

Oxford
Safeguarding Children Board

Serious Case Review
Child K

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1 INTRODUCTION

- 1.1 This serious case review was commissioned following the admission of a young person (Child K) to hospital in April 2016 weighing 37kg with a BMI (body mass index) of 13.7.¹ The medical assessment at this stage was that without medical intervention there was a significant risk to Child K's life. Child K was known to have been home schooled since the age of four and to have had significant contact with health services. Following their admission to hospital home conditions were found to be extremely poor with no hot water or heating.² As a result of the seriousness of Child K's condition and concerns about the way in which professionals had worked together the chair of Oxfordshire Safeguarding Children Board decided that the case met the criteria for a serious case review.
- 1.2 Jane Wonnacott, an experienced author of serious case reviews, was appointed as lead reviewer and a reference group of senior professionals from organisations who had contact with Child K and their family worked with the lead reviewer to complete the review. The process of the review which included contributions from relevant professionals and Child K is in Appendix One of this report. Child K's Mother did not wish to contribute to the review at that time but has since commented on a final version of the report. The review team are very grateful to both Mother and Child k for their contribution.
- 1.3 There has been a long delay in publishing this review as Thames Valley Police investigated the circumstances surrounding this case and it was three years before this was concluded and a decision was made by the Crown Prosecution Service that no criminal charges should be brought. Oxfordshire Safeguarding Children Board did not wish to delay the consideration of lessons learnt and a full detailed interim report, recommendations and the implementation of any policy or practice changes was agreed by the Board in 2018.
- 1.4 This final published report has been updated since the Board meeting to reflect the most recent Government Guidance in relation to elective home education. The report also does not include one of the recommendations agreed by the Board as this contains reference to information about family circumstances that it is not appropriate to share in a public forum.

2 CASE OVERVIEW

- 2.1 Child K's family had originally been known to services following the birth of their older sibling who had additional needs and after a period in mainstream education had moved to a special school prior to becoming home educated.

¹ This BMI placed Child K below the 3rdcentile (www.cdc.gov/growthcharts). i.e. their BMI was less than 97% of children the same age.

² Mother has since told this review that this was because they had broken and she was unable to get them fixed.

- 2.2 Child K had been home educated since the age of four. The reason given by Mother was that their constipation problems had not been managed within school and the stress had made the condition worse.
- 2.3 Child K had contact with a range of health services and by 2008 three different specialist constipation service were involved. There was also an assessment by a community paediatrician, another by PCAMHS³ and in 2014 a second opinion from a paediatrician at Hospital 2.
- 2.4 Children's Social Care involvement was primarily focused on Child K's sibling who was the focus of a core assessment in 2010. This was also true of police involvement. When police were called to the house in 2011 following a contact from Mother, the focus remained on the behaviour of Child K's sibling and an *adult* safeguarding referral was made. Child K's needs were not considered at this stage.
- 2.5 The sequence of events in March 2016 is important as at this point the severity of Child K's medical condition became apparent and the prompt intervention of the GP almost certainly was instrumental in preventing significant risk to Child K's life.
- 2.6 In March 2016, Mother took Child K to the GP and described Child K's weight loss and bowel problems. The GP was concerned about their weight which was 39 kg with a BMI of only 14.8. (normal BMI is 18.5 -24.9) and called the on-call paediatrician as well as sending a message to the GP practice safeguarding lead. The advice of the on-call paediatrician was to refer urgently to the community paediatrician as well as arrange blood tests and call MASH⁴ to ask them to check on the family. The advice was that if Mother did not engage with the community paediatrician then a safeguarding referral should be made. A more appropriate course of action would have been for the on-call paediatrician to refer to the acute paediatric service. This is discussed further in Finding One.
- 2.7 The call to MASH reassured the GP that there were no previous safeguarding concerns in respect of Child K and the GP made a diary note to make a safeguarding referral if Mother did not engage with the community paediatrician. There was then a delay in accessing a paediatric opinion as the community paediatrician was away and on their return a week later advised that Child K should be seen in the general paediatric services. This view was based on professional concerns about poor compliance, parental difficulties in getting Child K to appointments and better access to a range of services within the acute setting. It is now clear from information that Mother has given to the review that the poor compliance was as a result of mother finding it hard to cope with her family circumstances. This was not fully understood by professionals.
- 2.8 The GP then made an urgent referral to the acute paediatricians at Hospital 1 and hand delivered a letter to Mother with the appointment. The latter stated that if Child K did not attend then "social services would need to be informed". Although Mother

³ Primary Child and Adolescent Mental Health Services

⁴ The Multi Agency Safeguarding Hub

complained about the letter the GP refused to cancel the hospital appointment and arranged urgent transport for Child K.

2.9 MASH was contacted by the paediatrician from Hospital 1 referring Child K who had been admitted with very low weight (BMI 13.7) and concerns about Mother's treatment and care of her child. The case progressed to a single assessment the next day. There are notes in the children's social care records of two strategy meetings. Thames Valley police were not included in these meetings as would be expected practice where there are concerns that a child is a risk of significant harm. After the first strategy meeting s47 (child protection) enquiries started and legal advice was sought which agreed the threshold was met for legal intervention.

2.10 Children's Social Care reviewed the circumstances and due to increasing safeguarding concerns contacted Thames Valley Police. These concerns related to the home conditions and Mother wanting to remove Child K from hospital. Child K was placed under police protection and three days later the local authority was granted an emergency protection order.

3 FINDINGS AND RECOMMENDATIONS

3.1 The overarching finding of this review is that Child K was a child with complex medical, social and psychological needs and the system did not succeed in providing a well-co-ordinated approach to managing a care plan. In essence, no one professional had responsibility for understanding Child K's needs as a whole and:

- management of chronic constipation was fragmented between health professionals and assumptions were made that this was linked to autistic spectrum disorder (without a diagnosis) with no coordinated health plan being in place,
- the implications of elective home education were not understood by the professional community,
- the family dynamics were not well understood in relation to their impact on Child K's wellbeing and no one was aware of the poor home environment including lack of heating or hot water,
- assumptions were made about Child K's wishes and feelings and there was no understanding of what life was like for them at home.

3.2 Although Child K was home educated, they were not hidden from view as they had regular contact with health professionals in relation to chronic constipation. That is not to downplay the significance of elective home education in reducing opportunities to monitor the wellbeing of children such as Child K who was not seen in their home environment. There are common features between this review and other reviews where home schooled children have died, most notably the death of a 16 year old girl from chronic constipation (Cornwall Safeguarding Children Board 2013) and the death of an eight year old home schooled child of malnutrition (CYSUR and West Wales Safeguarding Children Board 2016). Whilst parents who choose elective home education are no more likely to abuse their children than the general population,

these serious case reviews do highlight the challenge facing professionals who may not have a full understanding of the rights of parents who choose this form of education and how these rights can reduce contact with external agencies.

- 3.3 Following Child K's admission to hospital it became clear that, at that time, they were living in conditions that were indicative of child neglect. No professionals were seeing Child K at home (the last visit had been by children's social care six years earlier) and the main opportunity to recognise their experience of neglect lay in the lack of progress with treating their constipation. Several factors came together which resulted in a failure to protect Child K from neglect and the following findings focus on those specific aspects of the safeguarding system that led to the neglect of Child K not being recognised.

Finding One

The management of Child K's health needs was fragmented and no one professional assumed responsibility for ensuring a coordinated approach.

- 3.4 Child K's chronic health condition was described by specialist health workers as not uncommon, "particularly for children on the autistic spectrum". This last comment is significant as the belief that Child K's problems were linked to autism diverted attention from a focus on what day to day life was like for the child, and parental capacity to meet Child K's needs. Safeguarding concerns were therefore not given enough attention and during the course of this review steps have been taken to ensure that local guidance makes it clear that safeguarding should always be considered when continence problems persist.
- 3.5 Although health professionals who were in contact with Child K believed strongly that they had traits associated with autism and commented on this in correspondence, this was not formally diagnosed. In fact, a PCAMHS assessment in 2008 had concluded that Child K did not meet the criteria for a diagnosis of autistic spectrum disorder.
- 3.6 Despite the lack of diagnosis, the assumption continued that Child K's behaviour, including reluctance to engage with treatment programmes and eat the recommended diet was linked to autism. When it was recognised by a paediatrician at Hospital 2 (giving a second opinion) that this had not been formally diagnosed this was recommended as a priority (although it took nine months for an appointment to be offered in respect of this). At this stage Mother told the doctor that "social services" had been involved and the assumption by the paediatrician was that they were happy with her care of Child K and that "social services would not let you go that easily".
- 3.7 Although the paediatrician at Hospital 2 recommended a plan of action, including a seven-day review, the GP did not receive the letter within seven days and was therefore unaware of the plan. When the letter was received from Hospital 2 the GP's first thought was "thank goodness something is happening" although, in fact,

professionals understood that Mother did not agree with the medication regime suggested by Hospital 2 and nothing changed in respect of Child K's management⁵.

- 3.8 It is not for this review to come to any conclusion about Child K's diagnosis of autism or otherwise, but it is apparent that there was a degree of confusion in the overall approach with no one person taking the lead and developing a holistic understanding of Child K and their needs. There was a piecemeal approach with a lack of coordination and follow through at key points. From Mother's perspective coordination was best during the time that a health visitor was working with the family.
- 3.9 In relation to the management of Child K's constipation there were three services involved:
- Childhood constipation services (delivered via specialist nurses in the clinic at the acute hospital)
 - The children's community nurse constipation clinic.
 - Bladder and bowel services provided at the local clinic.
- 3.10 It is not clear whether Mother understood the different role and function of each of these services. There is evidence of confusion even amongst health professionals, with the community paediatrician noting a referral to the constipation clinic for a one-off visit and phone support when this type of service is not provided by the childhood constipation services. There is also no evidence of this referral ever being received.
- 3.11 The Cornwall serious case review (2013) makes the point that a long-standing history of constipation can be fatal although this is rare, and GPs and paediatricians would be unlikely to see a fatal case during their career. The Cornwall review also noted that there were a significant number of different health professionals over time dealing with the same issue of the young person's constipation; a factor which is also relevant in this case. This problem was highlighted to the lead reviewer by the constipation specialists in Oxfordshire and would suggest that the issue of effective coordination of services for young people such as Child K may be an issue beyond this specific case. It was fortuitous that the right medical intervention was given to Child K in order to prevent a fatal outcome and the Safeguarding Children Board will need to be assured that the new pathway for the children's continence service is effective in meeting the needs of similar children.
- 3.12 Although there were plans developed by health professionals to address specific needs, the health care system did not adequately provide for one professional having responsibility for ensuring the plan was followed through. Whilst the system works well where parents are motivated to make sure their child's needs are met, if there are known concerns about parental engagement, there needs to be greater clarity as to who has overall responsibility for managing a health care plan.

⁵ Mother does not recall disagreeing.

- 3.13 For children attending school in Oxfordshire an additional safety net in responding to health needs is the school nursing service. In the case of Child K this was not available as they were home educated. This is discussed further in Finding Two.
- 3.14 At the point where Child K's medical needs were becoming critical there is further evidence of lack of clarity about the role of the various medical professionals. The GP was tenacious in following through her concerns but there was an unacceptable delay in establishing whether the community or the acute paediatricians had prime responsibility at this point. The on-call paediatrician considered that community paediatrics was the most appropriate route whereas a direct referral into acute services at that point would have been a better course of action and reduced delay. There was then additional delay due to the community paediatrician not having an opportunity to consider the referral for several days because of holidays and workload. When the information from the GP was reviewed by the community paediatrician, a direct referral into general paediatrics as well as a letter back to the GP would have been advisable.
- 3.15 The management of Child K's condition as a safeguarding concern continued to be ineffective after admission to hospital with the police not being invited to the initial strategy discussions. Legal action was not taken to safeguard Child K until three weeks after admission to hospital. Whilst it is understandable that there was a focus on the causes of their extreme low weight, this was a family with known vulnerabilities and home conditions were extremely poor. It would therefore have been best practice to follow child protection procedures from the point of Child K's admission to hospital. Oxfordshire Safeguarding Children Board will need to be reassured that when a child is admitted to hospital this does not delay implementing the appropriate child protection processes.

Recommendation One

Oxfordshire Safeguarding Children Board to recommend that health agencies review the guidance that is being developed regarding pathways for children with chronic constipation in order to ensure that:

- the role of each service is clear to professionals and families alike,
- the assessment of safeguarding concerns is integral to the process.

Recommendation Two

Oxfordshire Safeguarding Children Board to recommend that health agencies ensure that there is clarity regarding the role of the community paediatrician, primary care clinicians and child and adolescent mental health teams in situations where there are concerns about a child with health needs who may be at risk of significant harm.

Recommendation Three

Oxfordshire Safeguarding Children Board to recommend that children's social care provide evidence that the appropriate child protection procedures are being followed when a child is admitted to hospital including the involvement of the police at any strategy discussion.

Finding Two

The professional community does not have a good understanding of the implications of elective home education and its limitations in safeguarding children.

- 3.16 One significant aspect of this case was the choice made by Child K's mother to educate Child K and sibling at home. This ostensibly was driven by concern about the management of the constipation issues within the school environment, although the specialist constipation nurses are clear that this should never be a reason to educate a child at home. Elective home education meant that Child K was not seen regularly outside the home environment except by those health professionals who were focused on constipation management. The majority of the professionals either did not know Child K was being home schooled and/or that this meant there was no requirement for home visits from any statutory agency. All assumed that home schooled children were automatically visited at home and that this would provide an additional safety net in relation to Child K's wellbeing and safety.
- 3.17 Parents who choose to educate their child at home are not required to register or seek approval from the local authority and there are no requirements for the local authority to visit the home and monitor the standard of education being provided. Recent guidance⁶ is however clear that local authorities should work to develop positive relationships with home schooled children, for example by setting up voluntary registration schemes and making support available. The issue of how best to evaluate whether a child is receiving a full-time suitable education is more complex as there is currently no legal definition of full-time, and the type of education that can be considered "suitable" is varied and flexible.

There are no specific legal requirements as to the content of home education, provided the parents are meeting their duty in s.7 of the Education Act 1996. This means that education does not need to include any particular subjects and does not need to have any reference to the National Curriculum; and there is no requirement to enter children for public examinations.....Approaches such as autonomous and self-directed learning, undertaken with a very flexible stance as to when education is taking place, should be judged by outcomes, not on the basis that a different way of educating children must be wrong. (DfE Guidance 2019 para 2.4).

- 3.18 The only situation where the local authority can intervene is under section 437 of the Education Act 1996 if it appears that a child of compulsory school age is not receiving a suitable education. In such cases the local authority has the power to issue a School Attendance Order. The limitations of this power are described clearly in a recent SCR⁷

⁶ Department for Education *Elective Home Education: Departmental guidance for local authorities*. April 2019

⁷ Family W: a report into the case as it relates to the law relating to home education (2013) Unnamed LSCB. <https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2013FamilyWHomeEducationReport.pdf?filename=CC18C70DB7C8C3D49403BB94EB176F95207E5F66235DCA89651F5ED2BA7D89311A353B626FC11241A3DF9A45C443B55616B8DD60747F238D90D1006222D4393D74B37BBB140E8D79B41DA9B616490DE512EF04BD2060189F1D844FD911B33C2DCD846F&DataSetName=LIVEDATA>

The issue then arises as to the degree of evidence needed to satisfy the criteria of “suitable education”. Even at the stage of a formal notice there is no requirement upon parents to allow anything over and above a paper only consideration of the education provided.

- 3.19 There is no requirement for any independent verification and currently local authorities are expected to consider suitability on the basis of a paper report provided by the home educator alone.
- 3.20 One of the questions for this review related to the effectiveness of the elective home education system in both identifying children who are being educated at home and also its effectiveness in responding to their health needs.
- 3.21 Although there is no legal obligation for parents to inform the local authority that they are educating their child at home, in this case the local authority was aware that Child K had been removed from the school roll. Prior to 2015, Oxfordshire had encouraged parents to send regular reports outlining their child’s progress and Child K’s mother largely complied with these requests, sending lengthy reports albeit not always within the timescales requested by the local authority. This approach within Oxfordshire Education was criticised as being outside the scope of the legislation and after a consultation with parents the guidance was amended to ensure a less proactive approach in line with legislation. At the time this review took place there was a less intrusive approach to families choosing to home educate than was in place for the majority of the time that Child K was schooled at home.
- 3.22 In relation to health needs, home educated children do not have access to the Oxfordshire school nursing service. This is a gap in provision as, although not all parents may wish to use the service it would provide another opportunity to make sure that children educated at home are not disadvantaged in any way.
- 3.23 The problems of monitoring the education received by Child K notwithstanding the law is clear that where there are concerns about significant harm the local authority has a responsibility to exercise its safeguarding powers whether or not a child is educated at home. The problem in this case was that it was much harder to identify risk of significant harm and disentangle Child K’s medical needs from the care being given, when they were not being seen on a daily basis in school. There were limited opportunities to hear Child K’s voice and no one was aware of the extremely poor conditions within the home. These limitations of safeguarding children receiving elective home education are not well understood throughout the professional community.
- 3.24 As a result of this review it has become clear that all professionals working with children and families need a good understanding of the limitations of statutory involvement with children and families and to take this into account when working with children who are electively home educated. As a first step it would be prudent to make sure that all children’s records clearly note the form of education being

provided to the child whether at home or in a school. Children's services records already note where a child is home educated and Oxfordshire will be working with parents to encourage notification to GPs.

3.25 In terms of tracking the progress of children educated at home, within Oxfordshire the local education authority did their best to achieve this but was required to develop a less intrusive approach in order to comply with legislation. Whereas most children will thrive in a home-school environment, for a small minority the lack of day to day scrutiny by people outside the home may contribute to a failure to recognise risk of harm.

Recommendation Four

Oxfordshire Safeguarding Children Board to recommend that NHS England develops a "Read Code"⁸ for GPs which will signify on the child's record that a child is being electively home educated.

Recommendation Five

Oxfordshire Safeguarding Children Board should work with Public Health commissioners to disseminate information across the partnership about the availability of a school nursing service to children educated at home and positively promote take up of the service by parents.

Recommendation Six

Oxfordshire Safeguarding Children Board should disseminate information about the legislation and guidance underpinning the regulation of elective home education to all professionals working with children and remind them that they may be the only professional seeing the child and any safeguarding concerns should be referred to MASH in the usual way.

Recommendation Seven

Oxfordshire Safeguarding Children Board should bring this review to the attention of the Department for Education with a request that its findings are considered in the light of other serious case reviews involving elective home education.

Finding Three

No one professional had a good understanding of the family context and dynamics and the implications for Child K's wellbeing and safety.

3.26 Overall there was a failure to "think family" in this case with the issue of lack of coordination of an approach to the family's needs stretching beyond the health provision. For example, at a point that children's social care withdrew their involvement there was no named professional taking responsibility for coordinating services.

⁸ Read codes are universal codes used by GPs to highlight particular issues or conditions on the electronic GP records.

- 3.27 Part of the problem in meeting the needs of Child K was the dominance of concerns about their sibling's condition. It is notable that assessments carried out by children's social care were in respect of Child K's sibling rather than Child K and Child K has confirmed that this was how they experienced social care intervention. As a result, there was no clear analysis of how the overall family circumstances were impacting on Child K. No contact was made with Father and his role within the family remained unclear. The GP knew this family well and there was no evidence that children's social care contacted the GP when carrying out their assessment or informed the GP of the outcome.
- 3.28 Child K's voice was notably absent from assessments that were primarily focused on their sibling and it is now known that Child K had been known within the family to be experiencing various issues that had not been discussed with anyone outside the family unit.
- 3.29 The issue of the potential neglect of Child K's needs within a family with multiple stresses became lost. There was a tendency to view Mother as someone struggling to do her best in difficult circumstances rather than considering whether she was adequately meeting the needs of her children and services were tailored to meet her needs. The reasons that may have caused Mother to not follow through on advice relating to diet, not take Child K to hospital appointments and become increasingly irritable with services during 2015 was not properly assessed in relation to impact on Child K. This was made harder because no one had access to the family home. The poor physical conditions that were found at the point that Child K was admitted to hospital would not have been known to any of the medical professionals who were in contact with Child K at that time.

Recommendation Eight

Oxfordshire Safeguarding Children Board should ask for evidence that current assessments focusing on meeting the needs of disabled children include a focus on the needs of other children within the family and that GPs have been appropriately involved in providing and receiving information.

4 APPENDIX ONE: REVIEW PROCESS

4.1 Members of the reference group for this review were:

- Consultant Paediatrician Oxford University Hospitals (Designated Doctor)
- Designated Nurse
- Named GP for Safeguarding
- Lead Nurse for safeguarding children for Oxford Hospitals NHS Foundation Trust
- Education sufficiency and access
- Children's Social Care, Oxfordshire County Council
- Strategic lead for vulnerable learners
- Child Abuse Investigation Unit, Thames Valley Police
- Deputy Director for Safeguarding, Children's Social Care, Oxfordshire County Council
- Business Manager, Oxfordshire Safeguarding Children Board.

4.2 None of the professionals involved in the reference group had any previous direct contact with Child K or their family.

4.3 Each organisation that was involved with Child K was asked to complete a review of their files and complete a timeline of their involvement from Child K's birth until the critical incident. Organisations involved were:

- Children's Social Care
- Oxfordshire Clinical Commissioning Group
- Oxford University Hospitals NHS Trust
- Oxford Health NHS Foundation Trust
- Special Educational Needs / Education
- Thames Valley Police

4.4 The information supplied by organisations was reviewed by the reference group and the following questions were identified as relevant for the review. These questions would be refined and amended as further information emerged:

1. How effective was the Elective Home Education system in:
 - identifying children who were being educated at home
 - working at the interface of special education needs services
 - responding to the health needs of the children and any concerns about their wellbeing?
2. What meaning did professionals attribute to home education when assessing needs and considering the provision services and support to the children?
3. When responding to the needs of individual children in the family, how far did professionals understand these within the context of the whole family system and relationships within the system?
4. What does this case tell us about the challenge in identifying potential neglect in children with autism and special education needs?

- 4.5 Practitioners who had direct knowledge of Child K and their family were invited to contribute to the review. The lead reviewer had conversations with:
- The current team manager in children's social care (telephone discussion)
 - The family GP
 - The consultant community paediatrician at Hospital 1
 - The consultant paediatrician at Hospital 2
 - The nurses at a hospital constipation clinic
 - Managers from children's services with responsibility for elective home education.
- 4.6 Child K also met with the lead reviewer in order to ensure that their perspective is reflected within this review report.
- 4.7 As there were still ongoing police inquiries the final interim report with recommendations for practice change was presented to the Local Safeguarding Children Board in 2018. All recommendations were accepted, and an action plan was agreed.
- 4.8 Following conclusion of the police investigations and the decision by the Crown Prosecution Service that there would be no criminal charges, Mother was offered an opportunity to contribute to the review. She did not wish to do so immediately but did comment on the final report before it was finalised and ready for publication.