into Aiden's death.

The Coroner has asked to be kept informed of the findings of this Serious Case Review.

2.6. The Views of Aiden's family

Aiden's mother and father were invited to contribute to the review and separate meetings were arranged to speak to them.

As set out earlier in this report, mother found the meeting very difficult and it was agreed that the reviewer would either meet with her at another time or provide opportunities for her to contribute in another way.

Aiden's father kindly attended a meeting with the reviewer and the LSCB business manager. He spoke with great warmth and affection about Aiden who he described as his 'best friend'.

Father talked about his disappointment with the press who had pursued him for Aiden's 'story' which he felt had then been sensationalised.

Father described Aiden as a 'cracking lad' who was bubbly and sociable and had a good group of friends, although father said that underneath his sociability Aiden was quite a shy boy at heart. He said that Aiden was sensitive and caring and that he would always be on hand to help someone out if they needed him. Father said Aiden was a popular boy and known for being kind and caring.

He confirmed that Aiden had come to live with him when mother moved to another part of the country with Aiden's younger sibling. Father said that Aiden had said he wanted to stay with his dad and that it worked for them both. They shared interests and Aiden accompanied father to work when he was not at school. Aiden spent time a lot of time in the car waiting for dad and accompanying him on his delivery jobs. Father said that Aiden was quite happy doing this, and that he would play games on his mobile whilst in the car. Aiden and father also spent a lot of time together supporting football teams and were season ticket holders.

Aiden enjoyed school and had settled in well to high school. He had an excellent record of attendance, and father said that he made sure that Aiden attended school and was strict about this. Aiden had begun to get involved in sports at school, a teacher had taken a specific interest in Aiden to encourage him to get the most out of physical activity, and had recommended that father encourage physical activity out of school hours. Father said that Aiden was physically active and that, because of this, he didn't worry about Aiden's weight too much as he thought that the physical activity would balance this out.

When asked about Aiden's awareness and feelings about being overweight, father said that this didn't seem to bother Aiden. He said that Aiden didn't eat a lot of junk food, however father did mention that they often bought meals in from 'fast food' outlets, and that they ate 'take-away' once a week. Father mentioned that they had a special bin in the lounge for food disposal but that Aiden didn't always use this and it was sometimes messy. Father felt that the

main cause of Aiden's weight gain was sugary fizzy drinks, saying that he and Aiden shared a large bottle of a particular brand every day.

Regarding Aiden's soiling difficulties, father said that this had been a problem that went back to Aiden's childhood, and that there did not seem to be a solution to it. Father talked about contact with services who had said that Aiden was not purposely soiling. Father said he just accepted this, (he mentioned that mother didn't take the same view, and that she wouldn't have accepted the ongoing issue if Aiden had been living with her). Father said that Aiden was self-conscious about the issue, but that they didn't discuss it and just tried to manage it on a day to day basis.

Father told the review that in the few days before Aiden's tragic death, Aiden's feet had become very swollen and he had difficulty walking.

On the Thursday and Friday of the week before his death, Aiden's school was closed due to severe weather conditions. On the following Monday father rang in to school to say that Aiden would not be coming in for health reasons. The following day father decided to take Aiden to the GP, who examined him and took blood.

Father spoke about the day of Aiden's death and the events described earlier in this report. He said he became very concerned and rang the ambulance. He said he knew that Aiden was dead before they arrived, and described the time it took waiting for the ambulance when he was trying to resuscitate Aiden. Father felt that the ambulance had taken a long time to arrive (27 minutes from the call to arrival).

In summarising the lead reviewer asked father what learning he felt could be gained from the review that might help children such as Aiden, and avoid tragedies such as this from occurring in the future? Father said that agencies had been supportive. He said he wished that he had had more time with Aiden at the hospital, rather than all the attempts to resuscitate him. The reviewer asked if father thought that Aiden would want to say anything to the review. He said that Aiden would say 'don't have sugary drinks' but who wants to drink water?

2.7. Terms of Reference

The following terms of reference were agreed at the commencement of the review:

2.7.1. Daily Lived Experience (Voice of the Child)

TOR 1:

Did agencies have a complete picture of Aiden's daily lived experience? Was Aiden spoken to about his daily lived experience? Did agencies understand what Aiden wanted?

TOR 2:

Were agencies aware of any issues within Aiden's home environment and family life that may have raised safeguarding concerns?

TOR 3:

How did agencies work with Aiden's family to address his presenting needs? How might this be done differently in future?

TOR 4:

Did agencies give consideration to wider safeguarding issues including neglect?

2.7.2. Medical and Psychosocial Issues

TOR 5:

Did agencies respond appropriately to issues of weight management, including speaking to Aiden and his family regarding potential associated medical problems? If not, why might this be and what could be done differently in future?

TOR 6:

Did agencies give appropriate consideration to Aiden's emotional health and wellbeing? If so what actions were taken in this regard? If not, what could be done differently in the future?

2.7.3. Agency Working/Systems

TOR 7:

What multi-agency working took place? Was this robust and of a good quality?

TOR 8:

What is the role of school nursing in co-ordinating care for children such as Aiden?

TOR 9:

How can pathways of care be strengthened to respond to the needs of children such as Aiden?

TOR 10:

Are there any other aspects of agency involvement with Aiden that offer learning for the future?

2.8 Sources of information to the review

The following agencies provided information to the review:

- General Practitioner for Aiden (chronology, written information and participation in practitioner events)
- Primary School 2 (written information and participation in practitioner events)
- High School (chronology and participation in practitioner events)
- NHS Bury Clinical Commissioning Group (chronology and participation in practitioner events)
- Pennine Acute Foundation Trust (chronology and participation in practitioner events)
- Pennine Care Foundation Trust (chronology and participation in practitioner events)
- Greater Manchester Police (written information regarding home visit)
- North West Ambulance Service (NWAS – short report)

The review has also consulted relevant research, together with local and national policy and guidance in relation to childhood obesity and weight management, obesity as a safeguarding issue, soiling as a presenting difficulty in adolescence, and child mental health and emotional wellbeing. References are cited throughout this report and summarised in Section 6.

2.9. **Weight Stigma**

The review recognises that the issue of childhood obesity may be construed as contentious and has used the following position statement from the national Obesity Health Alliance as a guide in addressing obesity as a factor in this SCR.[2]

Weight bias is defined as negative attitudes towards, and beliefs about, others because of their weight.

Stigma can take place in a multitude of environments including; the workplace, health care facilities, educational institutions, the mass media, and interpersonal relationships.

Weight stigma has been known to impact children as young as three years old. Weight stigma exists because our society; blames the victim rather than addressing the environmental conditions that cause obesity; values thinness and perpetuates the assumption that a person's lack of willpower is the reason for their obesity; and allows the media to portray people with obesity in a biased, negative way. Evidence indicates that weight stigma can be harmful to individuals' wellbeing, with psychological, behavioural and social consequences for those affected by obesity.

[2] http://obesityhealthalliance.org.uk/wp-content/uploads/2018/10/Weight-Stigma-Position-Statement.pdf

3. Agency contacts with Aiden and his family

3.1 Context (Contact with agencies from birth to 2014)

Aiden's birth and early development appear to have given no cause for concern amongst professionals. He was the middle child in a family of three siblings. Aiden also had an older half sibling from father's previous relationship. It appears that Aiden's family moved to Bury in 2006.

When Aiden was around 4 years of age (2009) he was recorded by the National Child Measurement Programme (NCMP)[3] to be above the healthy weight range for his age.

At a routine screening by the NCMP in June 2009, Aiden was recorded as being 'very overweight'. There is no indication of any specific action being taken to address Aiden's weight at this time, although the review has learnt that the NCMP would routinely issue a letter to parents, informing them if their child was above the recommended weight range, and offering further guidance on weight management.

Aiden was diagnosed with asthma in his early years and continued to receive treatment from his GP until adolescence.

Aiden initially attended Primary School 1 from 2007 to 2008. He then moved to Primary School 2 in 2008, and remained there until 2014 when he transitioned to high school.

Records from Primary School 2 show that Aiden experienced difficulties with regard to soiling throughout his time at school. The review saw numerous written records made by the school, together with accounts of their liaison with Aiden's parents in relation to this ongoing difficulty.

It was noted that Aiden was subjected to bullying whilst at primary school. This was thought by school to be associated with what were perceived as personal hygiene issues, and with Aiden being overweight.

In 2010, Aiden's parents consulted the GP with regard to Aiden having some difficulty with toilet training. The GP offered advice and guidance, and suggested a plan for supporting Aiden with toileting. A further consultation took place later that year, where Aiden's mother expressed concern that Aiden may have a phobia with regard to using the toilet.

In 2011 Aiden's parents separated. In some of the records seen by the review there are indicators of domestic abuse in the relationship, however there were no incidents reported to police or other services.

Following the separation of his parents, Aiden lived with his mother and younger sibling. Father told the review that, at this time, Aiden spent a lot of

[3] https://www.gov.uk/government/collections/national-child-measurement-programme

time visiting him. Mother began a new relationship and it appears (from the Social Care record) that her new partner lived with the family.

In March 2012, Aiden's GP made a referral to a Consultant Paediatrician at the local hospital regarding Aiden's ongoing difficulties with soiling.[4] The GP referral also contained information that Aiden was being bullied at school.

At this time the School Nurse and Deputy Head Teacher at primary school 2 discussed ongoing difficulties with soiling, and planned to contact Aiden's parents to invite them to discuss how best to support Aiden, however the review did not see any evidence that parents were invited to a meeting, or that a meeting took place.

On 15th May 2012 Aiden was reviewed at the local General Hospital following the GP referral. A history was taken from Aiden's mother, who explained that he had some early difficulties with toilet training but had opened his bowels normally from the age of 4 years until November 2011 (age 6), at which time there were issues of bullying at school regarding Aiden being overweight.

During the consultation with the Paediatrician it was noted that the incidents of soiling were twice daily at home and also, more recently, at school. It was noted at the consultation that Aiden appeared well although slightly anxious, he had been biting his nails and chewing the sleeve of his jumper.

Behavioural strategies were discussed, and the need for consistency when spending time with either parent was emphasised. The plan was that progress would be reviewed in three months' time. An appointment was offered however Aiden was not taken to this. A subsequent appointment was also offered, however Aiden was not taken to this appointment.

There is no record in the notes at this time of any enquiry regarding Aiden's emotional health and well-being. Nor is there any indication that consideration was given to a referral to Child and Adolescent Mental Health Services. It would have been good practice to have considered mental health and emotional wellbeing, and to have given Aiden an opportunity to discuss how he felt about the difficulties that he was experiencing.

On 25th May 2012, the school nurse wrote to Aiden's mother to invite her to school to discuss the ongoing issues relating to soiling. No response was received to this invitation, and a further written invitation was sent for an appointment on 29th June 2012. There is no record of whether this appointment was attended by mother.

In July 2012 a member of the public made a call to CSC regarding concerns about a 'boy' who resided at mother's address being seen 'hanging out of the bedroom window'. The caller also reported that parties were taking place and that they had heard mother shouting at 'the children' and using bad language.

[4] https://www.nice.org.uk/guidance/cg99/chapter/introduction

The following day CSC conducted an unannounced home visit, where mother and both children (Aiden and his younger sibling) were seen. The social worker who undertook the visit noted no concerns regarding the presentation of the children, or regarding the home conditions.

Mother refuted the allegations made by the neighbour (she said she had lived at the property since August 2011). Mother reported that the children stayed with their father every Tuesday night. She told the social worker that her partner lived with her and the children at the property.

The social worker requested sight of Aiden's school report and noted that he was doing well. Aiden's younger sibling was noted to be starting school in September. There is no indication that either child was spoken to in order to ascertain their feelings and wishes. It would have been good practice to speak to the children in order to understand their daily lived experience.

The social worker concluded that there was no evidence to suggest any safeguarding issues in respect of the children. Advice was given to mother regarding ensuring the safety of the children. Mother said that she believed that the call was made by a malicious neighbour. There is no indication that the social worker followed up any further enquiries regarding mother's partner and his relationship with the children. It would have been good practice to have made such enquiries to ascertain whether home arrangements were safe and suitable for the wellbeing of the children. Following the visit it was agreed with the Team Manager that no further action would be taken.

In September 2012, police were called to mother's address regarding an altercation between mother's partner and his brother. Police attended and found 'both parties' highly intoxicated. A DASH risk assessment was offered and refused by mother's partner, who was recorded as the victim. It was noted that the children were not previously known to CSC and that the children were not present at the time and therefore did not witness the incident. Police referred the incident to CSC in line with policy. CSC recorded the referral for information only and no further action was taken.

In March 2013 the GP made a referral to the Children's Community Nursing Team (CCNT) service regarding Aiden's ongoing difficulties with soiling. The CCNT referred on to the specialist Continence Service, who in May 2013 service Aiden as having chronic constipation and offered treatment advice.

Two further appointments with the service were offered but neither of these were attended.

In June 2013 Ambulance Services were called to an incident involving Aiden's older sibling. The incident did not take place in the family home and it appears that Aiden was not present when the incident took place.

In around 2014 mother moved to another part of the country and Aiden's younger sibling moved with her. Father told the review that, at this time, Aiden decided that he wanted to live permanently with father, and moved in

with him. It appears that this was an informal arrangement in the family and did not involve any legal process regarding care or custody of either Aiden or his younger sibling.

3.2 Agency contacts from 2014 to the date of Aiden's death

2015

In March 2015, Aiden was measured by the NCMP and was recorded as being 'very overweight'. A letter was sent to his home address to advise that his parents or guardian should contact 'School Health' if they required any support with weight management. There is no indication of any response from Aiden's parents to this letter. At this time Aiden was now living permanently with his father (it is not clear whether mother was still living in another part of the country or whether she had returned to the local area).

In May 2015 a transition meeting was held between Primary School 2 and the Head of Year from the High School that Aiden would be joining in September 2015. At this meeting Primary School 2 verbally shared information that Aiden had been subject to bullying, and that there were some issues in relation to weight management. Information was shared that mother had moved to another part of the country with Aiden's younger sibling, and that Aiden was now living with his father. No information was shared regarding Aiden's difficulties with soiling.

Primary School also shared information that there had been concerns around hygiene and that Aiden sometimes looked unkempt. It was also noted Aiden was the only child from Primary School 2 who would be transitioning to the High School, and that Aiden had a cousin who was a pupil at the High School.

Following transition to High School, in late September 2015 the Head of Year asked Aiden's form teacher to speak to him regarding personal hygiene, as other pupils had commented on this. Aiden's form teacher spoke to him about this and the Head of Year spoke to Aiden's father.

2016

In April 2016, Aiden's form teacher made a referral to the school nurse regarding Aiden's weight management and personal hygiene. Aiden's father gave consent for the referral however Aiden was not aware of this referral.

On 17th May, the school nurse telephoned father regarding the referral. Father requested that a subtle approach be used with Aiden to addressing the issues raised.

On 18th May, the school nurse held a face to face consultation with Aiden in school. The school nurse explained to Aiden that she was seeing some year 7 students to see how they were settling in, and to provide information about the school nursing service.

In discussion with the school nurse, Aiden said that he liked school and that he had no concerns in relation to bullying. The school nurse discussed dental hygiene and ophthalmology screening with Aiden. General growth, body care and hygiene and its importance were also discussed and Aiden said that he was aware of puberty and the changes that would occur. They talked briefly about the changing body, the importance of clean clothing. Aiden reported that he slept well, ate well and that he ate a school meal each day, the benefits of healthy eating were discussed.

Aiden was made aware that he could approach his form teacher if he had any concerns. Aiden reported he lived at home with father, that he had an older sibling (it is not clear whether Aiden said where the older sibling lived) and a younger sibling who lived with his mother in another part of the country.

Aiden reported that all was ok at home and at school. He reported no medical conditions and no allergies. Aiden said had no questions to ask the school nurse. He was informed he could drop in to see the school nurse at lunchtime or could ask a member of school staff to be seen if needed.

On 6th October, one of Aiden's teachers raised a concern (with the Head of Year) regarding Aiden's weight management and hygiene, and a further referral was made to the school nurse. Arrangements were made for Aiden to have a separate changing area in PE sessions. It was noted that this resulted in a significant improvement in Aiden's participation in PE lessons.

On 16th November a meeting was held with father to discuss concerns about hygiene and weight management, and it was suggested that father encourage more physical exercise at home. Father agreed to referral to the school nurse and the GP and that he would support Aiden with increased physical exercise. There is no indication that father followed up making an appointment with the GP**.**

2017 There are no reported issues at school or any other agency contacts during 2017.

2018

In February 2018, the Head of Year called a meeting with Aiden's father, as there had been a noticeable decline in hygiene standards following the recent school holiday.

Father agreed to a referral to the school nurse and shared information regarding Aiden having had soiling problems in his early years, which father said were ongoing. An appointment was made for Aiden to see the school nurse the following day, however he did not attend the appointment. A further appointment was arranged for the following week.

On 5th March, Aiden's father rang school to say that Aiden had fallen in the snow and had hurt his feet, and that he would not be attending school that day. (Father did not recall that he told school that Aiden had fallen).

On 6th March, Aiden attended an appointment with the GP saying that he had swollen and sore feet. Aiden was accompanied at the appointment by his father. The GP was initially unable to fully examine Aiden as the condition of his feet was unhygienic, therefore the GP requested that Aiden return after bathing his feet, to enable thorough examination.

Aiden returned later and was seen by the GP, who diagnosed bilateral foot swelling. Aiden told the GP that he did not have an injury but had been struggling to walk this morning. The GP noted that there were no skin breakages to the feet but that both feet were warm. The GP was concerned that Aiden might be developing cellulitis and prescribed antibiotics and antifungal cream. He also arranged for Aiden to return later that day for blood tests (which Aiden did). He also noted that Aiden had psoriasis.

Father telephoned school to say that Aiden was having difficulty walking, and that they were awaiting the results of blood tests.

The results of the blood tests were received by the GP the same day. Nothing was shown that gave the GP any cause for concern, and this was communicated to Aiden's father. A review was arranged for 8th March.

On 7th March the events leading to this review took place.

4. Learning from the Review

4.1. Overview

The review learnt that Aiden experienced a number of challenges in his life, however he presented to professionals who knew him as a sociable and happy child, who had a close relationship with his father, with whom he lived from around 2014 until the time of his death. The review heard that father changed address frequently, although it has not been possible to verify the reasons for frequent changes of address.

From approximately age four, Aiden was above the expected weight range for his age. It appears that Aiden continued to gain weight throughout his childhood and adolescence. There is no indication that Aiden expressed concern to any professional regarding his weight, nor did his parents report that Aiden had a negative view of himself with regard to his weight.

Aiden had experienced problems with soiling from an early age, which appear to have remained unresolved into adolescence. This may have led to what were recorded by professionals as 'hygiene' issues. Aiden was bullied at primary school regarding hygiene and being overweight.

Aiden's family and home life had been subject to some disruption. Although the review cannot make assumptions about the impact that this had on Aiden, it is not unreasonable to suggest that the separation of his parents in 2011; the move to living with his mother and her new partner and the subsequent move of his mother and younger sibling to another part of the country (in

2014/15), may have affected his emotional wellbeing[5],[6]. The review, however, recognises that family disruption is a growing phenomenon.

4.2. Learning in relation to the terms of reference/analysis of agency practice.

TOR 1:

Did agencies have a complete picture of Aiden's daily lived experience? Was Aiden spoken to about his daily lived experience? Did agencies understand what Aiden wanted?

TOR 2:

Were agencies sighted on any issues within Aiden's home environment and family life that may have raised safeguarding concerns?

TOR 3:

How did agencies work with Aiden's family to address his presenting needs? How might this be done differently in future?

TOR 4:

Did agencies give consideration to wider safeguarding issues including neglect?

Findings TOR 1-4

The review has learnt that agencies did not have a complete picture of Aiden's daily life. There are examples in the review of Aiden being spoken to without adults present, however he was often represented by the adults in his life.

The consultation with the school nurse on 18th May 2016 is an example of good practice when Aiden was spoken to in a one to one consultation. There are, however, several occasions in which accounts of Aiden's health and wellbeing, home life and circumstances came solely from adults, and these accounts were used to build a picture of Aiden's lived experience.

There are occasions on which Aiden was spoken to about aspects of his life e.g. personal hygiene and soiling, however there is little indication that Aiden was given the opportunity to express himself or to seek guidance and support on his own terms

Opportunities were not taken to construct a complete picture of the changing circumstances of Aiden's lived experience, and the impact that these changes may have had on Aiden (and his siblings).

When Aiden was referred to specialist services and the CCNT with regard to soiling there appears to have been no consideration as to whether Aiden

[5] https://www.jrf.org.uk/report/divorce-and-separation-outcomes-children

[6] http://knowledgebank.oneplusone.org.uk/wp-content/uploads/2014/04/Parental-Conflict.pdf

would have benefited from referral for emotional health and wellbeing (or child mental health) support. It would have been good practice to speak to Aiden about his emotional wellbeing and to consider referring Aiden to Child and Adolescent Mental Health Services (Healthy Young Minds) if appropriate.

An opportunity was missed to speak to Aiden and his sibling about their home circumstances when CSC were called to the family home in July 2012. Whilst there had been no concerns raised regarding the home circumstances the review has learned the CSC record indicates that the visiting social worker was aware that mother had a new partner who she said was living at the family home. It would have been good practice to adopt Think Family principles and have enquired about the whole family, including mother's new partner. It would have been good practice to speak to both children separately and without an adult present at this visit.

Primary School 2 recorded incidents of soiling and bullying. Discussions were held with parents. However, incidents appears to have been dealt with in isolation, rather than in a planned and coordinated way. At the transition meeting for Aiden's Primary School 2 did not share information regarding Aiden's difficulties with soiling. This would have been good practice as it would have alerted high school to the issue and enabled a management plan to have been discussed.

Efforts were made to offer Aiden support when he experienced difficulties at high school with regard to privacy. It was good practice to offer mentorship, which appears to have been beneficial to Aiden. However, opportunities were missed to strengthen links between the work of the school nurse and teaching and pastoral school staff, which would have resulted in a more joined up approach to managing Aiden's health needs alongside his school performance and progress.

Agencies were not sighted on home conditions when Aiden lived with father, as no agency had any statutory right to enter the home at this time. Some professionals were aware that parents had separated and that mother had moved away with Aiden's younger sibling. It would be good practice to support professionals in exercising appropriate curiosity about home environment and home conditions.

Aiden's ongoing difficulties with soiling and weight management were not viewed holistically as indicators of potential safeguarding issues.

Parental involvement and compliance in attending appointments was not challenged, and therefore opportunities were missed to explore Aiden's presenting difficulties.

Work to strengthen relationships between school nursing, schools and GP's would help facilitate a more joined up approach. Team around the Family could have been used to bring agencies together.

The NCMP notifies parents of concerns regarding weight and invites their participation, however it does not have any jurisdiction in relation to co-operation.[7]

High school engaged father on a number of issues including personal hygiene and weight management. Father appeared to engage although there was no apparent change in Aiden's presentation.

The GP was active in making referrals in relation to soiling. However, lack of engagement by the family was not followed up by services.

It is not clear whether the school nurse was fully sighted on the history of soiling, which links to the lack of information provided at the transition meeting, and strengthened relationships between school nursing and GPs. It would be good practice in future to ensure that non-attendance and poor compliance by parents is noted and followed up with the family, and to ensure that school nursing is aware and up to date in relation to key presenting issues and any difficulties with family engagement.

The GP's response to Aiden's presentation in March 2018 was thorough, taking blood and ensuring quick results and communication to parent.

Agencies were unaware of poor home conditions until police visit after Aiden's death. Although a SUDC meeting took place following death, it would have been good practice to make a S47 referral to ensure that potential safeguarding issues were addressed.

TOR 5:

Did agencies respond appropriately to issues of weight management, including speaking to the child and family regarding potential associated medical problems? If not, why might this be and what could be done differently in future?

TOR 6:

Did agencies give appropriate consideration to Aiden's emotional health and wellbeing? If so what actions were taken in this regard? If not, what could be done differently in the future?

TOR 7:

What is the role of school nursing in co-ordinating care for children such as Aiden?

[7] https://www.norfolklscb.org/wp-content/uploads/2015/04/Safeguarding-Response-to-Obesity-when-Neglect-is-an-Issue-Guidance.pdf

TOR 8:

What multi-agency working took place? Was this robust and of a good quality?

Findings TOR 5-8

Other than communications following Aiden being weighed as part of the NCMP, and a contact with the school nurse in May 2016, there is no evidence of direct conversations with and support for Aiden in relation to weight management.

It would have been good practice for the GP or the Practice Nurse to speak to Aiden about his weight when he presented for other conditions (e.g. Aiden's early episodes and treatment for asthma could have provided this opportunity).

The review recognises that there is little guidance for GPs in relation to child and adolescent weight management, and a recommendation regarding training and support for local professionals is made in this regard.

The review highlights opportunities to strengthen the relationship between General Practice and School Nursing, this would have facilitated a more holistic approach to supporting Aiden and his family in relation to weight management. Relevant guidance from RGCP[8], RC. Paed[9] and NICE[10] is helpful in this regard.

Interactions with Aiden's family regarding weight management were sporadic and inconsistent. Aiden's parents did not respond to communications from the NCMP, nor do they appear to have spoken to the GP or other services (other than primary and high school) regarding Aiden's weight management. It is recognised by the review that parental support and engagement is an important element of weight management and a recommendation is made in this regard.

Both Primary School 2 and High School recognised weight management as a potential concern and referrals were made to the school nurse. High school also took a proactive approach in encouraging Aiden to be more physically active, which was good practice.

Policy and practice is developing in relation to stronger partnership working between schools and health agencies in relation to weight management strategies for children. It is recognised that there may be an over-reliance on

[8] https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/obesity.aspx

[9] https://www.rcpch.ac.uk/sites/default/files/2018-04/childhood_obesity_inquiry_-_health_and_social_care_committee.pdf

[10] https://www.nice.org.uk/guidance/qs94

schools to work with parents in relation to weight management. Multi-agency responses, policies and plans could be strengthened.[11]

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.

It would have been good practice for agencies to work together in a more structured way (Think Family) to support Aiden and his family in addressing these issues. This would have facilitated greater sharing of information, assessment of any risks and vulnerabilities for Aiden and his sibling(s) and facilitated appropriate professional challenge to Aiden's family when required. It would also have facilitated an understanding of Aiden's daily lived experience.

The role of the school nurse is considered by the review to be vital in this regard. The review recognise the role of the school nurse as the professional who has access to the entire child health record. The review acknowledges that national developments and funding have impacted on capacity within school nursing services, however this review demonstrates the importance of supporting and strengthening the school nurse function as a core offer to children and their families.

TOR 9:

How can pathways of care be strengthened to respond to the needs of children such as Aiden?

TOR 10:

Are there any other aspects of agency involvement with Aiden that offer learning for the future?

Findings TOR 9-10

The issue of childhood obesity is highly significant in this case, however it should not overshadow other complexities in Aiden's life. A holistic, child-centred approach to significant life events, presenting issues, self-determination and identity, Think Family, signs of safety and keeping children safe all resonate strongly within the review.

Factors relating to family lifestyle, which are complex and multi-faceted are present in the review. 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.

[11] https://www.nhs.uk/news/obesity/school-based-obesity-prevention-programme-has-disappointing-results/

5. Recommendations

5.1 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)

5.2 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)

5.2.1. 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).

5.2.2. The LSCB should receive assurance that training and support for professionals in relation to childhood obesity are in place.

5.2.3. The LSCB should receive assurance that local safeguarding partners develop guidance (based on research and practice cited in this review) that incorporates childhood obesity as a potential safeguarding issue.

5.2.4. That the role of parents in supporting lifestyle change and engaging with services is made explicit within the local pathway.

5.3 The Chair of the LSCB should raise the findings of this report (and other related Serious Case Reviews) with the Chair of the Greater Manchester Health and Wellbeing Board to raise the profile of childhood obesity as a potential welfare issue. (All TORS)

5.4. 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)

6. References and Useful Resources

6.1 National Guidance

- https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/obesity.aspx

- https://www.rcpch.ac.uk/sites/default/files/2018-04/childhood_obesity_inquiry_-_health_and_social_care_committee.pdf

- https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action

- https://www.nice.org.uk/guidance/qs94

6.2 Safeguarding and Obesity

- https://www.cornwallhealthyweight.org.uk/professional-zone/guidelines/early-years-0-5-guidelines/child-obesity-pathways/safeguarding-children-guidelines/

- https://www.norfolklscb.org/wp-content/uploads/2015/04/Safeguarding-Response-to-Obesity-when-Neglect-is-an-Issue-Guidance.pdf

- R. Viner (2010) Child Protection and Obesity in www.bmj.com/content/341/bmj.c3074

6.3 Encopresis and Emotional Health

- https://childpsychologist.com.au/encopresis-soiling-in-school-aged-children/

6.4 Schools

- https://www.nhs.uk/news/obesity/school-based-obesity-prevention-programme-has-disappointing-results/