Anika – Case Summary and Summary of Learning

Case Summary

Anika was a 17-year-old child diagnosed with autism and mutism and who had a severe learning disability. She died from a serious infection caused by her PEG tube receding into her stomach which resulted in peritonitis and a fatal sepsis. She lived with her mother who was a single parent. Anika and her mother are black British of Caribbean heritage. Anika had an older sister who was living away from the family home at the time of her death but was in regular contact with her mother. Anika's father didn't live with them and played no part in her life and the family had minimal contact with their extended family. The family were quite isolated. Although the family home was presentable downstairs, the upstairs rooms were not well maintained and showed signs of neglect. Her mother didn't always respond to calls from professionals on her mobile phone and it is unclear as to why she didn't respond. Anika had special educational needs and met the definition of a 'child in need' as defined in the Children Act 1989 and had an Education Health and Care Plan (EHCP). At the time of her death, she was attending a further education provision, a Saturday club, and a school holiday activity group. She didn't have any speech and her communication skills were limited. She responded well to one-to-one attention she was given when attending education and out of school activities. She was described as a very happy young person.

The review covered the time period May 2017 to Anika's death on the night/early morning of the 15th and 16th of April 2021.

The Child Safeguarding Practice Review explored the following themes.

- An exploration of the systems, processes, and thresholds by which children and young people who are experiencing neglect or are at risk of neglect, may expect to receive support and an examination of these systems for Anika.
- The communication between agencies and their professional curiosity in relation to the identification of neglect.
- To explore best practice principles should similar circumstances arise in the future.

Summary of Learning

- To ensure that health professionals receive mandatory training in the proper functionality of PEG tubes where the person with the tube is vulnerable.
- Ensure that a parent's capacity to manage PEG tube feeding is regularly reviewed and that parents are supported in the management of PEG tube feeding.
- Consideration and the need for curiosity by all agencies of the safeguarding implications of the failure of a parent to respond to repeated attempts to contact them, especially in cases

where the child lacks a clear voice because of their disability. Any inhouse training delivered by the statutory partners should incorporate this within their training packages.

- The key worker programme in Health services in Suffolk should ensure that in cases where several health professionals are involved, a named lead professional is identified to co-ordinate, oversee and monitor actions and ensure that children are seen and heard.
- Special Educational Needs and Disability (SEND) leads in Children and Young People's Service (CYPS) need to ensure that Education, Health and Care Plans (EHCP) are holistic and include an assessment of vulnerabilities and any potential impact these may have on their care needs and wellbeing.
- The MASH (Multi Agency Safeguarding Hub) should review their thresholds for referrals of children with special needs and disabilities.
- The Safeguarding Partnership to work with the Children and Young People's Quality Assurance and Professional Development Team to ensure that social work guidance includes advice on seeing the physical conditions of any property when visiting families.
- Public Health to consider extending the remit of the School Nursing Service to include post 16 young people in further education settings who are subject to EHCPs and who have significant disability and health needs.
- All agencies to review their transition arrangements for young people moving onto adult services.
- Local agency emergency planning arrangements need to ensure that should there be a resurgence of a new Covid-19 strain or any other pandemic or civil emergency that vulnerable children continue to be seen and home visits made.
- Practitioners across all agencies should have the skills and tools to better communicate with children and young people who have a disability which limits their ability to share their views and express themselves, be culturally competent in order to understand, assess and support the health and care needs of children with black and minority ethnic heritage who may not wish to engage or trust service providers and where social isolation is a concern because of the child's disability and their ethnic and cultural background , that practitioners recognise that this potentially places them at greater risk of experiencing neglect.