

*May 2023*

**Working with Families where Engagement Fluctuates**

There was a pattern of missed health appointments, cancelled home visits, and offers of support not taken up, which affected the support offered and professionals’ understanding of the family circumstances. Whether sufficient effort was made to support engagement with the family is a question we can ask with hindsight. Professionals should consider underlying issues that can lead to fluctuating engagement, for example domestic abuse, mental health difficulties, and pressures from living in a refuge. Professionals should seek to identify when families are difficult to engage, and adapt their approach to improve relationships and support better working with the family.

**Risk from Poor Diabetes Management and Child Neglect**

The risk from poor diabetes management for this child was severe enough that there were three hospital admissions prior to this incident, and it was known that parents struggled to ensure the child received necessary care for diabetes. There were also issues with school attendance and mental health. While the child and siblings had Child in Need plans in Herefordshire and, previously, in Worcestershire, it is not clear how effective those plans were in addressing the most pressing concerns for the children. The full picture of the family’s situation would have been best understood through multi-agency information sharing over a period of time.

**About the Rapid Review**

A Rapid Review is completed by the Local Safeguarding Children Partnership when a child suffers serious harm or dies, and abuse or neglect is known or suspected. The purpose of the rapid review is to identify learning among agencies involved with the family, so that improvements can be made to avoid these incidents happening again. At the conclusion of a Rapid Review, the Safeguarding Partners make a decision on whether the criteria is met to commission a Child Safeguarding Practice Review (Working Together to Safeguard Children 2018).

The sections below explain the learning identified in this rapid review, which professionals should take into account in their daily practice. In this case, the Safeguarding Partners agreed to commission a Child Safeguarding Practice Review as this was a “near-miss” and there was potential to identify additional learning.

**Background**

This case involved a teenager who was brought to hospital in a critical condition with Diabetic Ketoacidosis (DKA), which was a result of not following the child’s diabetes care plan. While the child recovered, a Serious Incident Notification was made due to the serious harm at the time of the incident and concerns of child neglect in that the child’s diabetes was not managed correctly. The child and siblings were on Child in Need plans at the time of the incident and had a previous Child in Need plan in Worcestershire. They had been living in a refuge in Herefordshire for less than 12 months, having moved from Worcestershire after fleeing domestic abuse.

**Cross-Border Information Sharing**

There were delays in agencies being aware of the family’s move to Herefordshire and in transferring information from Worcestershire. The family’s Child in Need plan in Worcestershire was also closed after the family moved, without a hand-over with Herefordshire Children Services. There should be no delay in monitoring and information sharing when vulnerable children move across local authority boundaries. In this case, where there were still ongoing concerns, there was no co-ordinated transfer with agreed objectives and plan. Each agency either closed the case or made its own transfer arrangement resulting in a lack of shared understanding of the history or possible risks.

**Further Reading & Resources**

[Diabetes UK - Know diabetes. Fight diabetes. | Diabetes UK](https://www.diabetes.org.uk/)

[HSCP Voice of the Child Participation Toolkit](https://www.herefordshiresafeguardingboards.org.uk/professional-resources/childrens-policies-guidance/hscp-voice-of-the-child-participation-toolkit)

[Disguised compliance, coercive control and families who are hostile or resistant to change | West Midlands Safeguarding Children Group](https://westmidlands.procedures.org.uk/pkplx/regional-safeguarding-guidance/disguised-compliance-coercive-control-and-families-who-are-hostile-or-resistant-to-change)

**Understanding the Child’s Daily Life**

Agency scoping at the Rapid Review suggested that very little was known about the child’s wishes and feelings and lived experience. Professionals did not articulate the reasons why the child was not following the diabetic care plan and not attending school. A better understanding of the child’s wishes and feelings may have helped to provide support that the child would be more willing to engage and comply with.

