Paediatric Pearls

by Dr Julia Thomson, Paediatrician

Edited this month by: Dr. Jacqueline Driscoll – GP Trainee and academic fellow with a special interest in safeguarding.

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Monthly paediatric update newsletter for all health professionals working with children – put together by Dr Julia Thomson, Paediatric Consultant at Homerton University Hospital, London, UK. Housed at www.paediatricpearls.co.uk where comments and requests are welcome!

Best wishes to you all from the whole Paediatric Pearls team for Christmas and the forthcoming holiday period and Happy New Year!

Disguised Compliance

It has been a very sad month for safeguarding news and Arthur Labinjo-Hughes and Star Hobson are uppermost in my mind as I write this newsletter. Full reports and recommendations will come in time but it is already clear that disguised compliance was a feature of both cases and as such, it is timely to review some resources on this topic.

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement.

Disguised compliance can take many forms and includes:

♦ engaging "just enough" to allay concerns or focusing on one issue only
♦ manipulating relationships with professionals and playing professionals off against one another as the professional who understands and the professional who does not
♦ regularly missing and cancelling appointments

Strategies to remain vigilant to the possibility it could be happening include:

♦ display professional curiosity when working with families
♦ do not accept information from parents and carers at face value without investigating further
♦ focus on establishing facts rather than opinion
♦ carry out some unscheduled visits
♦ centre the child's lived experience ie. listen to their perspective and version of events
♦ "think the unthinkable" (from https://pdscp.co.uk/wp-content/uploads/2020/02/SCR-Daniel-Pelka-2013.pdf, the SCR into the death of Daniel Pelka in 2013)

Log some CPD points and read this short guide from the NSPCC: https://learning.nspcc.org.uk/media/1334/learning-from-case-reviews_disguised-compliance.pdf

This helpful PDF from the Manchester Safeguarding Children Procedures manual expands on the above: https://greatermanchesterscb.proceduresonline.com/pdfs/policy_briefing_No-197.pdf

LESSONS FROM THE FRONT LINE

A letter from school came to the GP practice to ask for more information about why a 14 year old boy was only attending school 2 days a week for the past year? This boy wasn't well known in the practice and we have slowly started to build rapport and explore the issue with him and his Mum over a series of regular appointments. Everyone involved is motivated to improve things but it has become apparent there are no easy solutions.

His case got me thinking about the importance of early intervention when school refusal first begins to manifest as a problem for a child or young person and how we can support parents to support their child around school attendance.

There are really useful resources to direct parents towards on both
https://headspace.org.au/explore-topics/supporting-a-young-person/school-refusal/
and
https://mindedforfamilies.org.uk/Content/refusal_to_go_to_school/#/id/5e30acd1248b101ab8074d42

Many issues can lie behind school refusal including learning difficulties, bullying, anxiety, depression, sleep issues, attachment disorders and may require an MDT approach between school, CSC, primary care, paediatrics and CAMHS to address.

Key tips for success in breaking the cycle early:

- Listening to and validating worries
- Problem solving together with the child making suggestions on what could help
- Having a routine around getting up and going to school
- Setting clear expectations
- Providing motivation
- Relaxation techniques

https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are

Understanding Liberty Protection Safeguards (LPS)

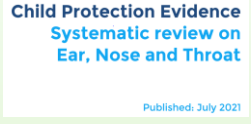
The LPS were introduced by the Mental Capacity (Amendment) Act 2019. It will be the system that will authorise arrangements amounting to a deprivation of liberty for people aged 16 and above in order to provide care or treatment to an individual who lacks the relevant mental capacity to consent to those arrangements, in England and Wales.

It has been delayed again but will eventually replace the Deprivation of Liberty Safeguards (DoLS) system which requires an application to Court of Protection if we want to treat 16 and 17 year olds who lack the capacity to consent. For us, this will be applicable to young people with severe autism and learning difficulties for example. Instead of obtaining a court order, we will now be applying to a "responsible body" for this permission. **More information on who the responsible bodies will be can be found at** https://www.scie.org.uk/mca/lps/latest.

Applying the legislation will require three assessments:
1: A capacity assessment
2: A 'medical assessment' to determine whether the person has a mental disorder
3: A 'necessary and proportionate' assessment to determine if the arrangements are necessary to prevent harm to the person and proportionate to the likelihood and seriousness of that harm. Want to know more at this stage? https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets has a number of factsheets about different aspects of the Liberty Protection Safeguards legislation.

Did you know? (with thanks to Dr. Dharini Chandrasegaran for this month's titbit)

RCPCH has an excellent evidence-based resource called Child Protection Evidence on their website with up-to-date systematic reviews on various presentations. This month we are highlighting their review on ear, nose and throat presentations that should trigger a safeguarding concern: https://www.rcpch.ac.uk/resources/child-protection-evidence-ear-nose-throat.



Key messages:

1. Any child less than 2 years of age presenting with epistaxis in the absence of known trauma or haematological disorders warrants a full evaluation for asphyxiation as a possible cause. The review finds that the **probability of asphyxiation**, either intentional or unintentional, in a child with **epistaxis is 19.6%** (95% CI, 12.7-28.8%)
2. Fabrication and induction (FII) of ENT signs and symptoms most commonly involves recurrent unexplained otorrhoea or ENT lesions which fail to heal despite appropriate therapy. See June's Paediatric Pearls newsletter for more from RCPCH on FII and perplexing presentations - https://www.paediatricpearls.co.uk/wp-content/uploads/2021/06/June-2021.pdf