CHILD H – 'Ananthi'
Child Safeguarding Practice Review

November 2021

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2 INTRODUCTION BY INDEPENDENT AUTHOR

The approach I have taken for this case is a focused review. This means that I have concentrated on the specific issues identified in the terms of reference, set by Merton Safeguarding Children Partnership. Some aspects considered at the start of the review have changed significantly as I have made progress in gathering information and hearing the family narrative.

The pandemic has hindered my work on the review. I have not been able to speak to Mrs H due to the restrictions and I am grateful to the Chair of the review Panel for meeting with Mr H to gain his views.

I have not spoken with Adi as I felt that this would have the potential to re-traumatise him. I have not been informed about any additional insights pertinent to the conclusions, raised by Adi during his sessions with his social worker.

It is a tragic ending for Ananthi; a lovely child who shone brightly. I am convinced that her demise would not have occurred if her mother could have found the help she needed, which was for professionals to understand the excruciating pain she had been suffering for months. This was seriously hindered by the extreme pressures of the early months of the Covid-19 pandemic which meant that that help was harder to reach. Nevertheless, the circumstances of Ananthi's death are, thankfully, very rare. Even though her mother did not get the help she needed, services were under overwhelming and unprecedented pressure. The Covid-19 regulations had a considerable impact on the management of all public services. The NHS was subject to a Level 4 alert from January 2020[1]. This meant that acute NHS services were required to *'free-up the maximum possible inpatient and critical care capacity; prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support; support staff and maximise their availability*'. Meanwhile, primary care services were guided towards using virtual appointments where possible, to reduce the risks of spreading the coronavirus.

We cannot use Covid-19 as an excuse for such a sad event, but I have attempted to extract the learning for the partnership of how families and professionals were disrupted by the first lockdown restrictions faced by the country. In particular, the impact of children not being able to attend school for months and how the pandemic affect access to health care. This case shows how school can be seen to be a safe place for children, but also for their families. If Ananthi and Adi had been at school between March and June 2020, there might have been more opportunities for them to raise concerns about their mother's health, or for staff to notice that Mrs H was struggling to cope.

Nevertheless, outside of the pandemic issues, I have highlighted how individuals, who do not have English as their first language, are listened to by professionals when, repeatedly raising concerns about their health. I have also considered how women from ethnic minorities access health advice and to what extent their fears for their wellbeing are heard.

I am grateful to the individuals who have contributed to my thinking for this review, and I hope I have done justice to the memory of Ananthi, and that the family are able to move forward in their lives.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf

3 METHODOLOGY

The methodology for this Local Child Safeguarding Practice Review is outlined as follows:

1. Examination of chronologies to establish significant events and key practice episodes.

2. Analysis of Individual Agency Management Reports (IMRs) to gain an understanding of the key practice issues, including enablers and barriers to effective practice. Of particular interest in this review are:

    - The mothers voice – interpreters and sensitivities around accessing services as a member of the Southeast Asian Community
    - Gender and dynamics of being a woman in the Southeast Asian community and potential barriers to accessing services for members of the Southeast Asian community, particularly in relation to mental health and domestic abuse.
    - The impact of reduced access to specialist services during lockdown and the impact of lockdown on mental health
    - The impact of delays to accessing diagnostic services and results.
    - Had COVID 19 impacted support normally available to Southeast Asian residents in the community?
    - Did lack of visibility prevent concerns being raised earlier?

3. These themes will be explored with practitioners in two ways.
    a. Firstly, there will be an event for practitioners who worked directly with Ananthi and her family.
    b. Secondly, there will be a learning event involving a wider range of practitioners to gain an understanding of current multi-agency practice and to share the lessons emerging from the review.

4. The learning from the IMRs, practitioners' events will then be summarised in an overview report which will
    a. identify key themes,
    b. highlight specific learning and
    c. make recommendations for system-wide practice improvement.

Scope

The scope of this Learning Review will be from October 2013 – 30 June 2020.

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and MSCP.

- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

4 BACKGROUND AND FACTS OF THE CASE

4.1 Background

On 30 June 2020 at 15:51, emergency services were called to an address where a woman and 5-year-old child were found with serious injuries, stab wounds. They were both admitted to hospital. The child was in cardiac arrest when found and was pronounced dead at 16.57, but the woman underwent surgery for her injuries. In the premises there was also a 10-year-old boy who did not appear to have any physical injuries but was a potential witness to the incident.

Due to the nature of the death of the child, Merton Safeguarding Children Partnership commenced a rapid review to identify learning for any services involved with the family.

Little is known of the family prior to 2014. Adi started school in September 2014 and the parents completed a questionnaire which was screened by school health. There were no concerns identified.

The family were reported to have lived in area since around 2014. They were part of a close-knit community and chose to use primary care services outside of the local area as they had access to Primary Care staff who came from same community and spoke the same language.

Ananthi was born in 2015. Ananthi was seen for a New Birth Home Visit and 7-week clinic check. It is noted that no interpreter was used for these consultations, although an interpreter was used by the hospital maternity unit for the antenatal check.

In December 2016 Adi reported to an adult, at school, that his father had chastised him and had previously done so using an implement. He was reported to state that his sister who was 1 year old at the time, also got slapped or flicked by their father. The disclosure was referred to the Multi-Agency Safeguarding Hub and an assessment undertaken by Children's Social Care. Advice was given to the parents on using inappropriate physical chastisement. No further action was taken and there was no child protection medical. The case was closed at the end of January 2017 and shared with the Health Visitor and School Nursing Service. It is important to note that the members of the review panel involved in following up this incident were of the view

that this was a one off and was not of relevance in the analysis of the case under review.

Ananthi was seen, or discussed by telephone contact, by the GP or Practice Nurse 27 times during her life between May 2015 and November 2019. These consultations were for routine immunisations, travel vaccinations, childhood ailments and dressing of a wound following a scalding incident in 2017.

In December 2018, there were behavioural concerns at school which led to Adi being excluded for 2 days. The reason recorded for the exclusion was physical assault against a pupil. It was one exclusion. The school reported that the parents were very disappointed for their child to be excluded but understood the school's decision and responded in a constructive way. The school report that it is not uncommon for the school to have fixed term exclusions, and these are set within the school behaviour policy and national guidance for reasons for exclusion. Adi was not viewed as being of concern to the staff.

The children attended school until the Covid-19 pandemic led to the school closure during the lockdown between March and June 2020. Neither child was viewed as meeting the criteria for the vulnerable children during this time within the government guidance.

As the lockdown lifted, some age groups were allowed back into schools on a voluntary basis. Both children were within these age groups, but the parents declined the offer of them attending school. From what the father explained this seemed to be due to the children being 'good at home'. This was not an unusual response within their community. Therefore, in the months prior to Ananthi's death, the children were not seen by professionals.

From September 2019 until the incident, Mrs H sought health advice for physical symptoms of gastric pain, dizziness, weight loss, bowel dysfunction and heavy menstrual bleeding. There were numerous contacts with Primary care and attendances at the Emergency department. It remains unclear as to what her actual diagnosis was. This appears to be the main contact with services that the family had between March and June 2020.

4.2 **Ananthi**

Ananthi was described by her father as:

"She was a lovely child. She was very confident at cycling, and you were going to remove the stabilisers on her bike. She was good at school and liked learning spellings and doing well in spelling tests. She wanted to be a teacher and really enjoyed role play games with teddy bears as pupils and her as the teacher. She loved dancing to music on the TV. She played really nicely with her brother and the neighbours all loved her."

Ananthi attended Nursery and Reception at the same school. Prior to the Covid-19 lockdown Ananthi's attendance was 90% and always attended on time. Ananthi was always presentable, clothes fitted well and would happily show off her new clothes during mufti day.

Ananthi was described by the school as being a happy ray of sunshine, often expressing her emotions freely and competently, sharing her love of learning and zest for life. She was often excitable and energised in her expression and love of all things. She was eager to share her knowledge and learning and proud of her work and achievements. Ananthi was achieving in all areas of her learning, meeting expectations, and would have been exceeding in some areas of her learning by the end of the academic year. She was often seen to role model exemplary behaviour in front of her peers. She was very warm, kind and caring to everyone she interacted with. She had a strong bond with all the adults within her learning environment, sharing all parts of her life with them including school learning and home life. Ananthi always demonstrated a kind and caring nature towards her classmates and often looked after children who were sad. She was a strong character within her learning environment and would confidently play with all children in her class.

The school also reported that Ananthi's parents were smiley and friendly and would attend stay and learn sessions and enjoy the time spent with their child. During parents evening they were eager and happy to know their child was doing well and behaving appropriately.

During the Covid-19 lockdown the parents and sibling described Ananthi as being happy. She would have a sleep in the afternoon between 2-2.30 pm and her mother would lay down with her.

4.3 Key Points Within Timeline

MSCP collated a timeline of events. This timeline showed key points of agency involvement with the family, and this was discussed at a panel meeting held on 22nd October 2020. This review is focused and, therefore, the key points have been divided into three periods to enable full analysis and learning.

The scope of the review was from 2013. The first significant incident involving Ananthi was that in 2017.

4.3.1 June 2017- 2018: Ananthi scalded and follow up

Ananthi was taken to the Emergency Department (ED) due to scalding to the chest. At A&E, Mr H gave the history. Ananthi treated for burns. Checks made with burns unit. No safeguarding concerns were raised by staff and the injury was treated as accidental. Discharged into care of GP for dressing management.

The incident was notified to the GP and Health Visitor with request for follow up. The HV contacted the parents to arrange a home visit. On 08 June 2017 HV2 spoke to Mr

H who explained that his wife's English language was not too good, and he wanted to be at home when HV visited.

On 09 June 2017, HV2 undertook a support home visit following Accident and Emergency (A&E) attendance for chest burns to Ananthi. Both parents were present.

Ananthi was observed to be very clingy to mother during visit.

Mrs H gave an account of incident, that she was making milk for Ananthi on the stove and upon turning around she slipped over child's leg and milk splashed milk on child's face. Father immediately applied a cold compress but did not realise hot milk had also caught child's chest area as this was only seen when the clothes were changed, they then took child to A&E.

HV2 observed that Ananthi had a dressing to right upper chest area. The dressing was saturated with yellowish fluid and had an unpleasant smell. HV2 advised taking Ananthi to A&E for the dressing to be changed due to risk of infection. There were no other concerns identified on this visit. This incident was assessed as being an accident.

The parents followed the HV advice and returned to A&E where the dressing was reapplied, infection treated but no other concerns noted. Advised to return on 12 June 2017 which they did.

On 28 June 2017 HV2 made phone contact with the parents following the A&E attendance. Mr H was reported to have said that the wound was healing and Ananthi was playful and alert. HV2 advised the parents to make contact if they needed further advice or support.

Ananthi was seen by the GP in August 2017 for a rash. No concerns noted.

On 12 January 2018 Ananthi seen for a routine weight review by Health Visitor in clinic. She was reported as having consistent growth, presented as happy child, and no concerns were expressed or identified.

4.3.2 February 2019- May 2020: Mother's health issues and access to services during Covid-19 pandemic

From February 2019 until June 2020, Mrs H was gradually seen to be increasingly seeking medical advice. She would contact and initially see her GP but also attended Accident and Emergency at times when she was in extreme pain.

Mrs H went through numerous tests and investigations. There was a range of potential diagnoses considered by the GP.

In September 2019, Mrs H was found to have low iron levels, possibly due to heavy menstruation. This led to investigations in October 2019.

In November 2019, Father phoned the GP to find out the results of his wife's investigations, but these were not available until later that month. When the GP phoned to discuss the results, which showed nothing significant, the husband

answered, and he stated his wife has been complaining of intermittent dizziness over past two months but had not mentioned to any doctors and he requested an appointment for his wife to be seen.

Mrs H was subsequently seen by the GP who explained the results of the tests done to date. Mrs H reported further symptoms including abdominal pain, bloatedness, intermittent dizziness. The GP referred to secondary care for further investigations of the abdominal pain.

During December 2019 and January 2020, the practice continued to see Mrs H for advice and blood tests.

In February 2020, Mrs H was reported to be seen in ED due to abdominal pain which had lasted 3 weeks. She was accompanied by Adi who translated for her. She was discharged home and advised to see the GP.

In February 2020 Mrs H was due an appointment for investigations, following the GP referral in November. The appointment was cancelled by the hospital and Mrs H was not sent a further appointment.

In April 2020, Mrs H had a telephone appointment with the GP. Mr H joined the call and mentioned that his wife had a cold from December with current productive cough with pain in central chest with cough.

At this time, Mrs H was treated for likely COVID/Respiratory Tract Infection with possible secondary bacterial infection, hayfever and dyspepsia. The GP was trying to get further investigations in place for her and so, meanwhile, treated all the symptoms.

Mrs H was supposed to have appointments for further investigations within secondary care, but these were cancelled or postponed, seemingly due to the NHS preparations for the increasing numbers of Covid-19 patients.

Later in April, Mrs H had a further telephone consultation with the GP reporting worsening symptoms. This led the GP to prescribe prophylactic treatment for the reported symptoms. The differential diagnoses included Covid-19 related gastroenteritis.

In late May, Mrs H's medication had run out and she attended ED in the evening, reporting a two-month history of epigastric pain which had become worse that day. She had a follow up GP telephone consultation. She was referred for further tests which did not show any significant concerns.

4.3.3 June 2020: Father starts a new job, mother struggling to sleep, children not back at school

Ananthi's father had taken time off work for a while but changed his job and could no longer continue to be at home. The family remained in contact with a friend but otherwise were in the home.

At the beginning of June 2020, Mrs H had a GP telephone consultation. The GP records noted that she was anxious due to recent gastro-intestinal changes. She was referred via the e-referral pathway to gastroenterologist with an appointment for the beginning of July 2020.

In the week prior to the incident, Mrs H had a further consultation with the GP in which she reported that she was finding it difficult to walk, intermittent chest pain, loss of appetite and tiredness. Her husband was concerned that she couldn't sleep. Both she and her husband agreed to monitor her symptoms following the treatment prescribed by the GP and to attend A&E if it worsened. The GP also arranged for a letter to hand into the gastroenterology team at the July appointment. This was due to the GP being out of the area of the hospital and so there would not be the direct access to GP records for the GI team and so the GP wanted to ensure that the GI team had full access to the blood results.

At the beginning of June 2020, Adi was spoken to by the class teacher. He was reported to say that both he and Ananthi were fine, but he was bored and missing school.

Mr H reported that Adi was:

> *"very helpful and would make tea for my wife when she felt weak"*

On 23 June 2020, the school offered the family the opportunity for both children to return to school. Mr H declined the offer due to the risks of Covid. Nevertheless, by this time Mrs H was reported to be very weak and would sit on a chair whilst the children played.

On 24 June 2020, an ambulance was called for Mrs H due to vomiting and dizziness. She was seen in ED, and she was discharged with a plan for further investigations. Whilst in ED staff reported that Mrs H denied any stress in her life, when asked.

On 30 June 2020 at 15:51, emergency services were called where Mrs H and Ananthi were found with serious injuries. Ananthi died shortly afterwards, whilst her mother underwent surgery and survived.

5 ANALYSIS OF PRACTICE

This section will consider the key lines of enquiry and examine four further aspects found during the review: lived experience of seeking medical help, changes in how to access support and services, mother's health, and the role of men. Additionally, areas of good practice will be highlighted.

5.1 Key Lines of Enquiry

5.1.1 The mothers voice – interpreters and sensitivities around accessing services

There was no evidence of any issues in accessing services as a member of the community, apart from the fact that the GP was out of borough which meant that

their system did not automatically link with the hospital system. However, there were concerns in how services addressed the mother's interpreting needs and how her husband's facilitation of her access to health care was enabled or prevented. This will be explored further in 5.2.

5.1.2 The impact of reduced access to specialist services during lockdown and the impact of lockdown on mental health

There was no evidence that any professionals identified any mental health issues for Mrs H, although the ED staff did check with her whether she had any stress in her life. (it is not clear if an interpreter was present for this) The GP explained that there had been no history of any mental health problems. Therefore, this issue did not impact on Mrs H's access to services, as her health symptoms were seen to be physical in nature.

The family reported to have seen other members of the community which would suggest that they were not totally isolated. However, Mrs H worried significantly about the cause of her symptoms and being in lockdown would have provided the environment in which to heighten her worries to a point of affecting her mental health.

It is not possible to conclude to what extent it was the lockdown, the delays in diagnosis or the impact of the symptoms on Mrs H's mental health that could be described as underlying factors in the death of Ananthi. However, when considered as a triad of factors, it is reasonable to hypothesise that the risk of harm to Ananthi would have been reduced by the absence of at least one of these.

5.1.3 The impact of delays to accessing diagnostic services and results.

There were delays in some services which had an impact in professionals not being able to provide Mrs H with a firm diagnosis for her symptoms. This led to her becoming more fearful about her health. She actively sought help from the GP, via telephone, and ED, in person. There should have been more consideration of the pain that Mrs H was suffering. Since she was known to be awaiting further investigations, there should have been more consideration within ED of how to accelerate her assessment. Instead, Mrs H was referred back to her GP by ED. However, the standard operating procedure for Primary Care had changed at the start of the pandemic, reducing the face-to-face contact with patients, and limiting the follow up of ED visits.

Mrs H's health had been deteriorating prior to the restrictions faced by services, but she had multiple symptoms which required a range of investigations. The length of time she waited, her escalating symptoms, should have triggered more intensive assessment and discussions between health professionals.

At the time there were restrictions to the use of the two-week wait referrals for some health concerns, such as gastro-intestinal, to only those over the age of 40 years. This meant that she did not meet the criteria to be seen within two weeks.

Although, in June, the GP did make the referral and Mrs H was due to be seen on 01 July 2020.

5.1.4 Had COVID 19 impacted support normally available to the community?

The GP used by the community was not local. This meant that they would have to travel during the restrictions set by the government throughout March to June 2020. Additionally, GPs were doing virtual consultations, where possible. For the practice involved, there was a considerable impact on the staffing due to the risks of the coronavirus. This meant that there was a limited service in place, resulting in more of a remote service, initially by telephone and then, later, video calls. There was no evidence to suggest that the GP urged a physical visit to the practice, although it would have been difficult for the family to go out at the time. Instead, the GP advised Mr H to monitor his wife's health and to keep in touch.

Had the GP practice been local to the family, then there might have been more opportunity to have face to face contact with Mrs H, which might have shown her deterioration. Nevertheless, she did make use of the hospital ED, and was seen there.

5.1.5 Did lack of visibility prevent concerns being raised earlier?

The children were not seen by professionals, although the school maintained phone contact with Adi who did not raise any concerns. Meanwhile, Mrs H was not invisible to services. Both GP and ED were aware that she had children to care for, but the focus seemed to be on her health rather than the impact of a parent's illness on their ability to safely care for their children. Nevertheless, neither of the parents were reported to have raised any concerns about Mrs H struggling to provide for her children.

5.2 Lived Experience of Seeking Medical Help

There was variable use of formal interpreting services across agencies for the mother. In some incidences Adi was noted to be used to translate for her and the extent to which this happened is of concern and is not in line with NHS England and Government guidance[2]. Following the incident, the Social Work Manager completed a home visit and spoke to Adi who asked about their mother and was worried about whether staff at the hospital would understand her. When this occurred within health services, this is of particular concern that a child was having to translate medical information which is unlikely to have been understood by the child.

Ananthi's father was spoken to as part of the review. He described how his wife became worried in September 2019, thinking she might have cancer. He felt that his wife was "thinking too much". There were reports, following the incident, of how she accessed online sites to investigate her symptoms. Subsequently, his wife continued to be worried and spoke to the GP but was not examined as it was always by phone.

[2] https://www.gov.uk/guidance/language-interpretation-migrant-health-guide#language-interpreting-general-principles : accessed 05 August 2021.

He reported that his wife was not getting better, she was losing weight and worrying too much. He explained that she went to A&E on her own but did not speak English.

"She wasn't getting better, she was losing a lot of weight and worrying too much. So, she went to A/E. My wife had to go on her own. She doesn't speak English. They said Gaviscon and sent her home. I couldn't speak to them"

He added:

"*The doctors did nothing. My wife was very weak. I had to pick her up off the floor three or four times as she couldn't get onto the bed, and she had collapsed. She was ill for 3-4 months with a bad stomach and diarrhoea five of six times a day…… My wife didn't have full care*."

He also reported that in the days before the incident his wife had not slept for 4 or 5 days and was eating very little. They had advice regarding a medicine from a neighbour who worked for the NHS but were told by the pharmacy that it was prescription only.

It must be noted that this was an unprecedented time for the whole country, during March to June 2020. Services were exceptionally limited in what their capacity to provide treatment beyond Covid-19. The GP practice was particularly restricted due to the impact of the coronavirus on the staff there. This meant that the practice had to balance how they addressed the needs of patients with the safety worries of their staff.

Meanwhile, the government guidance for the public was to remain at home and avoid meeting others. There were escalating, daily reports of deaths. Therefore, this was a frightening time for those who feared for their lives due serious illness, whether they were unwell in the community, or risking their lives to continue working.

5.3 Changes in How to Access Support and Services Due to Covid-19

5.3.1 In this case the access to emergency and primary care health services for the family was not diminished due to Covid-19. Certainly, there is evidence that Mrs H continued to attend A&E and contact the GP, albeit by telephone. There was no reason to suggest that she had any need for mental health services at this time, although her physical symptoms were escalating prior to the pandemic. However, she was waiting for a specialist appointment to investigate the cause of her symptoms and this appointment was cancelled during the first pandemic lockdown due to the impact of Covid-19 on the capacity and safety for hospitals to be able to deliver care and treatment for non-emergency issues.

5.3.2 Regarding education, only vulnerable children and those of key worker parents were in school during this time. These children were not viewed as vulnerable. Ananthi had apparently flourished at school and there had been no concerns raised about the parenting. Meanwhile, Adi was known to have some behavioural problems

but there had been no concerns about parenting since 2016/17 to warrant additional support during the lockdown beyond that of any other child.

The school confirmed that it is in an area of high depravation and many of the children can be vulnerable. Logs of welfare concerns are maintained and there are weekly safeguarding meetings in the school. Staff have training and there are systems in place for reporting concerns.

The school did contact the family, speaking to Mr H and Adi. Prior to the incident the school had opened for some year groups, including for the two children in this family. However, the chance for them to attend was declined by the father. Given the timing of the incident coming to the attention of emergency services was 15.51, had the children been attending school, they would not have long been home. This might have prevented the incident happening, although the likelihood would have been that Mrs H would not have been capable of leaving the home to take her children to school, or collect them, due to her deteriorating health.

Schools were following Government guidance and legal requirements to not have all children in school. There was no requirement for parents to send their children in for the classes that were open.

During the lockdown, the teachers of the two children were in fortnightly contact with the father to make sure that the children were accessing home learning. There were also several conversations between teacher and Adi who reported wanting to return to school due to being bored as they only had a balcony and no garden. There were also contact with Mrs H as she enquired about schoolwork packs. This level of contact is essential safeguarding practice during lockdowns.

5.4 Mother's Health

Mrs H started complaining about her symptoms in September 2019. It needs to be noted that she had not excessively used health services prior to this. Nevertheless, she was showing symptoms prior to the appearance of the coronavirus and had been referred to a specialist but these appointments were postponed due to the pandemic.

Of note, is that the parents did not seek health advice during the lockdown period in relation to the children. Prior to the pandemic they do not appear to have been taken to the GP more than would be expected. This is important as it shows that Mrs H was worried specifically about her own health.

Mrs H was complaining of severe symptoms for several months and there appear to have been several differential diagnoses explored. For most GP appointments she appears to have been alone but there does also seem to have been an acceptance that her husband would 'monitor' her health. This was discussed with the GP who reported that the husband was very worried about his wife's health and reported that she had been having sleepless nights prior to the incident, in fearful anticipation of the GI appointment on 1st July 2020.

Prior to the incident, there was an escalation of her experiencing excruciating pain alongside a pervasive belief that she had cancer and that she was going to die. Deteriorating health can result in post-traumatic stress disorder (PTSD) when there is poorly managed pain in palliative patients[3]. Although Mrs H was not palliative, she believed she was dying. Those who suffer pain to the extent that it impairs their ability to perform daily tasks can view this as being due to disease, which can result in emotional problems to the point of having a severe impact on their own, and their family's wellbeing[4]. Given that she was not actually examined by a GP who could fully understand her language and that when she was seen within ED there was no interpreter present, there was limited opportunity for this woman to fully articulate how terrified she was. It was reported that ED, in June 2020, did ask her if she was stressed about anything and she was reported to deny this. It was also reported that the assessment, in ED, did not conclude that Mrs H was suffering intense pain. However, without an interpreter it is concluded that Mrs H might not have been able to fully make her suffering understood.

Since the incident, Mrs H has been diagnosed with a severe depressive episode with psychosis. There was no report of any mental health problems prior to the incident, although, as already commented on, she was not actually physically seen by a GP for months and interpreters were not used within ED. This would have limited the ability for professionals to fully assess both the mental and physical health of this woman.

Professionals were trying to radically adapt their way of working, using virtual methods of consultations, whilst being viewed by the public as focusing on Covid-19. This meant that some communities were reluctant to access services for fear of catching the coronavirus.

It has also been confirmed that Mrs H, following the incident, tested positive to Covid-19 antibodies, which suggests that she did have the coronavirus at some point. However, it is not possible to clarify what impact the virus had on the symptoms she reported, although Covid-19 was considered one of the differential diagnoses by the GP.

It is important to note that there is emerging research which suggests a link between Covid-19 and new-onset psychosis[5]. This would not have been known to the GP or the hospital medical professionals, at the time of Mrs H seeking help.

5.5 Role of Men in the Community

Mr H was seen to be very caring for his wife and children. In the background to this case, there had been concerns as to his chastisement of his son. However, he was

[3] Roth, M.L. et al. (2013) Relationship between pain and post-traumatic stress symptoms in palliative care. *Journal of Pain and Symptom Management*. Vol 46. No.2

[4] Kosson, D. et al. (2019) The effect of the treatment at a pain clinic on the Patient's assessment of their pain intensity and the incident of mental disorders in the form of anxiety, depression and aggression. *International Journal of Environmental Research and Public Health* Vol. 16. No. 4.

[5] Kozato N, Mishra M, Firdosi M. BMJ Case Rep 2021;14 https://casereports.bmj.com/content/14/4/e242538 : accessed 25 August 2021.

reported to have responded well to the advice of professionals in the appropriate ways to discipline children. The information gained within this review has not raised concerns in relation to the death of Ananthi.

In respect of how Mr H cared for his wife, he was reported, by the GP, to be extremely concerned about his wife's failing health and how she was coping. Mr H was reported to agree to monitor his wife's health. This could, perhaps, be viewed as a cultural practice. However, he was clearly very worried about his wife. He did not attend all ED visits with her, which might have made a difference to how professionals were able to assess Mrs H. However, Mr H reported that he did attend ED with his wife on two occasions. During one, he was not allowed in with her and on the second occasion he reported being spoken to "angrily" by a doctor. However, within the hospital records there were no reports of who presented with Mrs H to fully understand the response from the staff.

The ED practitioners might have been trying to give Mrs H space for herself, but, without an interpreter, this was not effective in providing her with dedicated time. Other adults often enable access to health care for patients and her husband has taken this role with the GP and health visitor. Emergency department rules seemed to prevent this enabling access to her husband.

5.6 Good Practice

5.6.1 The GPs demonstrated good practice in reducing language barriers by having South East Asian speaking staff. Recognition by the GP of the difficulties faced by patients from outside of their locality, when referring to secondary care, due to IT systems not being linked and so limitations on access to results of any tests done prior to the appointment. The GP provides letters which include any results to be viewed and minimises any duplication for the patient.

5.6.2. The school demonstrated good practice in the maintenance of communication with the family. This provided an opportunity for families to raise any concerns. Additionally, the class teacher spoke to Adi and heard that, although bored, that he and Ananthi were fine. There were no indications from him of any concerns within the home.

5.6.3 In June, the school reopened to reception, as set by the government guidance, and had 35 children return. Although schools were only required to take Reception, Year 1, and Year 6 back at that point, the school also invited year 5 back but the father declined for either child to return due to the pandemic. This was at a time when the media were reporting the susceptibility of the Black, Asian and Minority Ethnic (BAME) population to the coronavirus[6]. Also, although schools were required to open some classes, parents were not required by law to send the children in[7]. It

[6] PHE (June 2020) *Beyond the Data: Understanding the Impact of Covid-19 on BAME groups* https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities
[7] Coronavirus Act 2020 c.7. Schedule 16.

was not unusual, in the community, for parents to be worried about sending their children back to school.

6 LEARNING POINTS

In this section, there will be consideration of what Ananthi's case can show about the wider practice in Merton.

6.1 Theme 1: Impact of Covid-19 Pandemic: Children

This case shows how the societal visibility of children was drastically reduced during the initial lockdown period of the pandemic. Health services were involved for the mother, but no advice was sought, by the parents, for the children; the school checked on the children on a weekly basis and offered school places as soon as there was an opening, but this was declined by the father. This raises questions for MSCP as to what has been learned from the pandemic lockdowns and how this will be used to inform practice in relation to monitoring of children who are not in school.

DFE guidance in March 2020[8] set out expectations for local authorities, schools, and partner organisations to identify vulnerable children and to find the best way to support children, if attendance was appropriate to encourage good attendance and follow up absences. In a large primary school in a diverse area, children such as Ananthi and Adi were not identified as vulnerable. The parents engaged, Ananthi was well and displayed no behaviour of concern. Adi's behaviour was, at times, challenging but the school reported that fixed term exclusions were not unusual events and the parents worked with the school to manage this.

The National Panel (2020)[9] identified four aspects of risk for children during the pandemic:

1. An increase in parent and family stressors
2. Exacerbated vulnerabilities for children and young people
3. Impact of school closure
4. Impact of adaptations for Covid-Safe practice

In the case of Ananthi this framework can be used to analyse the impact of the pandemic on the outcome of the incident.

1. An increase in parent and family stressors

There were likely to have been increased pressure on the parents due to Mrs H being unwell but having the children in her care constantly, whilst Mr H was starting

[8] https://www.gov.uk/government/news/schools-colleges-and-early-years-settings-to-close
[9] The Child Safeguarding Practice Review Panel (2020) Supporting Vulnerable Children and Families during Covid-19: Practice Briefing

a new job. Had the children been in school, then Mrs H might have been able to access some help from her husband's extended family or parents of the children's friends to enable her to have some rest. Indeed, the National Panel briefing found that the 'lack of contact with extended family members during lockdown meant the loss of a key protective factor'. Although in this case, there was some reported contact with local friends, but not enough, in the Covid restrictions, to provide the support the family needed. In the reports of the consultations with health professionals, there was no evidence of any questions about what support Mrs H had access to. When she attended hospital with her husband, he was reportedly ignored by the staff; whilst on other occasions Mrs H attended alone or accompanied by her son who was used as an interpreter. The professionals should have seen a picture of a family with a blurred background which needed exploring to gain more understanding of the support available. The social aspect is an essential, basic, principle of assessment within services.

2. Exacerbated vulnerabilities for children and young people

The children in this family were 'below the radar'. They were not viewed as being significantly vulnerable prior to the pandemic and were not actively known, at that point, to any service beyond school. However, this raises questions as to how children reach the sight of the radar when they are in schools, or communities, which have significant numbers of vulnerable families.

3.Impact of school closure

Although the children were not identified as vulnerable, the school closure meant that there was no environment where they could disclose any concerns. Knowing that Adi had previously disclosed the chastisement to teachers, if there had been any problems within the household during mother's illness, then it is possible he would have alerted staff to this, had the school been open.

The school did offer the parents the chance for the children to return to school at the earliest opportunity, in June, but the father refused due to concerns about safety. The teachers had been communicating with the parents and spoke to Adi and all seemed to be well. This demonstrates the impact of schools as safe places. (If the children had been in school, would the incident have occurred as this would have been shortly after the end of the school day.)

4. Impact of adaptations for Covid-Safe practice

The school undertook phone calls. There would not have been the capacity, or the safety, for visits to all families. (These were carried out by schools were they had no contact from families – but this family were open to contact) As Mrs H was known to use the internet, it is not clear whether the family could have received

video calls from teachers or health professionals which might have enabled more of a view into the household.

The impact of the deferred hospital appointments for Mrs H were significant. Had she been able to get some answers about her symptoms then that might have helped her to manage her health more constructively.

The practitioners' event was held in September 2021, over a year after the incident. This shed light on the impact of the pandemic on children since that first lockdown, that for the January 2021 lockdown led to a significant increase in parents requesting places for their children, due to families struggling to maintain children's routines.

Findings
The initial phase of the Covid-19 pandemic highlighted the risks to children when not in school regularly which could have implications for future practice in relation to children missing from education.

6.2 Theme 2: Impact of Covid-19 Pandemic: Access to Health care

This case suggests that, in the first wave of the pandemic, there was a significant impact on individuals left waiting to see specialists due to the national policy to place non Covid-19 issues on hold.

In January 2020, NHS England and Improvement (NHSEI) wrote to health services advising on the need to reduce non urgent appointments. There was a recognition, at this time, of the NHS rapidly preparing for the influx of patients due to Covid-19. This meant that outpatient appointments were cancelled by hospitals. There was further guidance from NHSEI during the first lockdown in the Covid-19 Pandemic between March and July 2020 for NHS Trusts and Primary Care. This led to a rapid increase in virtual consultations.

Emergency Departments were still open to those needing to be seen urgently. Nevertheless, both professionals and the public were in a period of not knowing what the outcome of the pandemic would be. The NHS was under severe stress and there was a high level of fear in some communities.

The evidence was showing that those of black or Asian heritage were among the most vulnerable to the coronavirus[10]. Consequently, this led to some reluctance to access health care when they needed it[11]. However, Mrs H was not reluctant to seek help. Therefore, she should have been more visible to services.

[10] Public health England (2020) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*
[11]House of Commons (Dec 2020) Women and Equalities Committee: *Unequal impact? Coronavirus and BAME people Third Report of Session 2019–21.*
https://committees.parliament.uk/publications/3965/documents/39887/default/

During this time when there was little familiarity with Coronavirus symptoms and Primary Care was not managing the Covid pathway, but the 111 service was leading on this.

Findings
The initial phase of the Covid-19 pandemic had a detrimental impact on the quality of health service delivery for conditions not identified as being Covid-19 related.

6.3 Theme 3: Language: Use of Interpreters not embedded within health settings

This case highlights the gaps in the use of translation services particularly in health settings. There is an issue of understanding medical information which requires a good use of the English language and certainly not something for a child to be expected to translate for their parent. Barnados (2019) highlighted the inappropriate use of children to interpret for their parents and recommended that NHS England assess the 'impact of not having access to interpreters is having on families and their treatment'.[12] Given the diverse nature of the borough, it seems appropriate for work to be done to proactively improve the use of translation services across health services. Additionally, the use of language should be considered across education and social care to ensure that there is unambiguous understanding of what children and parents are saying.

It essential that all staff recognise and respond to the need for interpreters when working with people who find it difficult to speak English. This has been identified in previous case reviews.

'The MSCP should ask all Partners to confirm that the data from and efficacy of practice arrangements for interpreting is monitored by senior management. This should include protocols on the inadvisability and possible risk to vulnerable people when family members act as interpreters. In addition, agencies should be asked to confirm how practitioners are supported in understanding cultural dynamics in assessments and ongoing support to families.' (MSCP 2020)[13]

In addition, the panel discussed how the safeguarding and health systems promote learning English and access to classes. Learning English would have empowered Mrs H.

[12] Barnados (2019) *Caring alone: Why Black, Asian and Minority Ethnic young carers continue to struggle to access support.* https://www.barnardos.org.uk/blog/caring-alone-young-carers-who-struggle-get-support*:* accessed 05 August 2021.
[13] MSCP (2020) Serious Case Review: Child D.

Findings
Despite the evidence of the need for interpreters in health settings, this is not yet embedded in settings. Children are still, inappropriately, being used to interpret for their parents.

6.4 Theme 4: Impact of physical pain on an individual's mental health

This case illustrates how chronic pain can have a significant impact on an individual's capacity to manage their daily activities. Align this with an absence of the cause of the pain and this can lead to severe anxiety and depression. It is important to note that pain always has a psychological component.

When there are young children to be cared for then it is important that services recognise their needs and explore the parenting capacity of the adult who is experiencing severe pain.

The GP practice involved with Mrs H is now actively screening for mental health issues for parents and there is a social prescriber in place who can help to identify any support needs. There has also been a practice wide reflective session about the impact of long covid on a person's mental health.

Findings
Intense pain can lead to an adult not being able to function in their daily life and have a negative impact on their mental health. Pain may impact an adult's ability to function and their parenting capacity.

6.5 Theme 5: Visibility of children in adult health services

Within this case there were several incidences of Mrs H seeking health advice. Professionals were aware that she had children, but no questions were asked about how she was managing to care for them.

This needs further exploration to understand whether this was an issue solely related to the Covid-19 pandemic or that, as the case would suggest, that there is insufficient consideration of a holistic assessment for adults who are parents or carers. Given the focus that the Covid-19 pandemic has placed on how isolated some families can be within society, it is imperative that both children and adult services embed some, non-intrusive, questions that provide an opportunity for families to tell their stories and gain access to community support.

Findings
A holistic view of an individual's life is essential to assessments within health, care, and education settings to promote the welfare of children and ensure that families are not left isolated.
A holistic assessment can indicate the level of resilience within the individual's, or family's, support network.

6.6 Theme 6: Equality and Diversity principles within health care

This case illustrated how, when health professionals do not listen to an individual seeking their help, this can cause distress about what illness the individual might have.

The panel discussed whether this was an isolated incident or that it represented the wider practice in Merton. There were anecdotal examples which suggested that there is a lack of consistency in how women from diverse cultures and ethnic backgrounds are treated within health settings. It is essential that there is an equitable service for all, no matter what gender, race, religion, or language[14].

Findings
Health services, in Merton, are not consistently providing services that promote equality of opportunity, equality of access, and are non-discriminatory.

7 RECOMMENDATIONS

Item	Review Finding	Recommendation	Agencies involved
1	The initial phase of the Covid-19 pandemic highlighted the risks to children when not in school regularly which could have implications for future practice in relation to children missing from education.	The MSCP should consider how all statutory partners and relevant agencies can take responsibility for promoting school attendance for the children of families they work with and to identify those who might be out of sight. The work undertaken by the Local Authority to review Children Missing from Education	MSCP and relevant agencies

[14] Equality Act 2010. https://www.legislation.gov.uk/ukpga/2010/15/section/29

		should be used to inform this work. This should lead to a commitment to promote school attendance from all partners and relevant agencies working with individuals in households where there are school age children.	
2	The initial phase of the Covid-19 pandemic had a detrimental impact on the quality of health service delivery for conditions not identified as being Covid related.	NHSEI and the CCG should provide MSCP with information as to what learning has been taken forward within the health system and what actions are being taken to minimise long term impact on health provision.	NHSEI SWL CCG/ICS
3	Despite the evidence of the need for interpreters in health settings, this is not yet embedded in settings. Children are still, inappropriately, being used to interpret for their parents.	• MSCP must be provided with assurance, from health providers, that professional interpreters are offered for all consultations where an adult does not use English as a first language unless this would unnecessarily delay essential immediate emergency treatment. This should be linked to the actions following the Child D case from January 2020. • St George's University NHS Trust must provide	Health agencies providing services to Merton population MSCP

		evidence of use of interpreters in ED and a commitment not to use children. • This issue should be raised with NHSEI and Improvement to strengthen the guidance for providers of NHS services in relation to use of interpreters as set out in the Barnardo's report[15]. • MSCP should consider how it promotes access to ESOL classes to Merton residents across health and social care system.	
4	Intense pain can lead to an adult not being able to function in their daily life and have a negative impact on their mental health. Pain may impact an adult's ability to function and their parenting capacity.	The learning from this case should be presented to frontline health professionals raise awareness of the need to check, when an adult is presenting with severe or chronic pain, with no clear cause, health professionals must consider whether the adult has any caring responsibilities. If the adult is a parent or carer then there should be a conversation with them to check on the needs of the child.	St George's University NHS Foundation Trust Lambeth GP
5	A holistic view of an individual's life is essential to	MSCP should undertake a scrutiny exercise with frontline practitioners,	MSCP statutory partners,

[15] Barnados (2019) Caring Alone https://www.barnardos.org.uk/blog/caring-alone-young-carers-who-struggle-get-support

	assessments within health, care, and education settings to promote the welfare of children and ensure that families are not left isolated.	across health services, education, and social care, who work with adults who are parents or carers of children. This exercise should explore how practitioners gain insights into the social networks that support families. The aim will be to raise awareness of the importance of a holistic assessment. The aim of this scrutiny to develop agreed improved practice.	relevant agencies, and Independent Scrutineer
6	Emergency Department and primary health services are not consistently providing services that promote equality of opportunity, equality of access, and are non-discriminatory.	The SWL CCG should review how the acute and primary care providers delivering services to the Merton population are complying with the Equality Act 2010 in terms of access to health care for women and use of interpreters to ensure equity of access.	SWL CCG, SEL CCG, St George's

8 APPENDICES

8.1 Individual Agency recommendations (These were developed at the Rapid Review Stage by Individual agencies)

Item	Recommendations
1	Children's Social Care
	Childs records continue to highlight the child's journey, ensuring there is a recorded trajectory using the Signs of Safety approach
	Continue to evaluate and consider parental history when supporting families.
	Continue to use chronologies throughout the child's journey, case summary updated and reviewed in supervision.
	Robust and consistent application on the use of Signs of Safety and Practice Model within case recording and risk management.

	Continue to build on and strengthen communication with Key partners for those children where Children's Social Care has no statutory involvement
2	Central London Community HealthCare NHS Trust
1.	To engage in Local Child Safeguarding Practice Review
2.	To reinforce the use of formal interpreters by the 0-19 service at all contacts with a parent or carer where English is not their first language to ensure: equal access to our services, understand their needs and concerns and to ensure their voice is heard.
3.	To review the availability of health information for parents where English is not their first language and taking into account cultural norms and practice.
4.	To reinforce the use and documentation of routine enquiry around DVA and future planning if it was not safe to enquire at a contact.
5.	To cascade learning from the review to the 0-19 service

8.2 Agencies involved

Merton Children's Services

St George's NHS Foundation Trust

NHS Merton CCG

Liberty Primary School

Central London HealthCare Trust

Streatham Hill Group Practice

Metropolitan Police

London Ambulance Service