

Khyra Ishaq serious case review published in full

As readers will be aware, this is the first SCR to be published in full. It follows the death of Khyra, at the age of 7, following mistreatment by her mother and partner. Khyra was severely underweight at the time of her death. She died from bronchial pneumonia and septicaemia with focal bacterial meningitis. Her siblings were also found to be malnourished.

The full Board report was published on 27 July 2010. It concluded that Khyra's death had been preventable. It identified missed opportunities and highlights that better assessment and information sharing by key organisations could have resulted in a different outcome. One example provided was that following a referral by the family Health Visitor about domestic violence the Health Visitor did not maintain contact or support following the referral and the referral was not followed up promptly.

Whilst the focus was on social services, there are some important reminders for ongoing practice for NHS colleagues. For example, school medical staff did not adequately address concerns raised by school staff, that one of Khyra's siblings who remained in the state school system (Khyra was removed into home schooling) was obsessed with food. Weight changes were not fully plotted in order to assess the impact of the fluctuating weight in Khyra's sibling. The mother's subsequent resistance to a n appropriate dietician referral did not appear to raise alarm bells for medical staff, generate concern or professional curiosity or prompt further safeguarding checks.

Recommendations made in relation to the NHS bodies concerned with Khyra's care which are of importance are as follows:

o **Recommendation 1**

The LSCB should commission work to identify how agencies across Birmingham can increase effective professional communication to improve the safeguarding outcomes for children and young people in compliance with policy and procedure.

o **Recommendation 2**

The PCT who oversaw the school nurses should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development.

o **Recommendation 3**

This recommendation was directed at PCT's generally. They should review processes for obtaining parental consent for child access to the school health service and implement this. This should include a process of follow up action for parental refusal or withdrawal of consent.

briefing continued

- o **Recommendation 9**

The LSCB should commission multi agency guidance and training to equip staff in all agencies to work effectively with aggressive and highly resistant parents and carers.

- o **Recommendation 15**

One PCT involved (who oversaw a GP services highlighted in the report) was directed to review and satisfy themselves that all GP's are aware of their professional responsibilities to communicate safeguarding concerns that arise as part of their interaction with children and families, in line with existing safeguarding procedures.

- o **Recommendation 17**

The PCT's involved were directed to provide evidence to demonstrate an effective response to missed or failed appointments.

The lessons learnt from this tragic case and the recommendations above are of particular importance to GP's, school nurses, health visitors, community paediatricians and their managers, as well as those practitioners involved more generally in child protection. As with previous enquiries in cases such as Baby P, the need for clear inter-agency communication (and follow up); thorough record keeping and a continuing focus on a child, especially in light of difficult/non engaging parents, is emphasised. In addition, keeping an eye on the 'bigger picture' such as a child's over all development, and their family unit, is highlighted as an important issue to consider throughout a health professionals contact with a child who is not thriving.



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