1. Background and Concerns

A Line of Sight was held jointly as part of the Child Death Review Process in respect of Child U, a 14-year-old child, who tragically died following a diagnosis of an acute illness.

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.

2. Purpose of the Review

The Line-of-Sight meeting was conducted to enrich the learning alongside the Child Death Review process. A joint approach between the HSCP and CDR systems allows for learning to be shared more broadly which contributes to wider system learning.

3. Key Lines of Enquiry

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.

4. Key Learning

1. 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.

2. Multi Agency Coordination

Key partners- including housing, Renew, school, and out of area clinicians- were not consistently included in planning. Lack of coordinated multi-agency meetings led to missed opportunities to share risk, plan discharge, and ensure environmental safety. Use of tools such as the Health & Care Passport would have improved joined up practice.

3. Escalation, 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
- Delayed CDOP notification demonstrated gaps in following statutory processes

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These issues require cross agency action and oversight.

4. Discharge & End of Life Planning

The rapid deterioration meant discharge occurred without essential multi-agency planning. Robust discharge planning is essential even when time pressures exist. Issues included:

- No pre discharge home visit
- New tenancy not assessed for appropriateness end-of-life care
- Medication supply issues due to cross hospital transfer and pharmacy incident
- Several agencies unaware that discharge was occurring

5. Voice of the Child

While Child U's end-of-life wishes were respected, the child's voice was not consistently captured in wider safeguarding processes for e.g.

- Child used as interpreter for parents- Professional translation must always be used where required.
- Voice not recorded in police responses to domestic abuse, despite being a victim
- A need for consistent trauma informed communication

6. 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.

5. Good Practice

Child U's end-of-life wishes were listened to and honoured, including the wish to die at home.

Community nursing provided "above and beyond" compassionate care, providing continuous comfort and presence.

Young Lives charity gave consistent emotional, practical and financial support throughout treatment and end-of-life care.

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."

6. Next Steps

- **Share the 7-minute guide** across all partner agencies to support consistent learning and reflective discussion.
- **Promote and utilise HSCP Learning Programme training** to embed key safeguarding learning across the partnership.
- **Ensure all safeguarding partners share review learning internally** within their own organisations to strengthen consistent, system-wide practice.

7. Further information – links

DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people,parents and carers

Health and Care Passport City Health Care Partnership

Families First Partnership programme - GOV.UK

Threshold of Needs Guidance – Hull Collaborative Partnership

Escalation and Resolution - Professional Resolutions...

Recommendations | End of life care for infants, children and young people with life-limiting conditions: planning and management | Guidance | NICE

Child death reviews – Hull Collaborative Partnership

https://www.ecdop.co.uk/HullER/Live/Public

How can we hear and facilitate the voice of the child? Practice points | NSPCC Learning