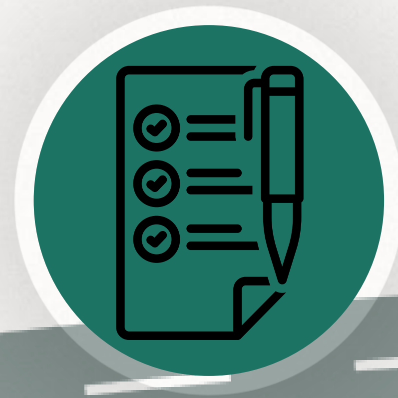
Hull Safeguarding Children Partnership

LEARNING FROM LINE OF SIGHT

Child U - Complex Health Needs and multi agency planning

https://www.hullcollaborativepartnership.org.uk/learning-reviews/line-sight-local-learning-reviews

WHAT IS A LINE OF SIGHT? (LOS)



The Line of Sight process is a core function of the Hull Safeguarding Children Partnership (HSCP).

The process provides learning opportunities across the partnership to strengthen multiagency working and focuses on improving outcomes for children and young people.

The process identifies specific learning themes through audit and multi-agency analysis.
Learning is implemented across the partnership to improve practice across the safeguarding system.

This Line of Sight was held jointly as part of the Child Death Review Process (CDOP)

Child U - Context

Hull Safeguarding Children Partnership

Background

A Line of Sight was requested by City Health Care Partnership (CHCP) in respect of Child U, who tragically died following a diagnosis of Leukaemia.

Child U was previously subject to a Child Protection Plan under the category of emotional harm due to concerns of domestic abuse within the family home, parental alcohol use and poor parental mental health. Child U was not regularly attending school and was staying out of the family home until late most nights.

Sadly, following diagnosis, Child U was not responding to treatment in an out of area hospital, Child U was discharged home for end of life care which was their wish for end of life.

Parents required an interpreter as English was not their first language.

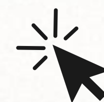
Light of Sight Purpose

To assess whether the multi-agency response has been:

- effective in terms of end of life planning.
- ensure multi-agency sharing of information
- The multi -agency response to Child U's health and social care needs.

MULTI-AGENCY FINDINGS

Communication & Information Sharing

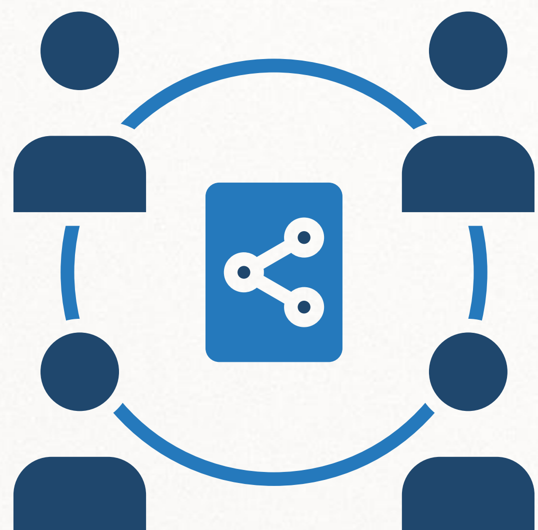


Accurate, timely, and complete information was not consistently shared between agencies.

Key missed communications included:

- Change of address prior to discharge
- Change from Child Protection Plan to Child in Need plan not shared with all partners
- Out of area hospital discharge information not reaching local teams

These gaps reduced agencies' ability to plan effectively and safeguard Child U.



Information Sharing

Advice for practitioners providing safeguarding services for children, young people, parents and carers

May 2024

MULTI-AGENCY FINDINGS

Multi-Agency Coordination

Practitioners should be aware of and actively include other health professionals supporting the child, such as paediatric specialist nurses, dietitians, and physiotherapists, within safeguarding processes. Tools such as the Health and Care Passport can support this coordination.

Health and Care Passport

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HEALTH AND CARE PASSPORT

Supporting me in a healthcare setting

My name is:

I like to be known as:

This passport has important information in to let you know how best to help me.

This passport belongs to me, please make sure it goes home with me.

Date of completion: Date of review:

RED: Things you must know immediately

AMBER: Things that will help you support me

GREEN: Things that will make things better for me

NHS

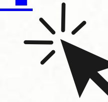
Key partners, including housing services and Renew, were not consistently involved in multi-agency meetings. This limited the scope of intervention to the adult, without fully considering the wider family context and needs. Out-of-area professionals supporting the child and family must be actively engaged in planning and decision-making.

Safeguarding concerns were not always communicated promptly or to the appropriate agencies. Practitioners must be familiar with and apply the HSCP Threshold Guidance to ensure timely and proportionate safeguarding responses.

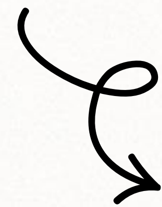
The multi-agency child protection teams under the Family First Partnership programme will aim to strengthen the robustness and coordinated approach to children on child protection plans.

MULTI-AGENCY FINDINGS

Escalation and Resolution



All practitioners must understand and follow escalation and resolution procedures when there are disagreements in decision-making or when they are excluded from multi-agency meetings. Clear pathways are in place across both children and adult safeguarding partnerships to address concerns and ensure inclusive practice.



PROCEDURES AND GUIDANCE

Escalation and Resolution

Professional Resolutions Practice Guidance for use by practitioners from all agencies with safeguarding responsibilities.

Date of Document:	April 25 (HSAPB)
Date Document Agreed:	
Date of Review:	April 26

ERSCP Keeping children and young people safe
EAST RIDING SAFEGUARDING CHILDREN PARTNERSHIP

Hull Safeguarding Children Partnership

Challenge & Professional Curiosity

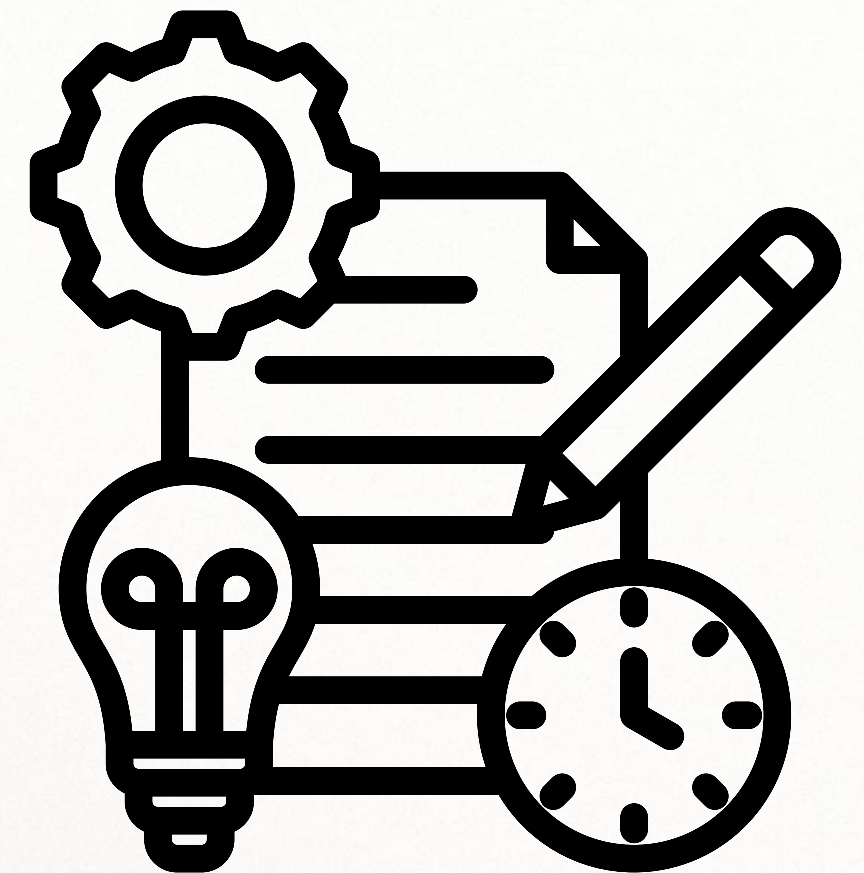
Staff did not always escalate concerns when excluded from decision making or when they identified unmet needs.

Examples include:

- No escalation when discharge planning did not involve core professionals
- Limited challenge around school non-attendance and missing episodes
- Professional curiosity around harassment and repeated reports to police
- Community nurses experienced emotional distress due to the complexity and deterioration in care, highlighting the need for reflective supervision and welfare support

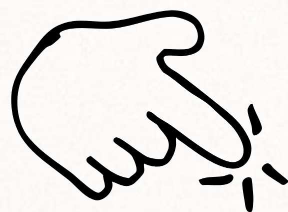
MULTI-AGENCY FINDINGS

Discharge & End-of-Life Planning



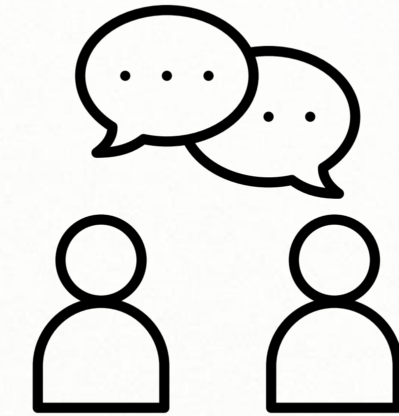
The Line of Sight review highlighted the need for robust discharge planning to ensure care and support needs are met within the community. In this case, the urgency of the situation led to discharge into accommodation unsuitable for end-of-life care.

Discharge planning meetings were not consistently inclusive of all relevant professionals, which impacted the effectiveness of multi-agency coordination and delivery of holistic support.

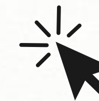


Notification of the child's death was delayed. Practitioners must ensure prompt notification to the Child Death Overview Panel (CDOP) to initiate statutory child death review processes in a timely and appropriate manner.

MULTI-AGENCY FINDINGS



Voice of the Child



The child's voice must be central to all safeguarding and care planning processes. While Child U's voice was actively listened to, the Line of Sight review identified areas where multi-agency practice could be strengthened.

The child was at times relied upon to interpret for their parents, which is not best practice. Professional translation services must be used to ensure clear, independent, and trauma-informed communication—especially when children are vulnerable or victims.

Children must be consulted in decisions relating to crimes where they are considered victims, ensuring their views are heard and respected.

MULTI-AGENCY FINDINGS

Contextual and Family Factors

Several vulnerabilities contributed to increased risk:

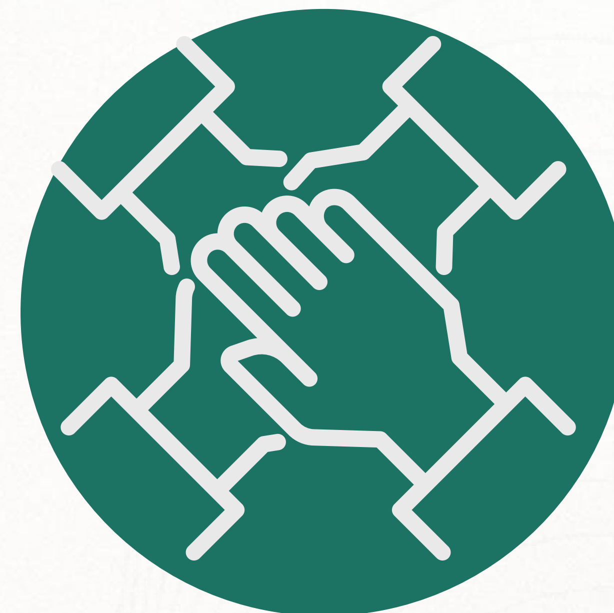
- School disengagement and reduced parental oversight were not explored sufficiently
- Domestic abuse history and parental alcohol misuse required coordinated oversight
- Language barriers affected parental understanding of clinical deterioration
- Poverty and housing issues created additional instability

These contextual factors required earlier and more proactive multi agency intervention.

GOOD PRACTICE

Voice of the child

The wishes and feelings of child U was captured and adhered too.



Young Lives provided focused emotional, practical, and financial support to the family, ensuring access to services and benefits and offering consistent presence for the child and their mother during hospitalisation.

Care Provided

The care provided to Child U was “above and beyond” with practitioners seeking to provide comfort and care.

GOOD PRACTICE

Housing acted quickly and flexibly, securing a new tenancy within weeks and covering additional costs; interpreter support was provided at tenancy sign-up

GP provided timely, flexible end-of-life prescribing and continued post-death support for the sibling.

Multi-agency professionals- including school- provided bereavement and emotional support for the sibling, with the school holding a "celebration of life."