Harrow

safeguarding Children Partnership

Child safeguarding Practice review

 ‘Child M’

 Publication version

Fergus Smith

24.06.21

# introduction

## Scope & purpose of review

### This review was triggered by the unexpected death in early 2020 of 12-year-old ‘child M’. Child M (a British-born male of Pakistani ethnicity) had significant disabilities and complex chronic medical needs. The eventual conclusion of a post-mortem some months later was that he had died as a result of ‘multi-organ failure, sepsis and cerebral palsy’.

### Initial agency responses included (in accordance with statutory ‘Child Death Review Guidance’[[1]](#footnote-1)) a ‘Joint Agency Response’ on 06.02.20 and on 17.02.20, notification of the National Child Safeguarding Practice Review Panel as well as initiation of a local ‘Rapid Review’.

### In the course of discussion amongst those participating in the ‘Rapid Review’, concerns were identified relating to child M’s medical / dental care, attendance at his special school and reported use of physical restraint. It was concluded on the basis of the then available facts that child M might have experienced ‘neglect’[[2]](#footnote-2) i.e. ‘a persistent failure to meet a child’s basic physical and/or psychological need, likely to result in the serious impairment of the child’s health or development’.

### A recommendation that a child safeguarding practice review be completed was accepted by the independent chairperson of Harrow’s Safeguarding Children Board and supported by the National Panel. The review was completed between September 2020 and May 2021 with the purpose of identifying any required improvements in the local planning and delivery of services intended to safeguard and promote the welfare of children.

### Independently authored reports were obtained from all involved agencies and a comprehensive merged chronology of service delivery developed. An experienced independent author was commissioned to evaluate overall service delivery and, supported and advised by a panel of relevant managers, formulate any justified recommendations.

### Relevant professionals were convened for a discussion of the initial findings of this case review and their opinions, experiences and ideas are reflected in this final publication summary. Panel members are grateful for the commitment of time that practitioners’ attendance represented. Child M’s parents were informed of this review and encouraged to contribute their views and comment on a final draft of this report. Regrettably, they have not responded to those offers.

### As illustrated overleaf, child M lived at home with his mother and father and two younger siblings. His condition mean that he required feeding via a ‘percutaneous endoscopic gastrostomy’ (‘Peg –fed’ is the commonly used abbreviation) . Child M was wheelchair-dependent and unable to speak.

**Father**

**Child M**

**Brother**

### For the period selected (September 2017 to February 2020) the following ‘lines of enquiry’ were pursued:

Use of restraints on children in Harrow apparently contrary to Government guidance – and attitudes towards their application to children with disabilities or communication difficulties

Effectiveness of the review system for Education, Health and Care Plans (EHCPs)

Any need for a ‘was not brought’ (WNB) policy for Harrow

Whether the threshold for safeguarding is being applied properly to children with disabilities

Whether prolonged school absences for disabled children are managed in accordance with local procedures

Identification of the partnership’s response to child M’s reported mouth pain and dental care

How well child M’s voice was heard, understood and taken into account in assessment and planning

How well was the culture of child M’s family understood and taken into account in assessment and planning

Reasons why child M’s death was not initially dealt with as an ‘unexpected death’

### Section 2 summarises what was for child M’s family and the professional network, a very demanding period and the substantial efforts expended to meet the many medical, emotional, care and social needs of child M. Section 3 provides responses to the review’s lines of inquiry and recommended changes to service design or delivery.

# Summaryof Service delivery

## Recognition of & response to health & other needs whilst at primary school

##### Restraints & Medication

### Though significant scope was found for improving the recording of prescribed medication, there is ample evidence of sensitive practice by school nursing assistants, teaching staff as well as speech and language therapists, occupational therapists and physiotherapists. Child M’s complex needs required the ongoing involvement of a local paediatrician as well as the expertise of *several* specialist functions.

### By half-term in Autumn 2017 involved agencies were aware of the use of ‘soft restraints’ used to prevent dystonic[[3]](#footnote-3) movements that might cause involuntary self-harm i.e. he could, as well as scratching face and eyes, potentially become stuck in a painful position. The class teacher responded by making large jumper sleeves to be slipped over her pupil’s arms and the arms of his wheelchair for use on home-school journeys. Child M could ask for them if they were needed during the day and was able to ‘eye point’ to either ‘sleeves’ or a symbol for ‘no’. The sleeves were thought to have a similar effect to a weighted blanket. Use of ‘soft restraints’ is also captured in the medical records of the consultant paediatrician in October 2017.

### Comment: *the intentions of father, school staff, consultant paediatrician and GP were positive and sought to incorporate the child’s wishes; there existed though, scope for further multi-agency debate and better co-ordinated responses*

### Joint and ultimately successful efforts were made by the paediatrician and occupational therapist to request the Housing Department to relocate the family so as to enable installation of a permanent hoist.

##### Initial Reports of Oral Discomfort

### Community Children’s Nurse Team records of late 2017 include a reference by the school to ‘intermittent mouth ulcers’. Practical advice was offered by the nurse who also recommended a ‘mouth area review’ by GP or specialist dentist. Her advice was not followed. In December 2017, a multidisciplinary therapy report for transition to Secondary School and a standard review of prescribed medication was completed. Arrangements were made for an appointment at the ‘Paediatric Neurodisability Unit at Great Ormond Street Hospital for an initial assessment and injections (under anaesthetic) of Botulinum Toxin[[4]](#footnote-4) to arms and legs.

##### Planned Transition to Secondary School

### In late March 2018, an annual review meeting was attended by father and Secondary School senior staff. Child M’s needs and a plan for his transition were agreed and included a referral (Common Assessment Form - CAF) to be sent to Harrow’s Multiagency Safeguarding Hub (MASH) seeking carer support at home. School staff believed that it would help the family if there were support with child M’s personal care and the value of holiday play-schemes was recognised by all. By May 2018 the family had moved to its new home. Physiotherapy staff discussed with child M’s father possible use of ‘night splints’ – their purpose to enable prolonged stretching. In the event, father’s concern about the impact on child M’s sleep prompted him to decline their use.

### Comment: *though intended to be therapeutic and their use discussed with father, there may have been little difference from child M’s perspective, between ‘night splints’ and ‘soft restraints’ to prevent accidental self-harming.*

### In mid-May 2018, during what was to be the final medical review by the school’s linked consultant paediatrician, increased dystonia was reported by father over the past 2-3 months and a second reference to mouth ulcers appeared, albeit said to be reduced in their impact. Classroom staff remained concerned about the severity of dystonia and the paediatrician planned to pursue further specialist opinion. This action and others identified at the above review were progressed.

### Comment: *the number of specialists from Health, Education and Social Care agencies rendered overall co-ordination of child M’s complicated needs challenging; sufficient recognition of the pressure on his parents and siblings is not apparent in agencies’ records.*

##### Planned Support over Summer & Handover to Secondary School

### Failed attempts were made by a newly allocated social worker in the Children’s Disability Team to organise respite care over as well as a review of occupational therapy needs over the Summer. By way of transition planning, a learning support assistant from the Secondary School began to visit him and develop a rapport. A ‘liaison morning’ with a family worker from the next school was also convened in late June.

### Comment: *arrangements negotiated between schools illustrate a high level of sensitivity and forethought.*

### Concerns about child M’s gastrostomy emerged during the final week of term and would have benefitted from School Nursing Service involvement and a lead health professional to coordinate responses to a child with complex medical needs and apparently in pain. In late August, the GP Practice asked its administrative staff to follow up (by means of inviting a phone consultation) the parental failure to present child M at a scheduled ‘Spinal Assessment’ appointment earlier that month, or to respond to phone calls or messages left on father’s phone. No record of that action or its results have been located.

## Secondary School & Concern About ‘restraint’

##### Internal Safeguarding Referral

### Child M achieved full-time attendance for a week in early September 2018 before being admitted via A&E and spending 4 days in hospital. Later that month, the assistant head teacher queried the use of restraints on school transport. A Community Paediatric Nurse initiated a safeguarding referral and alerted her deputy head teacher and ‘safeguarding lead’. She did not escalate the case via her Health hierarchy, apparently because of an understandable (misguided) reluctance to add to the heavy workload of their senior colleagues.

### There were in late October, extensive discussions and negotiations within the school and with other involved agencies about the need to resolve ‘seating’ and other needs before child M would resume attendance. After a half-day attendance in early November, child M was not seen again there until mid-May 2019.

### Comment: *the complexity of this situation and unmet need for co-ordination across the local network would have justified escalating the case.*

### A Personal Learning Plan (PLP)[[5]](#footnote-5) in December 2018 was unable to set new targets because of child M’s ongoing absence, though it was recognised that father was struggling to get his son into the current wheelchair. Child M was not present at a planned medical review which involved paediatrician, paediatric physiotherapist and neurodisability consultant. Recognising there were behavioural as well as medical issues associated with child M’s difficulties, it was agreed a referral would be made to CAMHS. Also ‘urgent’, though not achieved for 9 months, was a follow up to the neurodisability consultant at Great Ormond Street Hospital.

### Early in Spring 2019, a meeting of teaching staff and physiotherapist acknowledged child M’s reluctance to leave his house and use his wheelchair, which was thought to be ‘behavioural’ as opposed to ‘medical’. In a rare acknowledgement of the family context, a sibling with additional needs was reported to live at home, with another ‘in and out of hospital’.

##### Review of Education, Health & Care Plan (EHCP)

### Though there was an attempt on 12.02.19 by physiotherapist and occupational therapists to formulate a plan, the more formal annual review of child M’s EHCP was not completed. Extensive debate about child M’s absence and the underlying reasons followed. The need for a slow transition was agreed. Father was in agreement with the proposed way forward. A week later and again on a second occasion, father consulted a GP and reported that child M had a raised temperature and white spots / pus on his tonsils. The doctor diagnosed tonsillitis and prescribed antibiotics.

### The potential benefit of a school-based dietetic appointment in early May was lost as child M’s non-attendance continued. Records confirm attempts made by staff working in the ‘Family Liaison’ role to develop with father, a plan for child M’s gradual return to school. He managed only an hour-long session in mid-May 2019 and, after a renewed agreement about ongoing time-limited sessions, was absent for the remainder of that school year. School and CAMHS subsequently struggled to contact the family and the Family Liaison staff were ‘contemplating’ a referral to Children’s Social Care. Because he was not, after an unexplained delay of 10 months, presented to an Ear, Nose and Throat (ENT) appointment in March or again in June, child M was removed from its list. The clinic failed to notify the GP Practice of that action.

### At a ‘team around the family’ (TAF) meeting in school in late June 2019 father described an improvement in child M’s distress level, which he attributed to changes in diet. A ‘transition plan’ (seeking to avoid known triggers for distress whilst in school) was outlined by CAMHS. In late July, a planned ‘speech and language therapy’ session was cancelled by father and although re-scheduled for an earlier date was not, as result of non-school attendance, completed until October 2019.

### In mid-September father described ‘really bad’, albeit improving, mouth ulcers. Records of late September reflect child M’s return to school for about a week. Consideration was given to how medication at school needed to be sent home if he was absent, lest the stock at home be insufficient. It remains uncertain whether, with minimal school attendance, parents held sufficient supplies and made full use of the prescribed medication.

### In late September 2019, a ‘case closure’ letter was sent to the parents by Children’s Social Care. The decision apparently reflected father’s failure to respond to an undated phone call from a duty officer, though it also included a reference to a conversation in which father had reported resumption of part-time school attendance.

### Comment: *inadequacy of records renders it difficult to be confident about events, the Service response though, suggests a reluctance to acknowledge and carefully assess the self-evidently high level of support needs; even taking into account the insufficiency of co-ordinated multi-professional efforts, it must have been clear by then that the parents were struggling to respond to health-related appointments; addressing that issue head-on could have enabled a better appreciation of how (quite understandably) overwhelmed, the family may have actually been.*

### From late October until the end of term, child M achieved 2 half-days at school per week. In the school nurse assistant’s records, she captured the first reference father made to child M showing signs of pain because (he thought), of emerging teeth.

##### Safeguarding Referral to Children’s Social Care

### At the end of October during a pre-arranged home visit for a nursing re-assessment, restriction of child M’s hands and arms was observed. Socks had been slipped onto on his hands and the right hand looped in a scarf and tied (albeit not tightly) to his leg. This action was reported by father to prevent scratching of head, eyes and mouth. The community paediatric nurse’s view was that the parents were struggling to cope. She consulted her agency’s safeguarding nurse and it was agreed that child M’s father should be informed and a safeguarding referral made to Children’s Social Care.

### Upon receipt of that referral by the Multi-agency Safeguarding Hub (MASH), the details provided by the community nurse were noted and the case passed to the Disability Service to explore child M’s lived experience and parental ability to manage the demands his disability represented.

### Comment: *the reported facts would have justified a strategy discussion / meeting under s.47 Children Act 1989 involving health professionals; even operating under s.17, there was a clear need to explore the needs of the* whole *family not just those of child M.*

### No feedback to the referrer was provided and it would appear that this procedural failure was not escalated by the Nursing Service. The social worker allocated to complete an assessment, seems to have made no response until a home visit 6 weeks later when no record of his actions has been located. In response to notification of the above referral, a GP undertook a home visit and noted that ‘child M has thick gloves covering both hands with a soft cloth to his inner thighs that allows enough traction to prevent him hitting his face and lips and not a tight cloth tying his hands and feet together which was the impression he got from the email received. The GP noted that the family is caring and can see it is a challenge to manage this difficult and unpredictable situation.

### Comment: *the actions of the nurse were commendably cautious and provided an opportunity to better appreciate the lived experiences of child M and family.*

### On 03.12.19 the physiotherapist during a school-based review, responded to father’s report of continuing mouth ulcers by initiating a referral to the Community Dental Service[[6]](#footnote-6). This was received on 05.12.19, and included a description of the patient being a child with special needs experiencing pain and the need as ‘urgent’ (the expectation being that it would be triaged on the same day, the patient contacted by phone within 24 hours and an appointment offered within a week - in the event of difficulties in establishing contact by phone, a letter would be sent).

### In this instance however, no response was made untilearly January 2020 when an appointment was offered for early February. The contractual expectations, case triaging by ‘an experienced referral management lead’ and quality assurance systems appear sound. It *may* be that unrecorded attempts were made by phone to contact the parents. Prompted by its shared concern about the delay, the Dental Service has taken steps to optimise responses to the intrinsically complex needs of a patient such as child M.

## Child M’s Death & Subsequent responses

### In response to a telephone notification of death on a date in mid-January 2020, a detective sergeant from the Metropolitan Police Service (MPS) attended and was briefed on the reasons for his admission and observations of medical staff. The attending officer noted that the cause of death was at that time ‘unknown’ though thought likely to have been from non-suspicious medical causes. He liaised with the Children’s Social Care Emergency Duty Team where staff confirmed involvement of an allocated social worker. The sergeant and a second officer attended the hospital, spoke with the physician in charge who confirmed the earlier description of events. Having consulted the on-call detective inspector, it was agreed the matter could revert to the standard hospital protocol, in the knowledge that the death would be considered by the local Child Death Overview Panel (CDOP) and that the Coroner’s office had already been notified.

### Comment: *the immediate Police response to the tragic death was commendably cautious and sensitive.*

### The GP Practice was notified promptly of child M’s death (cause at that time ‘unknown’) and next day the standard ‘form 1’ sent by the Practice to the Coroner’s office. Apparently in consequence of unfamiliarity, the named doctor did not notify Harrow Clinical Commissioning Group of child M’s death. Though Police were not invited, a first ‘Rapid Response’ meeting was convened in early February and a further ‘Rapid Response’ meeting, attended by the detective inspector convened 11 days later.

## responses to Lines of Enquiry

#### Use of restraints

##### Law / Regulation / Guidance for Professionals

### Desk-top research of the lawful / professional expectations of community staff working with highly dependent children highlights:

‘*Use of Reasonable Force: Advice for Head Teachers, Staff and Governing Bodies’* published in July 2013 cited s.93 of the Education and Inspection Act 2006 which allows the use of ‘reasonable force’ in specified circumstances e.g. prevention of harm to an individual

More recent (27.06.19) non-statutory government guidance is to be found in *‘Reducing the Need for Restraint and Restrictive Intervention of Children and Young People with Learning Disabilities, Autistic Spectrum Conditions and Mental Health Difficulties in Health and Social Care Services and Special Education Settings’*[[7]](#footnote-7)and

‘*Keeping Children Safe in Education’* (2020) also provides updated statutory guidance for schools and colleges though contains no reference to use of physical restraint

### Other older regulations or Department for Education (DfE) guidance apply to specific settings such as Children’s Homes or Foster Homes. The use by or consent of, a person with parental responsibility to the use by another person, of proportionate and reasonable force to restrain a child who might otherwise injure her/himself or another individual is *not* proscribed in legislation *unless or until* its nature or frequency were to cause a local authority to conclude that there existed ‘reasonable grounds for suspecting that s/he is suffering or is at risk of suffering ‘significant harm’.[[8]](#footnote-8) Nonetheless, without regard to parental wishes or gaps in the currently published advice, it is clearly of vital importance that the most vulnerable of children are protected from all unintended consequences of well-meaning restraint as well as any deliberate harm.

##### Use of Restraint in Child M’s case

### Use of ‘soft mechanical restraints’ was well intentioned and entirely supported by father (and possibly mother). From late 2017, until the referral by the community nurse in late 2019, the practice was accepted by school, community paediatricians, GP, CAMHS (from an unrecorded date in 2019) and father. It may also be that the Children’s Social Care Disability Team knew of and accepted the practice. Whether the use of the ‘soft restraints’ was always *justifiable* is more debatable and an important example amongst many, of why there needed to have been a comprehensive, *coordinated multi-agency approach* to planning and reviewing child M’s needs. If professionals had been able to interpret more holistically, his unspoken wishes and feelings, an equivalence between the mechanical restraint represented by a large woollen sleeve and the medical restraints of which splints and administration of Botox injections were examples *might* have emerged.

### It is clear that health and education staff at the Primary School were committed and sensitive to his many needs. Some initiatives shown e.g. home visits to follow up absences, accessing father via a relative suggest action ‘above and beyond’ expectation. Involvement of family at the Secondary School was, reflecting chronic absence, more limited. Though monitored internally, it does not seem that formal notification was made to the local authority. It is likely that if child M not been disabled, the response of a mainstream school would probably have been different.

##### Effectiveness of the review system for EHC plans ?

### Insofar as school attendance was not at that time seen to be problematic, the last annual review at child M’s Primary School was held in March 2018. This involved parents and senior staff from the current and future planned school as well as those providing therapy to child M. It had the advantage of a well-completed ‘All About Me’ report (likes, dislikes, methods of communication, equipment, strengths and achievements, calming strategies etc). A further annual review report was drafted in January 2019 by occupational, speech and language and physiotherapists and a multi-agency meeting convened in mid-February. There was no Children’s Social Care representation and its value was limited by child M’s ongoing non-attendance.

### Child M’s Secondary School report that the annual review documentation received made no reference to self-injurious behaviour, need for restraints or the child’s high level of anxiety or gastric distress.This case review has been advised that the absence of any reference or contribution to the EHCP in child M’s school nursing records does not justify a recommendation with respect to their greater involvement. An assurance has been given that because the service with respect to pupils with complex health needs, is now being delivered by specialist nurses this will ensure sufficient information sharing.

#### need for a ‘was not brought’ policy for Harrow ?

### A report provided by the Central & North London NHS Foundation Trust provides confirmation of the existence of a ‘Was Not Brought’ (WNB) policy and an expectation that all staff should be familiar with it. The Trust’s report highlights the need to recognise the relative isolation of school nursing assistants and, in consequence of less intense and specified training, insufficient recognition of the significance of non-compliance with medication / medical intervention. This is arguably more obvious if a child patient is not presented to a clinic appointment and less when it is a secondary consequence of non-school attendance.

### The above report also highlights a further important, albeit less tangible, reason why the ongoing unreliability of child M’s medication was not better recognised. The report makes reference to what may usefully be distinguished from one another. The ‘written / formal contract’ of employment meant that the assistants could consult more senior registered school nurses for advice and support as/when required. The ‘psychological contract’ reflected both ambiguity (were *Education* staff rather than school nursing assistants responsible for taking the initiative?) *and* ambivalence (school nursing assistants were sensitive to the heavy workload of their senior colleagues). The absence of an ‘overview’ of all the abortive contacts reflected the lack of overall coordination reported elsewhere in this report and within the Trust, an unhelpful mixture of paper and electronic records. A single shared database would obviously ensure the possibility of better informed and more timely responses.

#### threshold for safeguarding children with a disability

### Some suggestions of unconscious bias or more arguably, institutional ‘disablism’[[9]](#footnote-9) can be found in the relatively passive responses of the GP Practice in May 2018 when father failed, having sought medical assistance, to follow up on child M’s reported mouth ulcers. The GPs knew each family member well and might usefully have better appreciated that child M’s health and well-being depended *entirely* on the actions / inaction of others. A second example is offered by the relative passivity of response when the MASH relayed the community nurse’s referral of November 2019 to the Children’s Social Care Disability Team. No feedback to the referrer was provided and little action taken for some 6 weeks. The legal foundation of the belated response was not confirmed as being either s.17 (in need) or s.47 (significant harm). It seems likely that the response provided, *had* it involved a non-disabled child, would have differed and might have prompted a ‘strategy discussion’.

### A health-related example of a possibly differentiated response may be found in October 2018 when the school nursing assistant’s sensitivity to her observations were relayed by way of an internal response *only* to the senior leadership team, rather than her Health seniors (possibly reflecting a sense that she belonged to the school ‘team’).

#### prolonged school absences for disabled children managed in accordance with local procedures ?

### It appears that no formal quantification or notification to the local authority of the extremely extensive (and possibly ‘authorised’) periods of child M’s absence from Secondary School was completed. The practitioner event highlighted the challenge of balancing attendance with the complex and frequently changing needs of pupils with a significant levels of disability. A positive organisational response has been to ensure all future ‘attendance panels’ include a representative of the Children & Young Persons’ Disability Service.

#### why the partnership’s response to child M’s mouth pain & dental care needs fell short of expectations

### During the course of this CSPR, the contractual obligations and expectations of the NHS England-commissioned Whittington Health NHS Trust’s Community Dental Service were provided and confirm the existence of clear, coherent requirements for service delivery including suitably informed / qualified and timely responses to referrals. It *may* be that further attempts to make telephone contact with child M’s parents were made and failed. Such efforts were not then recorded but in response to this case, a log of such efforts has been established.

#### Why Child M’s death was not initially dealt with as an unexpected death

### A delay and uncertainty about describing the death of child M as ‘unexpected’ reflected the manner in which the original notification of the event was provided by the hospital. Whilst the Coroner had been appropriately informed of the event, Harrow Clinical Commissioning Group had not been informed. The consequences of the delay were compounded by an inability to access the family home until members returned from a trip abroad. The existence currently, of a dedicated ‘Child Death Overview Team’ precludes the need for a local recommendation though (given that Child Abuse Investigation Teams are now managed within each Borough Command), it would be useful to confirm that all Boroughs are positioned to be compliant with all required responses to unexpected child deaths.

#### How well was the ‘voice’ of Child M understood & taken into account in assessment & planning ?

### During his attendance at Primary School, there are numerous examples of educational and therapeutic staff involved in the provision of education, medication and therapies demonstrating a careful and sensitive approach to the pupil’s immediate feelings and preferences. As a result of his vastly reduced attendance from July 2018 onwards, the advantages of coordination and care, skill and commitment from those who had related directly to child M was largely lost. Instead, his day to day care became almost entirely dependent upon his parents (the balance of responsibility between mother and father remains unknown). Though no evidence exists to suggest that parents were anything but caring and committed, they may often have been overwhelmed by the totality of child M’s needs as well as the care of younger siblings. Setting aside the fact that the practice had been known to many in the network for some two years, the initiative shown by the children’s community nurse in recognising and responding to her observations in late 2019 was commendable.

#### How well was the culture of the family understood & taken into account in assessment & planning ?

### In spite of the considerable sympathy and respect for the efforts made by his family to care for child M, few attempts were made and minimal progress achieved in understanding the reality of day to day life. Even basic information remained unrecorded e.g. neither Children’s Social Care, School Nursing or CAMHS records captured names, dates of birth of younger siblings, their respective individual needs or their wishes with respect to the impact of their profoundly disabled brother.

### The reality of frequent lifting, providing total personal care for child M and trying to present him at dozens of appointments must have placed huge and (as he grew older) increasing pressures on the adults within the household. Some recognition of this can be found in the referrals to Harrow Children’s Social Care in March 2018 and June 2019.

### Child M’s mother appears only once within the extensive records seen. Health records did capture the fact that her use of English may have been limited which offers one explanation about her very limited involvement in contacts with the professional network. A little more professional curiosity amongst any of the involved professionals might usefully have explored *her* experiences of caring for child M as well as possible explanations for father’s lead role in agencies’ contacts.

## Emerging Learning

### Transcending the specific ‘lines of enquiry’ above, it is possible to identify some overarching opportunities for organisational learning.

#### Listening to Child M

### Several examples of ‘best practice’ emerge from the material examined. Primary School staff, involved therapists and the CAMHS behaviour analyst were sensitive to child M’s feelings. The former professionals especially showed a willingness to interpret his responses in a manner which may have been inconvenient in relation to completing a proposed assessment of need, but sought to recognise the child’s rights.

#### Insufficient case co-ordination

### Material provided to this CSPR demonstrates that there were weaknesses in the following specific functions and interfaces:

Ensuring reliable administration and recording of medication whether child M was in school or at home

Ensuring that the information and expertise accrued by teaching staff, medical practitioners, therapists and (to a lesser extent) Children’s Social Care, were all factored into the review of the Education and Health Care Plan (EHCP)

Drawing upon the above to debate and determine the optimum way of protecting child M from any risk of harm

### The magnitude of challenge for professionals is made clear if one recognises the involvement of 15+ agencies and many more individuals within those organisations. Though the community paediatrician or GP Practice *might* have had some potential value at the coordinator of child M’s multitude of mostly health-related needs, the more obvious candidate for this unfilled role was the Disability Service within Children’s Social Care. By definition, a child with a disability is a ‘child in need’[[10]](#footnote-10). An assessment apparently begun in April 2018 at about the time the family moved to larger and more suitable accommodation failed to capture any detail of child M’s siblings or how the family was coping. Subsequent opportunities in June and November 2019 were also missed.

#### More EFFECTIVE SCHOOL NURSING / ASSISTANT ROLEs

### A lack of oversight of record keeping and insufficient supervision of complex cases meant that issues that needed to be addressed in relation to child M’s care, absences, medication etc were not explored further. In addition, documentation in or instead of the use of SystmOne, was often poor.

## Conclusions

### The overall learning emerging from this review suggests:

An unmet need to better understand child M’s lived experience at home and his family’s coping mechanisms

Insufficient case co-ordination and development of agreed ways to maintain health and minimise risk of harm

A need for a review of the respective roles of school nursing assistants and school nurses

A need for debate about the extent to which existing service user information systems support or constrain information exchange

A need for enhanced appreciation / application of existing ‘was not brought’ policies

A review of the extent to which Education, Health and Care Plans (EHCP) or non-school attendance policies are being applied to those in special education facilities

## Recommendations

#### Harrow Safeguarding children Board

### The Board should develop child-centred guidance on the meaning and application of ‘mechanical’ and ‘physiological / medical’ restraint to children living in the community (other than in regulated environments) who are additionally vulnerable by virtue of physical / learning disabilities

### The Board should ask each agency in the local partnership to take steps within routine communications and training programmes to remind professionals (including those in community settings such as GP Practice and School Nurses) of the existence and importance of compliance with the existing ‘Was Not Brought’ policy.

#### Central & North West London (CNWL) NHS Foundation Trust

### Health visiting and School Nursing ‘Units’ on SystmOne should be amalgamated into a single ‘Harrow 0-19 Unit’.

### The Trust need to review and distinguish the respective roles of school nurse and school nursing assistants ensuring that in both cases, appropriate levels of supervision are provided and recording requirements made explicit and monitored. [the panel has been informed that as of September 2021, Harrow as part of the North West (NW) London CCG, will be commissioning a specialist school nursing service provided by fully qualified children’s nurses, thus ensuring that expertise and professional oversight is maintained across the service].

### The Trust should formulate proposals for addressing the risks associated with records fragmented across connected functions e.g. School Nursing & Community Services.

### Seek confirmation that the current arrangements for ensuring School Nursing Service perspectives (e.g. missed appointments) that inform annual EHCP Plans are robust.

#### Harrow Education Service

### A review across all special schools is required to provide confirmation that non-school attendance responses are of comparable or superior standards than those applied to able-bodied pupils.

### Special schools should explore the possibility (understood to work well in neighbouring Brent) of seeking advance parental agreement to dental screening via ‘blanket consent’ obtained at the start of the school year.

#### Children’s Social care Disability Service

### On the basis of inadequate responses to child M’s situation (recorded and otherwise), there is a need to:

Review lawfulness, purpose and processes followed with respect to a ‘child in need’ (s.17(11) Children Act 1989) who is already known, or referred to the Disability Service

In consultation with partner agencies, discuss and agree the co-ordination role that the service could play in complex cases [‘remote working’ practices could facilitate the required service changes]

### Overview Child M Publication Version 24.06.21

|  |  |
| --- | --- |
| A&E Accident & Emergency Department  | MARS Medicine Administration Record Sheet |
| CAMHS Child & Adolescent Mental Health Service | MASH Multi-agency Safeguarding Hub |
| CCNT Community Children’s Nurse Team | NICE National Institute of Clinical Excellence |
| CDOP Child Death Overview Panel | OT Occupational therapy |
| CSPR Child Safeguarding Practice Review | PEG Percutaneous endoscopic gastrostomy |
| CAF Common Assessment Framework | PLP Personal Learning Plan |
| DfE Department for Education | PT Physiotherapy |
| EHCP Education, Health & Care Plan | SLT Speech & language therapy |
| ENT Ear, nose & throat | TAF Team Around the Family |
| GOSH Great Ormond Street Hospital | SNA School nursing assistant |
| LSA Learning support assistant | WNB ‘Was not brought’ |

1. See <http://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england> [↑](#footnote-ref-1)
2. Page 105 Working Together to Safeguard Children 2018 [↑](#footnote-ref-2)
3. Dystonia is a movement disorder in which muscles contract involuntarily, causing repetitive or twisting movements; the condition can affect one part of the body (focal), two or more parts (segmental) or all parts (general) [↑](#footnote-ref-3)
4. Botulinum toxin-A injections are designed as a temporary treatment to reduce muscle spasticity and works by weakening or paralysing muscles, thus decreasing pain [↑](#footnote-ref-4)
5. A pupil has a PLP which outlines targets for the term; targets are set which will enable her/him to make progress towards their EHCP outcomes, build on prior knowledge, understanding and skills, address any gaps in learning and focus on specific areas which are relevant to the individual. [↑](#footnote-ref-5)
6. NHS England commissions Whittington NHS Trust to provide community and specialist dental services to children with complex or additional needs who are unable to get appropriate care from a general dental practitioner. [↑](#footnote-ref-6)
7. S.47 Children Act 1989 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf> [↑](#footnote-ref-7)
8. [↑](#footnote-ref-8)
9. ‘Disablism’ is the consequence of disability as oppression, whereby negative attitudes, disablist policies, discriminatory practices and environmental barriers prevent the full participation and inclusion of people with disabilities in everyday society (Oliver 2009). [↑](#footnote-ref-9)
10. A child is ‘in need’ if s/he is unlikely to achieve or maintain, or have the opportunity to do so, a reasonable standard of health or development without provision of services by a local authority, or if her/his health or development is likely to be significantly impaired or further impaired without such services, or s/he is ‘disabled’ [s.17(11) Children Act 1989. [↑](#footnote-ref-10)