

**QUICK REFERENCE LEARNING POINTS FROM HARROW SAFEUGARDING PARTNERSHIP’S CASE REVIEW**

**CHILD SAFEGUARDING PRACTICE REVIEW: CHILD ‘M’**

**Learning about managing complex needs and practice regarding thresholds for children with disabilities**

**Background**

Child ‘M’ was a 12-year-old boy from a Pakistani family who had complex medical needs and a significant learning disability. He lived at home with his parents and two younger siblings - both of whom had additional needs.

‘M’ sadly died due to natural causes, but this was slightly earlier in his life than expected, so an initial review took place (Rapid Review) to see if there was anything to learn about the care and support he was given.

There were indications that services for this child and his family may not have been coordinated as well as they could have been and that thresholds for intervention and services did not appear to have been applied in the same way that they would have been had ‘M’ not been a child with disabilities.

It was agreed that a **Child Safeguarding Practice Review** would be undertaken to explore these issues further.

**Multiple and uncoordinated appointments**

Agencies were concerned about the high number of appointments missed by the parents for Child M. As with many families with multiple needs, the multitude of appointments (sometimes overlapping), became overwhelming for the parents.

**The need for oversight and coordination of services is essential for families with complex needs.**

**Use of Mechanical Restraint**

The use of soft materials to restrain Child M had become accepted over time by most of the professionals who worked with him. Whilst applied by his parents and others with good intention, only one professional explored this as a potential safeguarding issue.

A referral on the matter was not met with timely or rigorous response – either as a Child Protection or Child in Need matter.

**The review concluded that any such arrangement should be carefully considered, and any safeguarding issues referred. Final decisions should form part of the formally agreed multi-agency Care Plan for the child.**

**Voice of the Child and Family**

Some **excellent** examples of good practice were found where practitioners had been creative in reaching and responding to Child M’s wishes and feelings – which could only be expressed non-verbally by him.

However:

* Child M suffered intermittent dental pain. Dental assessment and treatment were delayed and lacked consideration of the child’s experience
* There were some services that relied too heavily on one parent for communication (the other may have benefitted from the assistance of an **interpreter**) and the **experience of Child M’s siblings** were not adequately explored.

**Low School Attendance**

The transition from primary to secondary school was followed by a significant decrease in school attendance for Child M, largely due to the complexity of his medical needs combined with the associated high number of health-related appointments. This is a recognised challenge when working with children with multiple medical needs and an unintended acceptance of the situation can mean that unlike for able bodied children, there is no formal or robust scrutiny of any prolonged period or multiple periods of absence.

**All future ‘Attendance Panels’ to include a representative of the Children & Young Persons’ Disability Service to ensure equal attention to the absence of children with disabilities**

