Luton Safeguarding Children Partnership

Child Safeguarding Practice Review

Oliwer

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Independent Chair: Alan Caton

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1. Introduction & synopsis of the review

1.1. This report provides a summary account of a Child Safeguarding Practice Review (CSPR) conducted by Luton Safeguarding Children Partnership (the Partnership) in accordance with statutory guidance[1]. The review examines the contact and involvement of agencies and professionals with a six-year-old child, who for the purpose of this review will be known as Oliwer. Oliwer (pronounced Oliver) was of dual heritage, with his mother and other household members all of Polish heritage. Oliwer died in December 2019 having been ill for four days. The cause of death was determined as Ketoacidosis with an underlying metabolic condition. This underlying metabolic condition was not identified until detailed medical studies as part of the post mortem were concluded. Therefore, at the time of decision making about conducting a Child Safeguarding Practice Review Oliwer's death remained unexplained. The Police, having conducted initial enquiries will not be taking any further action and as the cause of death has been determined there has been no Coroner's Inquest.

1.2. Oliwer was known to have autism and special educational needs. In the weeks and months prior to his death he had contact with a small number of agencies and professionals, and there had been concerns about his diet and general health. Oliwer's initial unexplained death and his known special needs has provided the Safeguarding Partnership an opportunity to explore the local systems and provision that were in place to support Oliwer & his parents at the time. In conducting a proportionate review whilst maximising the learning, the review has been keen to explore the quality and effectiveness of the multi-agency safeguarding response to young children with special educational needs in the Luton area, capturing information that might strengthen the Partnerships response in future.

1.3. By way of a summary, the following findings and learning has been captured as a result of this Review;

- During the timeframe under review, the quality and effectiveness of assessment and services available to children with special educational needs in the Luton area was not as strong as it needed to be. It is reasonable to conclude that these system wide issues impacted on Oliwer receiving a timely and holistic assessment of his needs.

- The management of Oliwer's additional needs was somewhat contained within his school setting, with good efforts made to respond to his behaviour and help him integrate which did, over time, have a positive impact. However, more was needed to support Oliwer's mother, and requests for additional help were ineffective with there being no challenge or escalation of decisions when they were turned down. Threshold criteria and decision making did not help Oliwer.

- Professional over-optimism and bias unwittingly contributed to some aspects of decision making and consideration about Oliwer's daily lived experience. Oliwer's mother did not feel listened to and she struggled to access support.

- The system and processes for families who have a child with special educational needs are not designed to enable them to navigate the array of services. The review highlights the importance of having a lead professional who can adopt a coordinating, advocating and strategic role.

2. Method for conducting the review

2.1. Following Oliwer's death in December 2019 the Partnership conducted an initial information gathering exercise as part of the Rapid Review process[2]. A decision to conduct a CSPR was confirmed by the Partnership in January 2020

[1] Working Together to safeguard children, HM Government, 2018.

[2] Working Together to safeguard children, HM Government, 2018.

however due to complications in obtaining expert medical opinion about the cause of death, the decision to initiate the review was delayed until November 2020. The pressures on all services caused by Covid-19 also contributed to this delay. The decision to conduct a review was ratified by the National Panel[3]. The following steps were then taken;

- Kevin Ball was confirmed as the Independent Reviewer[4] in November 2020.
- An initial Panel meeting of agency representatives was convened in January 2021 to agree the scope and terms of reference for the review; key lines of enquiry were established.
- A short briefing for single agency report authors was provided in January 2021, at which point the request for single agency reports was made to the relevant agencies listed below. This process provided each relevant agency with the opportunity to reflect on their involvement with Oliwer. Practitioners were interviewed as part of the single agency reporting and were able to offer their insight and contributions to the review. As a result, agencies have been able to consider actions required of themselves in order to make improvements.
- A further opportunity to gain practitioner views was provided with a reflective workshop held in May 2021.
- Further Panel meetings were held as necessary, with the review concluding in June 2021.
- The approach taken has complied with the principles as set out in statutory guidance[5] and as such, the process been able to capture and identify opportunities for professionals and organisations to learn and improve safeguarding practices from a whole safeguarding system perspective.

2.2. The following agencies have contributed to this Review:

- Luton Borough Children's Social Care
- Luton Borough Early Help Services
- Luton Borough Special Educational Needs Service
- Luton & Dunstable University Hospital
- Cambridgeshire Community Service NHS Trust
- The Clinical Commissioning Group (for the GP)
- Luton Borough Safeguarding in Education Service
- Primary School A

2.3. The timeframe under review was agreed as December 2018 to December 2019. Relevant history prior to this has been considered, in relation to the child but also the Partnership.

3. Family structure & contribution to the review

3.1. At the time of Oliwer's death he was living with his mother, his mother's partner, and three half-siblings. Oliwer did not have contact with his father, who was living abroad.

3.2. Seeking the contribution of family members has been an important consideration. Oliwer's mother was approached by the Independent Reviewer, via a Police contact who had built a rapport with her during the Police investigation. The Independent Reviewer spoke with Oliwer's mother via video call and she was able to expand on a number of issues that impacted on her care for Oliwer. There were two over-arching messages conveyed by Oliwer's mother.

- Firstly, she felt staff at Oliwer's pre-school/school were very supportive of Oliwer, patient with him and helped him make good progress to settle into school and learn. She found staff she came into contact with i.e., the Special Educational Needs Coordinator, the Senior Advisory Teacher and the Early Years Advisor (autism), a source of great support and understanding.

- Secondly, Oliwer's mother did not feel listened to, or taken seriously, by a range of health professionals, particularly those with whom she tried to explain the difficulties she was experiencing in managing Oliwer's diet and medication. Although Oliwer appeared healthy and not malnourished, she found herself, for example, struggling to ensure he remained hydrated without giving him sugary drinks which had an impact on his teeth and diet, but also struggled to give him oral pain relief when he was suffering with either stomach or tooth pain. It was difficult to know if the

[3] Child Safeguarding Practice Review Panel – an independent Panel with responsibilities under the Children & Social Work Act 2017.

[4] Kevin Ball is an experienced independent safeguarding consultant, with specific experience of chairing and authoring case reviews.

[5] Working Together to safeguard children, HM Government, 2018.

behaviour was being driven by the autism or by a pain or discomfort. She struggled and described sometimes thinking that professionals must have viewed her *as '… the crazy mother … but always being polite …'*, and *'… feeling helpless … not taking him to see people because I knew it would be the same as before and being ignored …'*. All of this resulted in her not feeling listened to or taken seriously.

4. Concise summary of relevant case history

Relevant information prior to the timeframe under review:

4.1. Records indicate that Oliwer was not brought to his two-year development check and he never received his pre-school immunisations; this is despite good efforts by the GP Practice and the Health Visiting Service to engage the mother in clinic appointments. Routinely, dental care information is shared at this developmental check. In December 2015, aged two years and four months, Oliwer was assessed by the Community Dental Service as needing multiple baby teeth to be extracted due to decay and being in pain; this initial examination was difficult due to his age. In August 2016, 14 out of 20 baby teeth were removed. Oliwer's mother had attempted to treat the problem at the point she first noticed decay in his first two teeth by seeking a remedy commonly used in Poland.

4.2. Oliwer began attending nursery/pre-school in September 2016. In April 2017 a referral was completed by the Special Educational Needs Coordinator for him to be assessed by the local Child Development Centre and the Special Educational Needs Service; this also included a referral to the Speech & Language Therapy Service (SALT). This referral was based on some low-level concerns about Oliwer's behaviour. The referral to the Special Educational Needs Service was turned down, recommending a different pathway to having his needs met i.e., through the SALT Service.

4.3. The initial assessment conducted by the Child Development Centre in August 2017 considered the possibility of Oliwer having Autistic Spectrum Disorder (ASD). His mother expressed concerns about his limited diet; but staff were unable to measure his growth/weight due to Oliwer becoming distressed but a plan was made to review him in 6 – 8 months and make a referral to the Special Educational Needs Service.

4.4. At that follow-up appointment in June 2018, a formal diagnosis of ASD was given and a referral to the Community Dieticians Service was made. His mother remained concerned about his sleep problems, his restricted diet and difficulties in getting him to nursery/pre-school. Oliwer's mother spoke about using a tablet form of Melatonin medication which she had sourced from Poland, to assist with managing Oliwer's sleep difficulties. Circadin, an alternative form of Melatonin was offered in accordance with local prescribing guidelines, with advice to not use the drug sourced from Poland. Routine investigations into the cause of Oliwer's delay/ ASD were discussed and the mother agreed to these. The associated request forms for blood tests were provided, however the investigations were not completed. The process for seeking an Education, Health & Care Plan (EHCP) was initiated at this time by the Special Educational Needs & Assessment Service although advice had been given to the school and mother in April 2018 by the ASD Advisory Team (part of the SEN Service).

4.5. In July 2018 the Early Help Service became involved following a referral from the Health Visiting Service and School, resulting in consideration about the Service coordinating support services to help the family.

4.6. Some 15 months after the initial referral regarding a Special Educational Needs assessment, an EHCP was discussed with the mother and relevant professionals in September 2018. Concerns about the mother's ability to cope with Oliwer persisted, with his attendance at school further declining and her reportedly being unable to get him to health appointments. When he did attend pre-school, it was noted that Oliwer often appeared tired – which was attributed to him starting the medication. There had been discussion between the school and the Early Help Service about whether a higher level of support, via Children's Services, was needed and whether a referral to the Integrated Front Door should be pursued; this did not happen because the involvement of the Early Help Service was judged sufficient - however the school remained keen that he should be assessed for a higher level of support and intervention. The involvement of the Children with Disabilities Team (CWDT) was also turned down as he was judged not to meet their threshold.

Relevant information during the timeframe under review:

4.7. The draft EHCP was discussed in September 2018, but the final EHCP was not issued until January 2019, some three months outside of timeframes. Throughout this time the Early Help Service were assisting the mother navigate support networks as well as provide physical support in managing Oliwer. For a short while, the situation settled but the mother still reported concerns with managing his behaviour, his diet and routines. Oliwer was observed to often be talkative and able to speak in five different languages.

4.8. In January 2019 the Early Help Service closed their involvement as it was viewed that his support needs were being met through other routes and there was no further need for the Service to be involved. The involvement of a Nursery Nurse to support the mother with routines, boundaries and nutrition had been agreed. Oliwer's attendance at pre-school was 70%. At a review at the Child Development Centre in February 2019 some improvements were noted but concerns remained; a 12-month review was scheduled. Also in February, the mother had been advised that Oliwer should see a dentist given concerns about dental care and oral hygiene.

4.9. The mother's engagement with Early Help support staff over the continuing months was mixed, sometimes not answering phone calls/texts, at other times readily speaking with practitioners and engaging in support groups. On assessment, the involvement of the SALT Service was not judged necessary given the input provided by the school. Due to non-attendance with the Community Dietician Service Oliwer was discharged from their Service in May 2019. The Early Help support worker seconded to the Cambridgeshire Community Services School Nursing Team submitted a new referral to the Community Dental Service on in May 2019; an appointment was offered however this was not taken up and Oliwer was discharged from the service.

4.10. Over September and October 2019, the school observed Oliwer to be tired and falling asleep; on one occasion necessitating the school to call NHS 111 and them having to advise the mother to take him to A&E for assessment. Ultimately, this resulted in a re-assessment by the Early Help Service during which the mother expressed continued concerns about managing Oliwer's behaviour and his poor diet. Again, the school expressed a view that a higher level of support was needed; this was not accepted resulting in the continued involvement of the Early Help Service. In September Oliwer was brought into hospital by his mother having been advised to do so by the GP with a history of weakness and two weeks of reduced eating. Following a paediatric review, no concerns were revealed and his care was discharged back to the GP.

4.11. In November 2019 an EHCP annual review was held, noting a number of positives particularly relating to his social skills developing well. A referral to the Community Dietician Service was discussed as something that was needed.

4.12. In December Oliwer had two episodes of being absent from school, with the mother reporting a stomach bug as the reasons for his absences. The school noted that several children were also absent for a similar reason. Later in December Oliwer died, with his mother and step-father reporting that he had been unwell for four days. The mother stated that she had tried to get a GP appointment but none were available and she had been advised to call NHS 111 or attend a Walk-In Clinic.

5. Findings & analysis

1. The emphasis of this review has been to explore the quality and effectiveness of the multi-agency safeguarding response to young children with special educational needs in the Luton area. Agencies were asked to submit information about their contact with Oliwer considering the following areas:

- The application of thresholds for stepping up and down between the Early Help Service and Children's Services.
- The quality & effectiveness of work across the multi-agency network when assessing need, risk & intervention.
- The quality and extent of professional curiosity and rigour when assessing risk, and possible neglect.
- Understanding about the impact of disability on parenting.
- Understanding about issues related to culture around the Polish community, and trust in access to services.

2. Through review of single agency submissions, discussion with Panel representatives, further contributions from practitioners, and a discussion with Oliwer's mother it has been possible to distil three features from the above areas, that capture points concerning the effectiveness of the multi-agency safeguarding response to children with special educational needs in the local area;

- Consideration about thresholds of intervention, linked to the assessment of need and risk.
- Human factors which contributed to assessment and decision making.
- Strategic oversight & management of children with special educational needs from a safeguarding perspective.

3. The report will consider these three features, using case detail to capture learning points for practitioners, managers and trainers. Importantly, the cause of Oliwer's death remains unascertained and whilst there may be questions and learning about the quality and effectiveness of the overall professional response to Oliwer, it is not possible to say with confidence that, had it been stronger, it would have prevented his death.

4. The findings of this review also need to be seen in context of the overall architecture of the arrangements at the time. In December 2018 Ofsted conducted a joint local area SEND inspection in Luton. This inspection highlighted a number of far reaching and systemic weaknesses in the local area's practice. This review does not need to repeat those weaknesses other than to note a small selection of comments that are likely to be relevant to this review, and which help place the findings of this review in context, *'… Professionals and families in Luton are left frustrated by long waiting times and slow identification of children and young people's needs. For many families, even once they have a diagnosis for their children, there is often little support and guidance available to them about how to meet their children's needs … The co-production of EHC plans and services with children and young people, and their families, is too limited in its scope and breadth …'*[6]. The findings from this focused inspection also need to be considered in the overall scheme of Luton Borough Council being on an improvement journey since 2016, at which point the Borough was judged as requiring improvement.

5.1. Consideration about thresholds of intervention, linked to the assessment of need and risk.

> Statutory guidance states' *… Local authorities, with their partners, should develop and publish local protocols for assessment … where a child has other assessments, it is important that these are co-ordinated so that the child does not become lost between the different organisational procedures …'. Working together, 2018, p.24. HM Government.*

5.1.1. Although it may be argued that Oliwer did not become '*… lost between the different organisational procedures …*', it is reasonable to consider that the significant gaps in provision and systemic weaknesses identified by Ofsted at the time, did have a direct impact on the timely assessment of Oliwer's needs and provision of support. It is positive that early advice was provided to the school by the ASD Advisory Team in April 2018; it is also positive that once received, the process for seeking information from relevant agencies was set in motion. However, the proposed draft for the EHC Plan was not issued until December 2018, some three months outside of the statutory 16-week timescale. The delays in finalising this have been cited as capacity issues in the SEN Advisory Team and awaiting information from Children's Social Care. Given that concerns were picked up and referred in a timely way it is arguable that Oliwer fell into a gap once in the system, rather than becoming lost.

5.1.2. Other than the EHC assessment, no information has been put forward for this review to indicate that there was a comprehensive assessment undertaken of Oliwer's holistic needs. No such assessment was completed by the Early Help Service and the issues being raised by both the mother, and professionals involved at the time were never judged to meet a threshold to warrant the involvement of Children's Services or an Integrated Front Door referral. Had this been the case, it may have prompted a more in-depth assessment via a Single Assessment approach. There are factors that contributed to this.

[6] Ofsted & CQC, December 2018, Joint local area SEND inspection report.

5.1.3. The Early Help Service's first involvement was in July 2018 following the receipt of an Early Help Assessment completed jointly by the school and Health Visiting Service. Based on the presenting issues, the referral was sent on by the Early Help Service to the CWDT for their oversight and decision in line with procedure at the time. The response by the CWDT was that it did not meet the criteria for them taking on the case; as such the case remained with the Early Help Service at a level 2 (additional needs) and for them to ensure the correct support was in place for the family using a Team around the Family approach[7]. From review of records, it is evident that a series of meetings, and attempts over the following months, were made to provide a package of support for Oliwer. At one point the school felt that the level of support should be increased to a level 3 (more intensive) however this was not felt necessary by the Early Help Service; when perhaps it should have prompted a more in-depth and holistic assessment. The Early Help Service then closed their involvement in September 2018. Records and discussions confirm that the role of the Early Help Service was viewed as a coordinating role to develop a package of support.

5.1.4. The issue around thresholds has highlighted important learning. It is reported that thresholds in the Integrated Front Door were seen as high at this time; the resultant effect of this being that some services, in this case, the pre-school Oliwer was attending, did not refer to the Integrated Front Door because they knew the referral would not be accepted and would not reach the level 4 (specialist) threshold they had hoped for. The referral to the Early Help Service was therefore made in the hope that it would reach a level 3 threshold (more intensive support). The final decision by the Early Help Service was that it met a level 2 threshold (additional needs). On two separate occasions (September 2018 & September 2019) the school expressed a view that Oliwer's needs should be considered at level 3 (more intensive support), and on both occasions this was rejected. Given the limited contact health professionals had with Oliwer and his family, the school were probably best placed to have a real sense about his level of need, and what was needed in order to manage those needs. This highlights two issues; firstly, the likelihood of the Early Help Service having to manage, and coordinate, cases in which there may have been higher levels of need (and therefore risk) beyond their remit, and secondly the value of professionals being able to challenge and escalate differences of opinion. An important learning point to capture as a result of this finding relates to all professionals feeling able to speak out about their views on thresholds and remaining child focused.

Learning point: Using a professional differences and escalation protocol is an entirely acceptable course of action to take if you have a difference of opinion that cannot be resolved at an informal level and where you continue to have concerns about a child's welfare. By not expressing your difference of opinion you are downplaying your professional status, and unwittingly colluding with what may be part of a bigger picture where-by the focus on the child is lost.

5.1.5. It is argued that Oliwer met the threshold to be considered a Child in Need, and for case management to be held under this framework rather than an Early Help approach. A Child in Need is defined[8] as a child that (a) *'… is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority … (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) he is disabled, … a child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed; … 'development' means physical, intellectual, emotional, social or behavioural development; and 'health' means physical or mental health.*

5.1.6. On the basis of the information reviewed it is argued that there was a level of over-optimism by the Early Help Service about the length of time a sustained level of input was needed in order to effectively support Oliwer and his mother. The sustained impact on the mother caring for a child with a high level of additional needs does not appear

[7] Luton Safeguarding Children Partnership thresholds framework, October 2017.

[8] Children Act 1989, Section 17.

to ever have been fully explored, with it noted at one point that the mother looked '*visibly drained'*. The opportunity to explore the impact on her wellbeing and what support she may, or may not, have been getting from her partner was not taken. There was also no assessment of Oliwer's dual heritage, the mother's perspective about what having a child with special educational needs meant for her and her partner and his children (all living in the same household), and how any special needs might have been managed differently if living in Poland. This could have been a valuable conversation given the fact that the mother seems to have sourced some medication from Poland to help manage his sleep difficulties, but had been discouraged to use this, instead using UK prescribed medication. Her use of a commonly used remedy from Poland for tooth decay also seemed ineffective.

5.1.7. Oliwer's contact with dental services is of interest. The lack of information sharing regarding the extraction of so many teeth for such a young child is of concern. Considerable efforts were made during the review to find out about the extractions. The mother advised that the procedure had happened in the hospital. No information was found in the hospital records, the GP records, nor with Cambridgeshire Community Services health records. Ultimately, records were tracked from the Community Dental Service which operates on the hospital site, but which works in isolation to the hospital.

Learning point: The British Dental Association webpages state, *'… Dental neglect may occur in isolation or may be an indicator of a wider picture of child maltreatment. The focus of this definition is on identifying unmet need so that the family can receive the support they need, rather than on apportioning blame. Children have a right to oral health, which forms an integral part of their general health ....'*

5.1.8. Oliwer's experiences of the dentist may have had a bearing on his responses to any future appointments (i.e., lack of attendance for blood tests) and his dietary intake. The dental history and information would have greatly supported analysis and appropriate advice from health professionals. As Oliwer was not presented for his two-year development review the opportunity for health professional to discuss dental care and provide his mother with dental advice was missed. The original referral to the Community Dental Service was made by the family's general dental practitioner stating *'… bottle caries, pain, uncompliant, requires extraction under general anaesthetic, … multiple teeth, … disturbed sleep …*'. Tooth decay at this age is commonly caused by sleeping with a bottle of milk, or sugary drink, a high sugar diet and insufficient cleaning. It is a debatable point as to whether this should be considered as a form of neglect. The British Dental Association provides comprehensive guidance and resources for those in the dental profession to help assess dental neglect but also what action to take should there be concerns about a child, which included seeking more specialist advice from a paediatrician or safeguarding nurse. This is something the Partnership may wish to promote but also for Cambridgeshire Community Services Health Visiting Service to review whether routine enquiry with parents at two year plus developmental assessments about accessing dental services could be considered.

5.1.9. By way of a summary, given Oliwer's mother perception that she was not listened to, but also the school's failed attempts to seek additional support for Oliwer and his mother, it will be important for the Partnership to target learning and improvement activity on:

a) how threshold criteria might be interpreted for children with life-long additional needs,

b) reducing the likelihood of professional over-optimism, and,

c) how parents are left when needing to manage a level of need, that is unmet by local services.

d) ensuring dental practices understand the need to consider dental neglect but also understand the appropriate information sharing pathways.

5.2. Human factors which contributed to assessment and decision making

Applying the concept of human factors to this review it is possible to capture learning. Human factors are *'… those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work …'. Patient Safety First, 2010, p.3, Implementing human factors in health care: How to guide*

5.2.1. Information provided by the Safeguarding in Education Service, on behalf of the school indicates a degree of sympathy for the mother and the situation she found herself dealing with. This has been captured as a result of examining his absences from school *'… conversations with the Education Welfare Officer who had several discussions with the mother would suggest that school had requested a gentle approach be taken, due to the special educational needs of Oliwer. It was felt that due to the [school] family worker team working with the mother in the school, a firm approach from the EWO was not required and had potential to impair the relationship with the mother and the school … between September 2018 and July 2019 … Oliwer is recorded as having 40 authorised absences, 39 unauthorised absences and 23 occasions when he was late for school … in the last term of his life, he is recorded as having 22 authorised absences and 5 unauthorised absences. Due to the gentle approach with the mother … recording would suggest that … professional curiosity was not always applied …*'. Whilst such an approach may be understandable, it is indicative of a sympathy bias and the formation of an anchored belief that a soft approach to the mother was the best approach. Whilst being sympathetic to the situation may have been entirely appropriate, allowing this to become anchored potentially impaired thinking which resulted in less objectivity. Such a dynamic makes it harder to then disentangle issues around neglectful or inadequate parenting alongside factors that may be connected to Oliwer's particular needs and disability. Further to this, prior to Oliwer's death, and during one of his final absences from school, the knowledge of a stomach bug causing illness with a number of children, provided a confirmatory bias towards Oliwer's absence in that there seemed to be a plausible reason for him not being in school. Again, whilst entirely plausible, the extensive number of absences alongside this additional absence reduced curiosity. These biases or '*inescapable errors*'[9] affect practice over time and can emerge unwittingly; disentangling the different characteristics of empathy and sympathy is important and highlights the importance of regular and reflective support and supervision for practitioners, regardless of setting, when working with children and families.

Learning point: Confirmation bias; *'… once we have formed a picture of a person or family, we have a strong tendency to keep to it, noticing any new information that supports it but tending to overlook or devalue any that challenge it … it is a major contributor to tragedies in child protection work …'.* Seeking a fresh pair of eyes on the situation can often help untangle what can become a problem at a later stage.

Munro, E., Guide to analytic and intuitive reasoning, 2009, Community Care Inform.

5.2.2. Whilst it has been acknowledged that the school, particularly the Special Educational Needs Coordinator, made really good efforts to provide consistent support for the mother, the other parts of the overall system that needed to respond were not fully synchronised with these efforts and the combined efforts of all professionals involved would have been stronger in identifying any actual, or potential, risk to Oliwer.

[9] Farmer, E., & Lutman, E., Working effectively with neglected children and their families – what needs to change? Child Abuse Review, Vol.23, pp262 – 273, 2014, Wiley Online.

5.2.3. Research[10] reminds us that *'… The concept of good enough parenting can be particularly challenging to apply with families of children with complex needs. Some children undoubtedly need more parenting or more skilled parenting than others; some children need 'intensive' parenting for much longer than others … parenting a child with complex needs is, by definition, likely to be more complicated, more time consuming, less familiar, more anxiety provoking, physically harder and emotionally more difficult … knowing what is involved in a child's day to day care can powerfully operate on our expectations about what is good enough parenting. One possible consequence of realising the demands is a downward shift in our assessment standards, for example lowering expectations of what constitutes reasonable parenting …'.* This case has highlighted that, not only did expectations shift about what level of service might be hoped for against what was felt to be really needed, but also sympathy played a part in the style of interaction with Oliwer's mother, resulting in a further shift in expectations. Coupled with Oliwer's mother not feeling like she was taken seriously this resulted in her somewhat disengaging in taking him to health settings. All of this had a powerful effect on how the situation was viewed.

> **Learning point:** Research into other Serious Case Reviews[1] states *'… without professional curiosity professionals fail to recognise risks, downplay them, or focus on parents' needs to the detriment of the child's … professional curiosity requires professionals to think 'outside the box' …'.* Exercising curiosity – the asking of questions – is a key task for all professionals working with children and families.
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> Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 159, University of Warwick & University of East Anglia, May 2016

5.2.4. In their submissions, Cambridgeshire Community Services identified that the mother reported that she often kept Oliwer off school to avoid upsetting him and wanting to '*keep him happy'*. They also note that the acceptable and child centred home environment and the mother's eagerness for him to remain happy, impacted professional perceptions about whether more could have been done to challenge her parenting approach which avoided *'controlling'* him. During their interactions with the mother, it was noted that she made all the decisions about Oliwer's care and parented him in isolation of the step-father. This was not challenged and there was no full assessment or professional curiosity about how the parenting role might be shared; assumptions were made about her occupying the main carer role. Assumptions can be a symptom of busy professionals working with hectic schedules or there being an absence of procedural routes or standards for dealing with an issue. An example of this can be seen with the mother not engaging and not attending appointments offered, most notably the Speech & Language Therapy Service, the Community Dietician Service and Community Dental Service, and then being discharged. At the time, no specific chronology of missed appointments for Oliwer was being used, nor was use made of the available 'significant events' template. The consistent use of the significant events template has been a learning point for Cambridgeshire Community Services and was part of the immediate action plan from the Trust's internal enquiry. It is now standard practice across all services that children not brought to appointments are recorded on this template.

5.2.5. The number of appointments the mother had to attend, or was offered, may also have been a contributory factor, as well as her understanding of English. There is a mixed view about how confident the mother's reading of English was, but the greater view seems to be that she was competent and able to understand written and verbal information. No information has been provided to indicate that agencies or professionals dealt with Oliwer or his mother any differently due to their Polish heritage. The mother attended a parents ASD support group and met with other parents in similar situations; those running the group have confirmed that Oliwer's mother did not feel an interpreter was necessary and was able to answer questions and describe situations at home so that advice could be

[10] Marchant, R., Making assessment work for children with complex needs, p. 208, in The Child's World, The comprehensive guide to assessing children in need, Edited by Horwath, J., 2nd Edition, 2010, Jessica Kingsley.

given. Nevertheless, since January 2020 a Polish interpreter is available at all ASD support groups and a private space is offered if needed.

5.2.6. Just prior to Oliwer's death the Mother had attempted to take him to a Walk-In clinic because there were no GP appointments available. She attended one but decided not to wait because of having to manage Oliwer in the waiting area. Without speculating, it is impossible to know whether, had Oliwer remained and been seen by a clinician, whether his death was preventable. However, Oliwer's mother has described some challenges of following advice by Doctor's and health professionals given, notably keeping him hydrated but only being able to use sugary drinks, and giving pain relief but struggling to get Oliwer to take oral medication.

5.2.7. By way of a summary, findings have captured the potentially powerful effect of human factors when assessing levels of need but also risk factors. It has highlighted the need for professionals to have access to regular reflective supervision and support that can challenge the emergence of bias and assumptions thereby provoking greater curiosity; these are essential elements of remaining child focused especially when working with children that have additional needs and may need a greater level of parenting.

5.3. Strategic oversight & management of children with special educational needs from a safeguarding perspective

> Statutory guidance states *'… If children … with SEN or disabilities are to achieve their ambitions and the best possible educational and other outcomes … local education, health and social care services should work together to ensure they get the right support … Local authorities and health bodies must have arrangements in place to plan and commission education, health and social care services jointly for children … with SEN or disabilities …'.*
> *Special educational needs and disability code of practice: 0 to 25 years Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities, January 2015, p 24, HM Government*

5.3.1. As noted above, the findings of this review need to be considered in context of the systemic weaknesses identified by Ofsted in their 2018 inspection in relation to children with special educational needs. Following a thorough and systematic investigation conducted by Cambridgeshire Community Services as part of their internal review, they have identified and concluded that *'… no one professional undertook to coordinate health care and act as a single point of contact for the family of a child with additional needs, needing to navigate the health and educational systems …'.* The following additional findings are of particular note *'… The school were unaware of the missed appointments with the Community Dietician Service … there was a common professional assumption that weight monitoring was the role of the Dietician Service … Concerns were not directly shared with the GP Service when the mother initially disclosed using Melatonin obtained from Poland. However, this information was documented in SystmOne records which is a shared record and visible to the GP Service. Ordering/collection of prescriptions was not checked by the GP Service …*'. It has also been suggested that there was an element of other professionals that were in contact with Oliwer believing that he was being seen by specialists at the Child Development Centre and therefore adopting more of a

Learning point: For children that have complex needs i.e., health, medical, social and educational, and which often necessitates the involvement of multiple agencies/services there is merit in having a clear line of reporting and oversight in order to help manage the complex interactions that will inevitably emerge. Complexity makes it harder for professionals to understand cause and effect, track and predict events and promote outcomes for children. To manage this complexity and ensure a holistic approach, it is important that the professional network operates strategically rather than a collective effort of isolated interventions and there is a designated lead professional for the whole professional network that is best place to support the child.

passive role because they perceived the Centre as having some level of oversight and monitoring role; this was not the case. Ensuring all professionals understand the extent and parameters of other professional's input is important so that expectations can be managed and assumptions can be avoided.

5.3.2. Cambridgeshire Community Service have identified that information was not always shared and different professionals were not fully aware of Oliwer's complex health needs. This resulted in both care and service delivery problems that would have benefitted from having a lead professional to act as a conduit for all information to be channelled through. Whilst positives were noted about some of the efforts by the Service, overall greater clarity about roles and responsibilities is needed. This is further exacerbated by learning that the different review processes i.e., EHCP, annual medical reviews are not aligned. In practice this means that a child may be reviewed by the Child Development Centre, but if the EHCP review is 6 months later, the information provided may be out of date as the Centre may not necessarily review the child again ahead of the EHCP review; potentially resulting in there being no holistic, coordinated and aligned review. The complex interplay of issues for those children where this may be an issue is important to understand so that developmental milestones can be effectively and holistically assessed, in order to then provide and target the best support. Also, professional curiosity about welfare concerns may be weakened because they are diluted over a longer time frame.

5.3.3. A further example of information not being shared, as a means of providing timely support, has been captured. This stems from the ASD Advisor and SEN Advisory Team not being aware that the school had made a further referral to the Early Help Service requesting an assessment. As such, this was not considered alongside the input by the ASD Advisor, nor was it considered in the EHC Annual Review which took place in November 2019. This reinforces the finding made in section 5.1. about possible over-optimism, in that without the more specialised input from the SEN Service, making threshold decisions and judgements by those with influence over the gateway to additional services, is likely to be flawed and based on an incomplete account of the whole picture.

5.3.4. The SEN Advisory Team were not aware of the involvement of the Early Help Service, and the school had not informed the ASD Advisor about the extent of their worried about Oliwer's heavily restricted diet and referral to the Early Help Service. Combined, there was no holistic view taken that understood, or evaluated, Oliwer's overall needs and safety and the impact for the mother in managing Oliwer on a day-to-day basis, nor was there a universal view about what each agency and set of professionals were providing, and what they could each add.

5.3.5. The roles of the Designated Clinical Officer and Designated Medical Officer are of interest to the review. At the time of Oliwer's needs being assessed for an EHC Plan and support being offered, Ofsted[11] noted *'… There is no designated medical or clinical officer (DMO/DCO) actively in post. The provisional arrangements for the interim period fail to ensure that basic strategic and operational duties are being undertaken. This is drastically hampering the CCG's ability to have oversight, awareness and assurance about how health services are meeting the needs of children and young people …*'. Learning from this review has confirmed the importance of having strategic oversight of individual cases and for someone to take a lead in coordinating all services, plans and interventions. Whilst that may be needed across health services, it is also evident that it is needed by those services outside of the health framework; the bridge between the two, if there are to be two lead professionals, is critical to avoiding further problems arising.

6. Conclusion

6.1. This Child Safeguarding Practice Review has examined the contact and involvement of a number of agencies with a six-year child who died in December 2019. The cause of death has been determined as Ketoacidosis with an underlying metabolic disorder. As an over-arching area of interest, the review was keen to explore the quality and

[11] Ofsted & CQC, December 2018, Joint local area SEND inspection report.

effectiveness of the multi-agency safeguarding response to young children with special educational needs in the Luton area, capturing information that might strengthen the Partnerships response.

6.2. The review has benefitted from information being submitted from those agencies involved with the child, the thoughts and perspectives of the professionals most closely involved with the child, as well as the contributions of the child's mother.

6.3. The review has found that services available to children and families in the Luton area during an important stage of the child's development were not as strong, coordinated or effective as they needed to be; in this case, it resulted in delays, limited coordination of support services, and a lack of holistic planning and intervention.

6.4. The review also found that good efforts were made by the school the child attended, with him making good progress and his mother feeling very supported by the efforts made. However, human factors impeded judgement and decisions made and requests for additional, and much needed, support were not effective. Threshold criteria, decision making, over-optimism and communication issues all affected the levels of support offered to the child and his mother.

6.5. The review has prompted those agencies involved with the child to consider actions of themselves; as such single agency action plans have been developed. This review concludes with recommendations for the Partnership.

7. Recommendations for the Partnership

7.1. In addition to the individual learning and actions captured by each single agency, the following recommendations are made for the Partnership:

1. Examine the best way to ensure dental practices in the local area are alert to dental neglect in children, familiar with referral pathways for them to seek specialist safeguarding support for individual cases where there may be concerns, and understand the need to share information appropriately where neglect/harm may be a feature.

2. Seek assurance, through focused audit, about the quality of assessments for those children with complex additional needs (medical, educational, health, social) and who are also likely to also have special educational need. The assurance exercise should include examining the quality of recording about unmet needs and assessing the contribution of the Designated Clinical Officer role.

3. Seek assurance about how schools provide the appropriate support and safeguarding supervision for individual cases, in order to ensure staff are able to reflect and critically evaluate the welfare and safeguarding needs.

4. Examine whether all partners across the Partnership are satisfied about:

a) how threshold assessment and decisions are applied and interpreted for children with additional and complex needs, especially those where support needs appear to be the main issue, rather than those children that are in need of protection.

b) whether the threshold guidance is sufficiently clear to allow transparent decision making.

c) whether further work is required to support challenge and escalation where there may be differences of opinion.

5. The Partnership, in collaboration with the Children's Trust Board, should:

a) facilitate a dialogue with the relevant agencies about which role within the current professional network is best placed to take the responsibility for lead professional for children with additional or complex needs and who have special educational needs.

b) for those children that have special educational needs and open to Universal Services there is no current process for sharing information about when those children might be absent from school without good reason, unless there are presenting concerns. In tandem with 5 a) above, consideration could also be given to the creation of a process and information sharing agreement regarding children (both SEND and Universal children) whose absence from school is consistently unexplained. This would enable oversight of any health needs that may be preventing a child from accessing school.