Local Child Safeguarding Practice Review
Commissioned by The Bradford Partnership - Concerning HARRY

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1. The Child and the Circumstances Leading to the Decision to Carry out a Child Safeguarding Practice Review

1.1 Harry has a complex range of physical and learning needs due to his diagnosis of chromosome 9 abnormality. He is non-verbal and at the time of the incident, was almost 12 years old.

1.2 Harry was admitted to hospital on the 21st May 2021 with severe weight loss and numerous severe pressure sores; his body weight had fallen by a third since his last recorded weight in November 2020.

1.3 The Bradford Teaching Hospitals Foundation Trust specialist safeguarding nurse made a referral to children's social care on the 25th May 2021 under the category of neglect.

1.4 The decision to undertake a Serious Case Review was agreed following a Rapid Review conducted on 11th June 2021.

1.5 A criminal investigation was commenced on 26th May 2021 and closed in January 2022; no charges were brought against any party.

2. The Review Process

2.1 This review followed the process outlined in Chapter 4 of Working Together to Safeguard Children 2018.

2.2 A Review Panel with the following membership was established to oversee the review:

- Carolyn Eyre, Independent Lead Reviewer & Overview Report Author;
- Child Safeguarding Practice Review Lead, Bradford Safeguarding Partnership;
- Deputy Designated Nurse, Bradford and Craven Clinical Commissioning Group;
- Consultant paediatrician /Named Doctor, Bradford Teaching Hospitals Foundation Trust;
- Named Nurse, Bradford Teaching Hospitals Foundation Trust;
- Named Nurse for children, Leeds Teaching Hospitals Trust;
- Chief Inspector, Safeguarding Partnerships, West Yorkshire Police;
- Head of Safeguarding, Bradford District Care NHS Foundation Trust;
- Education Safeguarding Officer, Education Safeguarding Team, Children's Services, Bradford Metropolitan District Council;
- Service Manager, for CCHDT, Bradford Children's Social Care;
- Area Safeguarding Manager, Multi-Academy Trust.

2.3 The Review Panel decided that the review should consider a period from January 2018 when the mother requested support and respite services to 25th May 2021 when the s47 referral was made by the safeguarding nurse at Bradford THFT. Agencies which had been involved with the family between these dates were asked to provide chronologies and analytical reports of their involvement including relevant background information which pre-dated this time period. The key learning from these reports has been used to inform this Overview Report.

2.4 Reports were provided by the following agencies:

- Bradford District Care NHS Foundation Trust;
- Bradford Metropolitan District Council, Children's Social Care;
- Bradford Metropolitan District Council, Education Safeguarding Team;
- Special schools 1 & 2 attended by Harry;
- Bradford Teaching Hospitals NHS Foundation Trust;
- Bradford and Craven Clinical Commissioning Group, Continuing Care Team;
- Bradford and Craven Clinical Commissioning Group – regarding General Practice;
- Leeds Teaching Hospitals Trust;
- West Yorkshire Police.

2.5 Other agencies involved with the family were identified during the review, and reports or additional information were subsequently provided by:

- Medical supplies provider;
- Sibling's primary school;
- Bradford District Care NHS Foundation Trust, Paediatric Dental Service.

2.6 The terms of reference for this review were set by the Review Panel in consultation with the Lead Reviewer.

2.7 Chapter 4 of Working Together to Safeguard Children 2018 states that the safeguarding partners should seek to ensure that:

"practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith"

"families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively"

2.8 In order to fulfil the first of these principles, the Lead Reviewer held a learning together event to which front line staff and their managers were invited. This helped the Lead Reviewer to gain a greater understanding of the context in which practitioners worked with the family and the reasons for the decisions they made and the actions they took. This in turn has assisted with drawing out relevant learning and recommendations for action and as such has been an important part of the systems approach that has been used.

2.9 The Lead Reviewer met with Harry's mother and sibling after the police investigation had been closed; Harry was also present. Attempts to meet with Harry's father and paternal grandmother were unsuccessful.

3. Family Circumstances

3.1 Harry is White British. He has a complex range of needs due to his diagnosis of chromosome 9 abnormality with brain malformations, severe cerebral palsy, congenital heart disease, asthma, visual impairment, epilepsy, scoliosis, global developmental delay and osteoporosis which makes him highly susceptible to bone fractures.

3.2 Harry has a gastrostomy (a feeding tube directly into the stomach through the abdominal wall), although he does eat some food orally. He has no bladder or bowel control, is unable to sit or weight bear; he uses a wheelchair and is entirely reliant on adults for his care needs. His incontinence, low weight and immobility means that he is vulnerable to pressure sores.

3.3 He is non-verbal although he can communicate pleasure, enjoyment, recognises known carers and can call for his sibling's attention. Carers who know him are able to recognise when he is experiencing pain.

3.4 He has an education, health & care plan (EHCP) and attends a special school. Sibling attends a local mainstream primary school.

3.5 Harry lives with his mother and younger sibling. Father does not live at the same address although he and mother were in a relationship until 2019 and he often stayed at the family home. Paternal grandmother is closely involved with the family, providing practical and emotional support to mother and the children.

3.6 Mother has a difficult and sometimes volatile relationship with her birth family.

3.7 There has been a pattern of violence within the family over a number of years. Mother has experienced domestic abuse, both verbal and physical, perpetrated by maternal family members and her partner, Harry's father. The first incident recorded by police was an assault perpetrated by her brother during her pregnancy with Harry. The children have been present during some of these incidents. In addition, the

parents have been victims of a robbery, threats and intimidation from external parties, possibly linked to drugs. There have been no recorded incidents of domestic abuse since the parents apparently separated in 2019.

3.8 WYP have been involved in relation to the alleged production and /or use of cannabis in 2012, 2019, 2020 and 2021. In March 2019 and January 2021, cannabis production equipment was discovered at the home address of mother and the children along with a separate offence of abstract electricity, where the electricity meter has been bypassed, being recorded. There is a strong indication that father was using the bedrooms for the production of cannabis. There is no evidence in police or CSC records that this information was shared with CSC regarding cannabis production in the household and the potential harmful impact of this activity on the health, safety and wellbeing of the children.

3.9 Harry has had significant periods of absence from school. His attendance in the years 2017-18 (49.7%), 2018-19 (49.5%) and 2019-20 (38.2%) was well below national averages; almost all absences were authorised as medical. Where Harry was absent due to illness or incapacity, the hospital education team was sometimes involved in provision of home tuition. Sibling has an excellent school attendance record.

4. The Facts - Summary of Agency Involvement

4.1 ***Introduction***

4.1.1 This section of the report provides a factual summary of key areas of agency involvement with the family. It is not a comprehensive record of all contacts with the family but focuses on key episodes that are considered to be significant to the way the case developed.

4.1.2 Harry has been known to paediatric health services in Bradford and Leeds since birth. Due to his complex needs, he and his mother have, or have had, contact with a large number of medical professionals including paediatricians, specialist physiotherapy services, occupational therapy, dietetics, community nursing team, school nursing special needs team, orthopaedics and orthotic services. Harry has also been admitted to the Accident and Emergency Department on numerous occasions, including as a result of prolonged or repeated seizures, chest infection, fractures and following a road traffic collision.

4.1.3 Mother and both children are registered with one GP practice. Father is registered with a different practice.

4.1.4 Harry has been under the care of the BDCFT paediatric dental service since 2015. He is seen for routine checks every six months and the dentist reports that mother's engagement with the service has been positive. Harry was not seen as planned in April 2020 due to the pandemic; however, face to face appointments were reintroduced and Harry was seen in April 2021 and early May 2021. The dental service uses a RAG rating for safeguarding and Harry has always been considered to be 'low risk'.

4.1.5 Harry attended special school 1, a provision for children aged 2 - 11, until the end of year 6 in July 2020. It was anticipated that he would transfer to special school 2, which caters for children aged 11 – 19, that September as stated in his EHCP. He was placed on the school roll but mother was unhappy with the placement and indicated during the Summer term 2020 that she intended to appeal for a place in a neighbouring local authority. In the event, his last attendance at special school 1 was in February 2020 and at the point he was admitted to hospital in May 2021 he had never been on site at special school 2.

4.1.6 Bradford Children's Social Care (CSC) first had contact with the family in July 2009 when Harry was one-month old following a referral from the Health Visitor due to concerns that mother's brother was living in the household. It was confirmed to CSC by the Youth Offending Team that the brother was no longer at the address and the case was closed although there is no further information in CSC records to indicate why the Youth Offending Team was involved or what risk the individual might pose.

4.1.7 Between 2009 and 2018, CSC received 12 contacts from West Yorkshire Police; two contacts from maternal family members, one contact from a member of the public and three referrals from professionals working with the family. The professional referrals included one from the children's centre requesting support and respite care in 2013; it was noted in CSC records that a Common Assessment (CAF) was in place and no further action was required. In 2015, BTHT paediatrician 2 made a referral to Children's Social Care due to concerns regarding possible neglect and disguised compliance; it was believed that mother had not been collecting or administering Harry's anti-epileptic medication and was not being truthful about this. A child and family assessment was completed by CSC with no concerns identified and it was recommended that a health-led CAF should be put in place.

4.1.8 It is recorded on the SystmOne safeguarding node for both Harry and his sibling on 9th February 2016 that the school nursing special needs team had been informed by GP4 that mother was not collecting prescriptions for Harry's anti-epileptics. It was noted that the same concerns had been raised the previous year with CSC but the case had been closed. CSC and GP records indicate that a month later, in March 2016, GP6 in the same practice contacted CSC to advise that the concern in February 2016 had been resolved as Harry had received his medication from the hospital. CSC noted that they were not made aware of the concern in February.

4.2 ***Key episode 1 – Parents' and children's experiences of violence, aggression and domestic abuse***

4.2.1 The first agency record of mother's experience of domestic abuse was an assault perpetrated by her brother in March 2009 when she was pregnant with Harry. Between February 2010, when Harry was 8 months old, and February 2019, records indicate that there were fifteen incidents involving West Yorkshire Police (WYP). There have been no recorded incidents involving the police since 2019; mother has told the reviewer that she and father separated that year.

4.2.2 Many of these incidents were recorded as domestic abuse including verbal abuse between father and mother. Father was cautioned twice in this period, both during 2011, when mother was pregnant with Harry's sibling. Mother also experienced a further assault perpetrated by family members and both parents were victims of crimes perpetrated by unknown adults outside the family. A house robbery in 2013 and harassment experienced by father in 2017 were suspected to be linked to debt or the production of cannabis.

4.2.3 West Yorkshire Police completed a domestic abuse, stalking and harassment (DASH) risk checklist on each occasion that they responded to a domestic incident between mother and father. The risk was categorised as standard or medium each time. Attending police officers informed CSC that there was a child with complex needs living in the household, the parents were stressed with little sleep and that the house was 'extremely untidy'. Following an incident in November 2013, WYP made a follow up referral to CSC to request respite services for the family although there is no reference to this referral in CSC records.

4.2.4 Of the 15 incidents between 2009 – 2019 known to have been notified by WYP, only nine were recorded in CSC records; the outcome is recorded for each of these as 'no further action'.

4.2.5 It was clear from individual agency records and the learning together event that the history of violence was not known to professionals involved with the family since 2018. Special school 1 had known Harry since he was very young but there was no information regarding domestic abuse in his CPOMS file, the school's digital child protection record. The sibling's primary school staff know both parents well but were unaware of the history and understand that the parents are still in a relationship. There was no record of domestic abuse in Harry or his sibling's health record on SystmOne, the clinical healthcare recording system used by GPs, school nursing team and primary care services.

4.2.6 The GP practice was a notable exception. The journal section of mother's SystmOne record included information regarding incidents of domestic abuse in 2012 and 2014 and reference also to cannabis being grown in the house. This information was not copied across to Harry or his sibling's health records as the incidents predated the introduction of the SystmOne safeguarding node in 2015. On the 10th February 2021, mother had a telephone consultation with GP8 regarding minor illness; records show that the GP noted the historic concerns of possible domestic abuse and the 2015 / 2016 entries regarding Harry's medication. On 28th April 2021, in responding to a telephone appointment relating to Harry, GP8 again noted the previous concerns from 2015 and 2016 but also that Harry was under the care of several secondary care professionals; there was evidence of mother proactively seeking medical advice and there had been no safeguarding concerns highlighted in Harry's medical records since then. The GP was not aware that Harry was subject to a CiN plan.

4.2.7 Although the information was available to SW2, the Single Child and Family assessment undertaken by CSC since 2019 did not adequately consider the history of violence and domestic abuse and there is no consideration of the impact on the children. It is observed in the CSC single agency report that, given the nature of the Children with Complex Health & Disabilities Team (CCHDT), referrals are made to request

services (s17) rather than to respond to safeguarding concerns (s47) and SW2 approached the assessment purely in terms of services that might be offered to Harry and his family.

4.2.8 There is no indication in agency records that mother ever disclosed her experiences of violence and domestic abuse to health or education professionals or with the social worker.

4.2.9 At the learning together event, professionals considered the potential impact of violence and aggression on mother's attachments with both children, particularly as she had experienced assaults during both pregnancies. However, health professionals and school staff observed that mother did have a strong bond with both children.

4.2.10 Professionals discussed how Harry and his sibling might have experienced the incidents of domestic abuse where they were present. Although Harry has profound learning disabilities, he will be sensitive to mood and atmosphere and may have felt fear or distress even though he could not articulate this. The primary school reports that the sibling has shown none of the negative indicators associated with children living with domestic abuse.

4.3 ***Key episode 2 - agencies' understanding of the relationships within the family***

Practice insights:

"If we had known about the domestic abuse, we might have made more careful observations during home visits and recorded more thoroughly."

"More careful assessments of mother's wellbeing and capacity to cope with (his) complex care needs."

"We have known him from birth and we have not had any of this information."

"For home tuition they would complete it in his room and take toys to enhance that. [If home tuition team had known] they may have found a reason to go elsewhere [in the house] or been more approachable."

4.3.1 Many of the practitioners involved with Harry understood mother to be a single parent with lone carer responsibilities. Father was generally not recorded in medical notes as present at appointments and there was little understanding of his involvement with Harry. GP records

indicate that all contacts were with mother except one call in September 2019 regarding a rejected request for an x-ray. Father was registered with a different GP practice.

4.3.2 Harry's mother appears to have attended all his appointments and to all his physical and emotional needs and the LTHT reviewer noted that father appeared 'absent' from every appointment entry reviewed. However, during two episodes where Harry was admitted to hospital (May 2020 and September 2020), information was gathered on the ward regarding the names of both parents and other significant people in his life.

4.3.3 There are records of mother and Harry attending BTHT hospital appointments with the maternal and paternal grandmothers on occasion, including an incident in 2015 recorded in CSC records where both grandmothers had been verbally abusive. During a telephone call with mother in August 2019 to follow up a missed clinic appointment, the paediatrician asked appropriate questions regarding who lived in the family home and what family support was available. Mother stated that she, Harry and his sibling lived in the home, father visited regularly and picks up sibling but "does not provide care to Harry because he is scared". Paternal grandmother was also identified as a significant person.

4.3.4 Harry's schools both recorded mother as the main contact and had little formal interaction with father although staff from special school 1 said at the learning together event that father was known to see the children most days, he did sometimes collect Harry from school and was seen during home visits. Father did not attend the annual reviews of Harry's EHCP although he was invited.

4.3.5 Special school 2 did not have any contact with father regarding Harry's non-attendance and neither the school nor the local authority SEND team sought his view on mother's expressed intention to appeal for a different school.

4.3.6 Sibling's school reports a good relationship with both parents; father regularly brings or collects from school. School staff also know Harry and say that his sibling is very happy when their brother comes to their school events; and likes friends to meet him.

4.3.7 The medical supplies provider had contact details for both parents and routinely called father if they were unable to contact mother; they were successful in speaking to father twice during the period 2018 – May 2021. On one occasion, he stated that he was not directly involved in the care needs of his son and the company should contact mother. On the second occasion, father confirmed that there was still a supply in the house and no delivery was required.

4.3.8 In January 2020, SW2 recorded in the case file that father "*is very much involved in Harry/children's lives*." She subsequently made two unsuccessful attempts to contact father during the assessment. At the learning together event, it was noted that a single child and family assessment under s17 is a voluntary process and parents cannot be required to engage. Since the incident that led to this case review, father has shared, during assessments and child protection planning meetings, that he found it difficult to engage with professionals because he feels some terminology is hard to process.

4.3.9 Mother told the Lead Reviewer that father has a close relationship with the children and visits frequently but does not feel confident managing Harry's care needs; she said that father had once witnessed Harry being resuscitated and this had affected him deeply.

4.3.10 Paternal grandmother is a key adult in the lives of Harry and his sibling but was not included in the single assessment undertaken by SW2. Mother told the Lead Reviewer that she has a strong bond with paternal grandmother and describes her as '*like a mother to me'*.

4.3.11 There is little evidence of a holistic 'Think Family' in CSC assessments of Harry's wider network of significant people; his father, his sibling and grandmother. Initial requests to CSC for support had made reference to mother's desire to spend quality time with Harry's sibling. However, from the point that the case was referred to SW2, there is no evidence that the sibling's needs were ever considered and there was no contact with her school to ascertain whether they had any concerns. There is no evidence of any assessment of how sibling might be impacted practically or emotionally by growing up with a brother with profound needs. The primary school DSL reflects that this has been a common theme since the incident in May 2021 and that the s47 multi-agency conferences and review meetings have barely touched on any needs the sibling might have.

4.3.12 Most frontline practitioners at the learning together event were not aware of the "Think Family" approach; this was not the case for senior health professionals with a designated safeguarding responsibility or for frontline professionals working in Leeds. The Bradford education safeguarding team confirm that "Think Family" is not covered in Designated Safeguarding Lead training for schools.

4.4 ***Key episode 3 – mother's requests for services / support***

Practice insights:

There was almost universal acknowledgement that mother was seen as the primary carer and that more opportunities could have been provided for father to be included.

Mother consistently described herself as a single parent and was considered to be so even by professionals who had frequent contact with father. Professionals formed a view of the family structure based on what they were told rather than what they were seeing: -

"We can be guilty of not having included dad. Dads can be uncomfortable. I thought dad was at work but he was upstairs - I made an assumption."

"The more you know adds up to one big picture - you need to know the tiny things."

4.4.1 Referrals/ requests for support were made to CSC on mother's behalf by a range of professionals between 2013 and 2018; these included the children's centre (2013) and numerous referrals from paediatrician 1 (between 2015 – 2018). Mother had expressed concerns prior to 2018 that she needed support but requests for respite services became more frequent from 2018 onwards; CSC received a referral from the occupational therapist in October 2018 for regular respite to enable mother to have quality time with Harry's sibling. Sibling's primary school CPOMS record indicates that a SW made enquiries, stating that a request had been received for support for mother; the primary school advised that they had no safeguarding concerns regarding the sibling. CSC also made contact with special school 1 to ask whether school had any concerns regarding Harry. The school had no concerns; no further information was received from CSC and the school made no additional enquiries of mother. CSC records show that the case was stepped down to Early Help.

4.4.2 At a paediatric appointment in Bradford in December 2018, mother reported that a referral to the local children's hospice had been rejected because Harry did not meet their criteria. She also shared that the occupational therapy service was planning for adaptations to the home. Recognising that Harry's needs were not being met and that mother was 'struggling', paediatrician 1 made a referral to Early Help services.

4.4.3 There is no record in the paediatric notes of an outcome to this referral. However, in March 2019, Harry was seen in clinic with mother and grandmother and paediatrician 1 recorded that mother was pleased that support was to be put in place to secure a new mattress. Mother told the paediatrician that Harry had bed sores; the paediatrician checked and observed that the site was dry.

4.4.4 In August 2019, paediatrician 1 telephoned mother following her failure to bring Harry to a clinic appointment. The paediatrician asked what family support was available and, with parental consent, made a second referral to social care for Early Help although there was a three-week delay before this was completed. The paediatrician received no feedback from CSC regarding the referral and asked mother at an appointment in November 2019 whether the referral had led to any outcome; mother responded that she had an appointment with them the following week. At this point, SW1 had already undertaken the first home visit but this was apparently not shared with paediatrician 1.

4.4.5 Following telephone contact with mother in October 2019 where mother informed the school that the social worker was to make a referral for respite services, special school 1 made a referral to the regional children's hospice but this did not meet the threshold. There is no evidence that the school considered any other actions or services that could be put in place. The school did not ask mother for any further information regarding the social worker's name, contact details or why s/he was involved.

4.4.6 During this time period, it was recognised that Harry's wheelchair may no longer be suitable. Paediatrician 1 made a referral to wheelchair services and then followed this up on a regular basis. Mother was noted to be concerned about Harry's disrupted sleep patterns and discomfort; a referral was made for a sleep system assessment although this was subsequently delayed by cancelled appointments in December 2019, once by the company and once by mother, and then the suspension of home visits in the initial stages of the pandemic. The sleep system was eventually delivered and set up in May 2020.

4.4.7 Following discussions with mother in March 2020 and a supervision meeting on 28th April 2020, SW2 made a referral to local respite services and submitted a continuing care pre-assessment checklist to the Continuing Care Team (CCT) for a care package. Both referrals were unsuccessful; the respite provider was closed due to Covid. The continuing care pre-assessment checklist had been completed without any health input; some sections were left blank. CCT reviewed SystmOne where the school nursing team records indicated that they had not seen Harry since January 2020 due to his "non-attendance at school as a result of not having a suitable wheelchair". CCT also noted that Harry was dormant on the CCNT caseload, indicating that no current nursing was required. CCT notified the SW within 5 days that Harry did not meet their criteria, and provided a clear explanation for this.

4.4.8 Following discussion in supervision in May 2020, SW2 made a referral to the Children's Community Support team (CCST) sleep clinic. On the 2nd February 2021, the CCST notified SW2 that they had agreed with mother to close the referral due to lack of progress; CCST recounted repeated unsuccessful attempts to work with mother and her failure to provide the sleep diaries needed for analysis. SW2 asked mother about the CCST decision to close the referral; mother's response was that Harry had been ill. This was not challenged by the SW despite sleep issues being identified as one of Harry's unmet needs and the reason for requests for respite, which was still not available to the family.

4.4.9 On the 12th February 2021, SW2 advised mother in a telephone call that SENDIASS, an independent support service provided by Barnardo's, had closed the case; their attempts to contact mother since October 2020 had met with no response. Mother informed SW2 that she had been busy and needed time to herself. SW2 appears not to have challenged mother despite this being the second service to report a pattern of non-engagement within the same month.

4.4.10 During the same telephone conversation, mother stated that Harry was "currently struggling with bed sores" and that she had been waiting a significant period of time for an air mattress to be provided by the hospital; this was to support Harry's spine which had been damaged during a seizure. SW2 contacted the children's community nursing team on the 26th March 2021 to request support in securing the air mattress due to recurrent pressure sores; she said that mother had reported the team to be unhelpful. The nursing team advised that they had spoken to mother in February but she had indicated that Harry had no current pressure sores and she had no support needs. CCNT had offered a home visit but this had been declined. The CCNT recorded the information from SW2 as a complaint and action was taken the same day – a staff nurse contacted mother by telephone but she again stated that there were no current pressure sores and declined a home visit. CCNT attempted to contact the SW the same day to provide feedback and telephone contact was made on the 6th April.

4.4.11 At the paediatric appointment on 11th May 2021, conducted by phone, mother shared a significant amount of information regarding Harry's unmet needs. She reported that Harry had no suitable wheelchair following advice from LTHT spinal and orthopaedic clinic in February 2021 that the new wheelchair was not suitable. House adaptations had still not been actioned so she was having to lift Harry manually. She believed that he needed a new bed and a bath seat. He had pressure sores and was reported to be in significant pain, requiring Oramorph once or twice a day to manage this, and was still on the waiting list for local respite services. The paediatrician recognised that mother was struggling to meet Harry's needs and agreed to put in a new referral to the regional children's hospice on the basis that his clinical situation had changed. The paediatrician also requested a home visit for Harry from the child development service; this home visit on the 21st May led to Harry's admission to hospital.

Practice insights:

"We were not aware of those referrals - had we known we would have wanted him in school as much as possible."

"Disguised compliance is to wilfully mislead but if you are in crisis, disguised compliance may be a coping strategy - ''I'll tell them what they need to hear'"

4.5 ***Key episode 4 – the single child and family assessment***

4.5.1 In September 2019, paediatrician 1 made a referral to CSC for support for mother and Harry; it was considered that the referral met the threshold which led to an initial home visit by SW1 on the 11th October. Mother shared a significant amount of information regarding Harry's complex needs; she also stated that Harry was not currently attending school. SW1 recorded that mother was a single parent and that she struggled to take the children out or find activities suitable for both children.

4.5.2 Although it is not recorded in CSC records, SW1 contacted the school nursing special needs team on the same day that the referral had been received from the paediatrician; this was not recorded on the safeguarding node of SystmOne or in CSC records. SNSN advised SW1 that school nursing team could not comment on the referral and advised the SW to contact the referrer directly. SW1 commented that they thought Harry's problems were "*medical and not for social care*."

4.5.3 Following the home visit, the referral was processed and allocated to SW2 from the children's complex health and disabilities team (CCHDT). It took one week to process the referral and allocate a named SW – this should have been completed within 24 hours. As a result, there was a one-month delay from receiving the referral to commencing the assessment.

4.5.4 Four weeks later, with no progress made, the case was closed and re-started. The manager's reason for this was the delay in allocating the case. Assessments should be completed within a maximum of 45 days; the CSC reviewer noted that closing and reopening the case - in effect, re-starting the statutory timeframe clock - was not the correct process. As a result, Harry was recorded on the system as a child in need (CiN) in November 2019 but the plan included no identified needs due to lack of assessment.

4.5.5 SW2 undertook a home visit on the 22nd November 2019 during which mother provided contact details for father and the names of a range of professionals involved with Harry. At this point, SW2 did not contact father or any agency apart from the paediatrician's secretary to

request copies of clinical letters. She did not ask to speak to the paediatrician directly; as the referrer, a conversation with paediatrician 1 should have been an important part of the assessment.

4.5.6 SW2 recorded in the case file in January 2020 that they intended to contact father to gather his views as "*he is very much involved in Harry/ children's lives*." The SW subsequently recorded in the case file that two unsuccessful attempts were made to contact him, in January 2020 and again in April 2020 in advance of the CiN meeting.

4.5.7 In February, Harry was discussed in supervision; the only action recorded by the team manager was for the SW to complete the assessment. The following day, in contravention of statutory guidance, a management decision was made to close and restart the incomplete single assessment with the rationale given as SW2 had been absent from work due to illness.

4.5.8 In telephone calls between mother and SW2 during February, mother indicated that Harry was still not attending school due to lack of an appropriate wheelchair, and that there were continuing challenges around Harry's sleep difficulties. Mother reported that paediatrician 1 and the school were making appropriate referrals. The CSC reviewer noted that SW2 accepted mother's information at face value; she did not contact either agency to confirm that Harry could not attend school, and no consideration of the potential impact on him.

4.5.9 At a home visit in March 2020, mother and SW2 discussed a referral to respite services due to Harry's disrupted sleep. There appears to have been no analysis of the impact of Harry's non-attendance at school on anyone other than mother. Mother also indicated that she intended to appeal the school allocation and SW2 agreed to speak to the local authority SEN team. There is no information in CSC records to indicate whether Harry was seen at the home visits or any observations of his presentation.

4.5.10 From March 2020, all contacts between SW2 and mother were via video conferencing or telephone call due to the pandemic. SW2 asked whether the children's community nursing team (CCNT) were involved with the family; mother indicated that they were but only on an emergency basis. SW2 failed to contact CCNT to clarify their involvement with Harry and involve them in the single assessment.

4.5.11 The first CiN meeting was held on the 27th April 2020. A CiN meeting is intended to be multi-agency in order to gather all the relevant information from partner agencies and allow key professionals to contribute to the plan but there is no evidence that any health professionals were invited and the only attendees were mother and SW2. There is no information available to this review regarding SW2's failure to engage the many health professionals involved with the family or the context in which SW2 was working.

4.5.12 The SW had emailed special school 1 on the 22nd April to request an update for the CiN review meeting. The email was vague and did not make clear whether the school was invited to the meeting. There is no record on CPOMS of the email from SW2 on 22nd April 2020 requesting

information; however, the school stated in an email to the SW that they were having difficulty contacting mother by phone and she was not replying to messages.

4.5.13 Special school 1 case record indicates that they became aware that Harry was a child in need on 24th April 2020 when the local authority provided a list of children known to CSC for the purpose of identifying vulnerable children who should or could attend school during the first lockdown. The school states that they were unaware of Harry's CiN status before this point although the school records show that mother had made reference to the social worker in October 2019 and they had received an email from the SW on 22nd April 2020, two days before the local authority list was received. The school did not make a record on CPOMS of Harry's status as a child in need; as a result, this information was not passed to special school 2 during the transition phase.

4.5.14 Minutes of the CiN meeting were circulated to special school 1 and mother on 19th May 2020; copies were not sent to any health or other professionals involved with the family. All information in the health section of the completed plan appears to have been provided by mother.

4.5.15 Harry was seen by SW2 during a virtual meeting with mother on 21st May 2020. Mother stated that paediatrician 1 had requested an emergency appointment with wheelchair services and that Harry's anti-epilepsy medication had been adjusted due to an increase in frequency of seizures. There is no evidence that SW2 considered this information in the light of the 2015 referral and she did not contact the paediatrician to confirm the reliability of mother's information.

4.5.16 During a virtual visit in June 2020, mother informed SW2 that Harry had bed sores which may be as a result of his new sleep system and that she was awaiting a call from the physiotherapist. Mother advised SW2 that she has experience in caring for his pressure sores. SW2 appears not to have explored the issue of Harry having pressure sores any further and did not contact the physiotherapist to confirm the information or seriousness of pressure sores in a child with complex needs.

4.5.17 Mother made reference to the social worker in a telephone conversation with the school on 2nd June 2020 when she advised that she intended to appeal for a different secondary school to the one allocated and, as a result, the SW had told her not to complete the transport application. The school did not make any enquiries with the SW at this point, nor did they make a record on CPOMS.

4.5.18 In case supervision on the 23rd June 2020, it was agreed that Harry should be stepped down to 'stable' despite the significant range of unmet needs identified; Harry was still not attending school, the wheelchair issue had not been resolved, respite care had not been sourced, adaptations to the home had not been forthcoming and Harry was experiencing bed sores possibly caused by the sleep system intended to improve his quality of life. There is no information in the supervision notes to indicate the rationale for this decision. Marking the case as 'stable' meant that the frequency of visits could be reduced from 4-weekly to every 6 - 8 weeks.

4.5.19 In October 2020, SW2 was involved in email correspondence with special school 2 and the local authority SEN team regarding Harry's non-attendance at school and mother's intention to appeal the placement. SW2 subsequently emailed the SEN team on 20th October to request a written update for the CiN review meeting which was, in theory, happening the same day.

4.5.20 There is no evidence that a virtual review meeting took place on the 20th October 2020; the only information recorded was provided by mother. This was not challenged by the Team Manager who agreed the 'minutes' of the meeting but did not add any comments. The contributions of school and health professionals, and an opportunity to triangulate information provided by mother, would have provided an opportunity to challenge assumptions and identify routes to meeting Harry's unmet needs. The CSC reviewer describes this CiN meeting as a paper exercise and, as such, "*a complete failure in respect of multi-agency working and information sharing.*"

4.5.21 On the 4th February 2021, the local authority Service Manager for integrated assessment and psychology contacted the executive head teacher regarding concerns raised by the SW at the lack of remote learning provision for Harry. This was the first time that special school 2 became aware that Harry had a named social worker; there appears to have been no attempt to contact the social worker to clarify the reason for their involvement or to share information regarding his non-attendance.

4.5.22 In February 2021, mother told SW2 that Harry once again had pressure sores but that a specialist air mattress to be provided by the hospital had not yet arrived. SW2 did not record whether she had checked that medical attention had been sought. Mother also stated in an email on the 22nd February that paediatrician 1 had prescribed morphine due to spinal damage caused by a seizure; the wheelchair was now unsuitable and LTHT was to contact wheelchair services regarding this. She also stated that the orthopaedic consultant in Leeds had advised that Harry should not attend school due to the fragility of his bones. This is not corroborated in any LTHT records. SW2 advised mother to inform the school that it was not safe for him to attend.

4.5.23 Information from mother to SW2 in February 2021 suggested that a number of health professionals were actively involved in meeting Harry's needs and this was accepted at face value. Mother also indicated that special school 2 was undertaking weekly welfare checks with Harry and mother; it appears that SW2 understood these to be home visits rather than weekly telephone calls to mother and led her to believe that partner agencies were involved in physically monitoring Harry's wellbeing. SW2 recorded in the file *"[Mother] is a proactive mother and engages well with professionals to advocate Harry's needs.*" This assessment can only have been drawn from information provided by mother as there is no record of SW2 communicating with health services. The assessment is also at odds with the two agencies closing their cases that month due to lack of engagement from mother.

4.5.24 On 25th March 2021, SW2 sent email invitations to mother and a range of staff from special school 2. The case file notes that an email was also sent to the local authority SEN team administrator. No health professionals were invited.

4.5.25 A CiN review meeting was recorded to have taken place on the 13th April 2021. No professionals attended this meeting. At the learning together event, the DSL stated that it was school policy to only attend the CiN review meetings of pupils for whom there were safeguarding concerns. A report was provided by special school 2 in which it was stated that there was good communication with mother but they were unable to comment on Harry's likes and dislikes, social interaction, communication or what is not working well "*because due to Covid situation haven't had the opportunity to meet Harry yet.*" The school also provided an update regarding the arrangements for remote learning.

4.5.26 Minutes of the CiN review meeting were circulated to special school 2, paediatrician 1 and the SEN team. SW2 recorded in the minutes that Harry was currently unable to attend school or access the community due to the lack of a suitable wheelchair; this was not correct. The information mother had provided to SW2 eight weeks previously was that he could not attend due to the risk of fractures during moving and handling. SW2 did not verify the information with a health professional or challenge mother on the discrepancy. There appears to have been no consideration of what impact his inability to leave the house might have on Harry.

4.5.27 On 30th April 2021, SW2 undertook a virtual visit and records that Harry was seen. Mother informed SW2 that pressure sores had settled, Harry was managing to eat orally as well as via his feed system, that he had been to the dentist the week before and that special school 2 was still undertaking weekly welfare visits. This implies that Harry was being physically seen by a range of professionals.

4.5.28 On 19th May 2021, SW2 made a request to Team Manager for permission to continue with virtual visits due to mother's desire to continue to shield Harry. SW2 recorded in the notes "*There are no safeguarding concerns in respect of Harry or the family.*" SW2 made a telephone call to inform mother of the agreement to continue with virtual working, during which mother stated that she had requested an appointment with the paediatrician due to Harry not gaining any weight despite having all his feeds and additional oral feeding. She also stated that his pressure sores had returned so she intended to ask paediatrician 1 to arrange for an air mattress. Mother told SW2 that she feels paediatrician 1 is not taking her concerns seriously. There is no evidence that SW2 re-considered her assessment of risk in the light of the new information.

4.5.29 Harry was admitted to hospital 2 days later.

Practice insights:

The current CSC team manager reflected that, while closing and restarting an assessment was unacceptable practice, the CCHDT was holding a high number of complex cases at the time: -

"We've learnt that if an assessment came in and workers were off sick, they got left. Then when a new worker came, we would close or restart. We don't do that now."

"We did try to involve dad and he didn't want to engage. We had no power to pursue him - he didn't want to; he was in the background."

4.6 ***Key episode 5 – Harry's absence from school***

4.6.1 Harry missed significant periods of education at special school 1, ostensibly due to his complex health needs, an accidental fracture and a road traffic collision. His attendance in the years 2017-18 (49.7%), 2018-19 (49.5%) and 2019-20 (38.2%) was well below national averages but almost all absences were authorised. Where Harry was absent due to illness or incapacity, the Hospital Education Team was involved.

4.6.2 During 2018, the Nutrition and Dietetics service made a number of requests to SNSN for a weight check. SNSN advised that this was not possible due to Harry not attending school.

4.6.3 In March 2018, Harry developed problems with a protruding plate in his hip which led to conflicting accounts regarding whether he could attend school. SNSN recorded that mother had been advised to seek advice from the GP regarding the protruding plate. During a hospital appointment with paediatrician 1 on 13th March 2018, mother stated that school was refusing to allow him to attend. The paediatrician was supportive of Harry returning to school. Immediately after the hospital appointment, there was good information sharing with colleagues in Leeds and Bradford, facilitated by SNSN. A part time timetable was agreed, commencing on 15th March although he only attended one session of the next ten.

4.6.4 Due to subsequent surgery, Harry did not attend school again until the 9th September that year.

4.6.5 At an appointment with paediatrician 1 in March 2019, mother stated that Harry's school attendance was good; at this point, he had attended 10 of a possible 94 sessions since the start of the January term.

4.6.6 On 6th February 2020, special school 1 recorded that Harry had been advised not to use his wheelchair for medical reasons. There is no record of who provided this information or of the school making attempts to confirm that this was the case.

4.6.7 Four weeks later, school staff undertook a home welfare visit during which the mother informed school staff that a complaint had been made to wheelchair services, that the waiting list was long, and that the paediatrician and physiotherapist had also contacted wheelchair services. There is no evidence that the school followed this information up with health colleagues. Home tuition (one half day per week) was arranged but mother cancelled this two-weeks later due to the pandemic.

4.6.8 Like all schools nationally, special school 1 closed on 18th March 2020 as part of the national lockdown. In line with Government advice, the school drew up a document for all pupils, prioritising vulnerable children who should continue to attend school; this group included children of critical workers and those with a social worker. Harry was recorded as 'safer at home' due to his complex underlying health needs. The school was not aware at this point that Harry was subject to a child in need plan and should have been included in the priority group.

4.6.9 Special school 1 reopened fully in June 2020 in line with Government guidance. At this point, Harry could have returned to school but mother had received a letter from BTHT confirming that he was clinically vulnerable so he was recorded on the school register as 'shielding'.

4.6.10 Harry reached the end of primary education in Summer 2020 and should have transferred to special school 2 for the start of year 7 that September. In May 2020, special school 1 offered support to all Year 6 parents to complete documentation such as transport applications. On 2nd June, mother informed the school that she intended to appeal for a different school closer to home but in a neighbouring local authority and that her social worker had advised not to complete the transport form. There is no evidence that the school attempted to contact the social worker to clarify her involvement or advice.

4.6.11 The school care team and school nursing teams from special schools 1 and 2 met in June/ July 2020 to complete health assessments and hand-overs for pupils in Year 6. It was noted that Harry may not join special school 2 in September as mother was appealing for another school.

4.6.12 Harry did not join special school 2 in September 2020 and the transport service later confirmed that no transport application had been received from Harry's parents.

4.6.13 Parents would normally be expected to continue to send their child to school regularly while appealing for an alternative placement; for a child who has an education, health and care plan, it can take many months for the changes to take effect. Weekly welfare calls were made to mother but the school made no attempt to instigate attendance procedures and there is no evidence that the school made contact with father to ascertain his views on Harry's continued non-attendance. Between September 2020 and February 2021, special school 2 did little

to engage with Harry or to provide remote learning opportunities. The school had technical difficulties in setting up remote learning for a number of pupils; they did provide learning packs to some shielding pupils but these were not provided to Harry. No explanation has been provided by the school for this omission.

4.6.14 In November 2020, there was a further national lockdown although schools remained open to vulnerable children; this included guidance on working safely with children like Harry who require aerosol generating procedures (AGP). However, the transport provider's policy was not to transport any pupils who require AGP; mother was advised of this.

4.6.15 In a telephone call with SW2 on 9th February 2021, the deputy head teacher (DHT) asked whether Harry should be attending school. SW2 recorded in the case file that her response was that Harry may be better accessing remote learning due to his clinical needs but advised the DHT to verify this with the school nurse or paediatrician. There is no information in the CSC records to indicate that the DHT provided SW2 with feedback on the school nursing/ paediatrician's view on whether Harry should be attending school. The school file for Harry makes no reference to the telephone conversation with SW2 on 9th February 2021 or any indication that the DHT did contact health professionals for clarification of Harry's status. However, SNSN records show that an email was received from DHT enquiring as to whether Harry had a shielding letter or should be attending school. SNSN confirmed that mother had received a shielding letter although SNSN had not seen this.

4.6.16 In fact, mother had received a letter from BTHT in July 2020 informing her that Harry no longer needed to shield.

4.6.17 Mother informed paediatrician 1 on the 1st December 2020 that Harry was still not attending school. There appears to have been no discussion of the reasons for this or whether it was in his best interests. The paediatrician was aware at this point that there was a named SW but made no attempt to contact them to discuss Harry's needs or any plan in place to reintegrate him at school.

4.6.18 There is no information in LTHT records to indicate whether clinicians were aware that Harry had not attended school since February 2020.

4.6.19 On 22nd February 2021, mother informed SW2 that the orthopaedic consultant in Leeds had advised Harry should not attend school due to the risk of fractures. SW2 advised mother to inform the school. Harry had attended clinic on the 19th February but there is nothing in medical records to corroborate mother's information.

4.6.20 Between February and March 2021, the school continued to make weekly calls to mother who reported that Harry was unwell and in pain, had been hospitalised due to a seizure and, on 9th March 2021, that Harry's wheelchair was unsuitable and she was awaiting a response from wheelchair services. There is no evidence that special school 2 made attempts to contact health services or the social worker to confirm that partner agencies were aware that Harry was in pain although they did contact wheelchair services.

4.6.21 Harry did not attend any school between 5th February 2020 and his admission to hospital on 21st May 2021.

Practice insights:

"He had hives, breathing difficulties, lots of seizures. Sometimes it was deemed that school all day was too much - so that was why he had a medically authorised part time timetable."

"If he had been at school, mum would have had a break."

"We are extremely concerned about provision of equipment; it's a huge challenge - we do our best but things go wrong."

"With no wheelchair for 9 months, he was stuck in the house. Even in that lovely weather."

"Mum gave different people different reasons for him not attending school."

4.7 *Key episode 6 – Harry's weight loss*

4.7.1 As a result of his chromosome 9 abnormality and other health conditions, Harry is very small for his age. He is fed via a gastrostomy (**PEG**), a feeding tube which is inserted through the skin of the abdomen, but he also eats soft foods orally. The sensory experience of eating, tasting and swallowing is important to a child's development but oral food should be in addition to, not a replacement for, tube feeds. His slow growth is recognised; his weight has been carefully monitored for a number of years and the feed prescription is adjusted by a dietician as required. The established system is for the GP to generate each prescription on request from the external medical supplies provider and send a paper copy to the provider for delivery.

4.7.2 Weight measurement was a standard task at his BTHT paediatric appointments. In December 2018, a small drop in weight was noted by paediatrician 1 and the dietician was informed. At hospital appointments in Leeds, his weight was also usually recorded. Family health records indicate that Nutrition & Dietetics sent regular tasks to the GP regarding adjustments to Harry's prescriptions for feed.

4.7.3 All children placed in a special school in Bradford have an initial health assessment arranged by the School Nursing Special Needs team (SNSN). SNSN use the initial health assessment to inform any care plans needed in school and also staff training needs. SNSN liaises closely with other health services involved in a child's life and can undertake routine tasks allocated by other health professionals. SNSN was closely involved

with Harry at special school 1. Routine weight checks were undertaken on request, except during periods when Harry was not attending school, and the recorded weight was uploaded to SystmOne each time. This included weighing Harry four times between January 2018 and November 2019 at the request of the Nutrition and Dietetics service. In January 2018, his weight was recorded as 13kg. Subsequent weights were recorded as 13.2kg (March 2019), 14.6kg (July 2019) and 15kg (November 2019). On one occasion, the SystmOne task from the dietician states that Harry's feed had been increased due to poor weight gain.

4.7.4 SNSN team records rarely included information on Harry's appearance, presentation or communication. On two occasions, his weight was taken by a health care support worker (HCSW) and uploaded to SystmOne. As a delegated task, the expectation would have been that the HCSW discussed the outcome of the task with a school nurse but this did not happen.

4.7.5 Prescriptions for Harry's feed were for a monthly amount. GP records indicate that in the years 2018 to 2020, the prescriptions requested by mother via the medical supplies provider were for the equivalent of 6 months, 9 months and 3 months. In the period from January 2021 to May 2021 and Harry's admission to hospital, only one prescription was requested. The GP in attendance at the learning together event reflected that, while robust systems exist to identify patients over-ordering, a GP practice has no way of monitoring how often prescriptions should be requested or picking up concerns when those medicines do not seem to be being collected. The Designated Nurse later confirmed that interpretation of feed ordering requires specialist knowledge together with close monitoring of the child's weight, taking into account factors such as whether a child is able to supplement enteral tube feeds with oral food and whether this could potentially reduce the volume of feeds ordered. GPs do not have this specialist knowledge and rely on the dietetics service to monitor children and advise on prescription.

4.7.6 The medical supplies provider stated in their report that Harry's feed was not always requested at the point their system indicated that stock at home would be getting low. In this situation, the provider routinely contacts patients to ask whether a delivery is required. From January 2018 to May 2021, the provider made 13 (2018), 22 (2019), 20 (2020) and 8 (Jan 2021 to Harry's admission) attempts to contact the parents. There were frequent difficulties in contacting the parents; of the 63 attempted calls, 29 were not connected, mobile phone numbers were often unavailable or the person answering would end the call. The medical supplies provider introduced a system of automated text reminders in an attempt to address this. The provider called both mother and father's numbers each time; they were successful in speaking to father twice during the period 2018 – May 2021. On one occasion, he stated that he was not directly involved in the care needs of his son and the company should contact mother. On the second occasion, father confirmed that there was still a supply in the house and no delivery was required.

4.7.7 The medical supplies provider has a team of safeguarding nurses but concerns regarding Harry's feed delivery pattern and difficulties in contacting parents were not escalated as a safeguarding concern.

4.7.8 The dietician stated at the learning together event that their service has no way of knowing how many prescriptions for feed are issued by GPs. The medical supplies provider did not contact the dietician at any point to inform them of the difficulties contacting mother and making deliveries.

4.7.9 Mother has told the review that the reason she did not order the amounts expected was that the medical supplies provider frequently delivered double quantities; the provider has been able to check stock systems and states that this is not the case.

4.7.10 When the pandemic began in Spring 2020, all BTHT appointments moved to telephone consultations which meant that Harry was not weighed in clinic after February 2020 when a small weight loss was noted. From this point on, almost all weight information recorded in the BTHT medical records was provided by mother.

4.7.11 During a telephone consultation with the paediatrician in July 2020, mother reported that Harry was tolerating his feeds well and she believed that he had put on weight because she had had to loosen his trousers.

4.7.12 During a telephone appointment with the dietician on the 10th November 2020, it was noted that Harry had lost 1.2kg since May 2020. Mother was advised that she could contact CCNT if she had further concerns re weight loss, otherwise the next weight would be in clinic in January 2021. The dietician subsequently made contact with CCNT to request a home visit to weigh Harry. It is not clear whether the weight loss of 1.2kg was reported by mother or a reflection on the historic weight recordings from before the pandemic. However, the dietician's decision to give mother options including weighing him herself, allowing CCNT to visit the home or wait for the next clinic appointment indicates that there was no significant concern in the dietician's mind.

4.7.13 CCNT responded immediately with an offer to weigh the same day; mother responded that she had transport problems. Subsequent attempts by CCNT to weigh Harry met with difficulties. A home visit was arranged for two days later but this did not take place due to mother stating that she was currently locked in the house. The visit was rearranged for three days later. On the 16th November 2021, CCNT recorded that mother was still having problems with the door and had advised that she would weigh Harry herself and call them with the result. In a further contact the same day, mother stated that she had no batteries in the scales and would go out the following day to purchase new batteries which appeared to be at odds with being locked in. On the 17th November, mother reported Harry's weight to be 14.12kg.

4.7.14 There was no evidence in the case notes that CCNT had explored with mother why she was locked in or whether the family would be able to escape in an emergency. When the Lead Reviewer visited Harry and his family, further information was sought on this incident. Mother stated that, at the time, the front door was stuck and the back garden was very muddy due to work being undertaken; she said that the CCNT had physically visited the home but were not prepared to cross the mud. CCNT later reiterated the information in their records; they did not visit the family home because mother advised that they would not be able to enter the house.

4.7.15 In January 2021, mother informed SW2 that Harry was waking in the night hungry despite his feeding system being on; after eating orally, he would go back to sleep. Mother stated that she had requested a call from paediatrician 1 to discuss this. There is no evidence in the case file that SW2 explored this further with mother or asked how she knew he was hungry. The SW did not contact the paediatrician or dietician to confirm the feeding arrangements in place and whether oral feeding was acceptable.

4.7.16 It was known that Harry could eat some food orally, for example, soft puddings or cereal. Attendees at the learning together event discussed how important it is to some parents of children with complex needs that their child can engage in 'normal' life experiences wherever possible and it was felt that mother may attach this importance to Harry eating orally. Special school 2 observed that his current care plan states how much feed he should have each day "*unless he has eaten orally at lunch time;*" there is no guidance on how much oral food is needed in order not to provide the PEG feed.

4.7.17 Harry was seen in the orthopaedic clinic in Leeds on 20th April where it was noted that he had pressure sores. Mother indicated that she was awaiting a prescription for dressings which implied that these had been assessed by a medical professional and the appropriate treatment prescribed. LTHT clinicians provided mother with appropriate dressings as an interim measure. Harry was described by clinicians as 'emaciated' although he was not weighed as there were no suitable horizontal scales immediately available in the clinic area. An offer was made to admit Harry as an in-patient which mother declined; it was agreed with mother that LTHT would refer Harry back to community services in Bradford which happened the following day.

4.7.18 Harry was seen by the BDCFT paediatric dental service on 26/04/21 and 05/05/21 as reported to the social worker by mother. The paediatric dental service records indicate no safeguarding concerns at those two appointments although there is no information recorded regarding his presentation. The dentist confirms that their observations and records relate primarily to a child's teeth. The dental service uses a RAG rating to categorise potential for safeguarding concerns and Harry was considered to be 'low risk'.

4.7.19 In a telephone call on the 19th May 2021, mother told SW2 that she had made an appointment with paediatrician 1 for the following week due to Harry seemingly not gaining weight despite having oral food and all his tube feeds.

4.7.20 On admission on the 21st May 2021, Harry's weight had fallen by more than a third since his last measurement by a professional in November 2019.

4.7.21 Once he had been admitted to hospital and was receiving the prescribed feed regime, Harry gained weight rapidly.

4.7.22 At the learning together event, it was discussed that during the period from March 2020 to May 2021, some professionals, such as the SW and paediatrician, regularly saw Harry on screen and were reassured by this even though he was often covered by bedding. In addition, staff

at special school 2 saw Harry remotely but did not know him so would not have been in a position to identify that he had lost a significant amount of weight in a relatively short period of time. Others expressed regret that the continuation of telephone appointments due to Covid had prevented them from identifying Harry's weight loss. They also acknowledged that even if they had had sight of him on screen, it is unlikely that they would have been able to identify weight loss or pressure sores.

Practice insights:

"It would be useful to have a pro-forma from dietetics and expectations for primary care – there are lots of systems to stop over ordering but not under ordering"

"We could have a system of automated delivery every month but that could lead to stockpiling. Receiving the feed wouldn't necessarily have meant it was used."

"The feed has a limited shelf life; it would end up in the bin."

"A child may not grow if they only have 6 months' feed over 12 months."

"Mum was plausible, and we have trusted - doubtful - the feed he was on. His weight is always low - it was accepted."

"We relied on what mum said he weighed on the scales at home, which indicated gain. It possibly led us done the wrong path."

4.8 *Key episode 7 – the impact of Covid-19*

4.8.1 When the pandemic emerged in March 2020, national guidance in was that people should stay at home if at all possible, should maintain social distancing and should not enter other people's homes; this would be particularly pertinent to a child with complex medical needs and his family. All agencies had to find new ways of working. Government guidance and legislation was evolving rapidly and there was confusion regarding the 'stay at home' edict.

4.8.2 Bradford Child Development Centre (paediatrics) cancelled or rearranged all non-urgent appointments; all other appointments were via telephone.

4.8.3 Despite moving more than half of their appointments to virtual or telephone consultations, LTHT recognised Harry's needs and demonstrated good practice in continuing to offer him face to face appointments throughout the pandemic.

4.8.4 CSC moved rapidly to introduce remote multi-agency meetings. SW2 noted in Harry's case file on 30th March 2020 that a remote CiN meeting was to be arranged and partner agencies would be invited to attend virtually or to submit a report instead. The CSC reviewer notes that this was incorrect; only as a last resort would a report suffice.

4.8.5 In theory, schools closed in March 2020 as a result of the first national lockdown. However, Government guidance was quickly issued, making clear that schools should provide care for the children of critical workers and vulnerable children; this included children who have a social worker. At this point, the school was not aware that Harry had a social worker. The multi-academy trust issued an emergency safeguarding response procedure to all its academies in March 2020, setting out a tiered structure for identifying risk and need and the expected levels of contact schools should make with children. The MAT tier 1/ priority 2 group included all children with a special educational need or disability.

4.8.6 As a priority 2 group child, staff at special school 1 maintained weekly contacts with mother, including telephone calls and home visits to deliver milk and food vouchers. On two occasions in Spring 2020, school staff spoke to mother or a male adult in the garden but Harry was not seen. Covid guidance at the time was not to enter other people's homes. In the early stages, there was also daily contact with mother via DoJo, a digital communication system, although mother became less responsive over time. During one telephone call, mother told the school that she had not yet been able to use the food vouchers provided. This was a missed opportunity; the school was aware that Harry did not have a wheelchair but showed no curiosity about whether mother was able to leave the house to buy food and other essentials and what support network the family might have in place.

4.8.7 SNSN instigated a monthly welfare call system for children not attending school; mother was contacted in April and June 2020. In May 2020, mother contacted the team because the suction machine was not working; she reported that a new one should already have been provided but she hadn't heard anything. Mother was advised to contact community nursing or the physiotherapist.

4.8.8 School records indicate that in May 2020, the school safeguarding team concluded that Harry was safe; "*Mum always asks for support and help and think she would continue to do this at this time*." It appears that the school came to this view on the basis of their previous interactions with mother, despite not seeing Harry directly and with no contextual information regarding his status as a child in need. In June and July 2020, staff from special school 1 made home visits for Harry's birthday and to deliver his graduation box. Harry was seen on both occasions.

4.8.9 Special school 2 would normally have transition visits for pupils joining the school – due to the pandemic, this was not possible in the year that Harry was due to join them. The SNSN team did have a transition meeting with special school 2 where it was stated that Harry may not join in September as mother was appealing for a different placement.

4.8.10 Special school 2 did not implement the direct weekly contact with Harry expected by the MAT. At the learning together event, the DSL reflected that they were not aware of his status as a child in need and that, due to their Covid risk assessment, they did not carry out home visits for pupils unless they had concerns for that child's welfare. There is no satisfactory explanation for the discrepancy between the MAT safeguarding response procedure and the school's risk assessment.

4.8.11 The annual review of Harry's EHCP was undertaken by telephone call with the mother on 12th January 2021. Harry was not seen and there was a missed opportunity to confirm which services and professionals were involved in his life; as a result, no other agencies were invited to the review meeting. The school states that this was because the information had not been shared with them; as good practice, the school should have asked the parents as part of the preparation for the annual review meeting. The SNSN team, who had been involved in writing the health section of the plan in previous years, was not asked to contribute.

4.8.12 In March 2021, mother made references to the long wait for a suitable wheelchair in two phone conversations with special school 2. The school contacted wheelchair services who reported that they could only provide a minimal service due to the pandemic. There is normally a wheelchair clinic operating in school although Harry could not access this as he was not attending

4.8.13 Special school 2 experienced technical difficulties in setting up remote learning for pupils not attending school; in the event, this was not resolved until Spring 2021. This meant that school staff had no sight of Harry from September 2020 to April 2021.

4.8.14 Special school 2 stated in their report for the CiN review meeting in April 2021 that they had not yet met Harry due to Covid. The pandemic may have had some impact on Harry's attendance but was not the main cause; the mother's given reasons for non-attendance over that seven-month period included the intention to appeal for a different school, Harry's ill health, and the lack of a suitable wheelchair. Although Covid may have delayed the necessary wheelchair assessment, this was only relevant from February 2021 onwards.

4.8.15 At the learning together event, some practitioners expressed feelings of regret and guilt that they had not seen Harry during the pandemic even though this had mostly been out of their control. It was acknowledged that all agencies and individuals had to establish new ways of working very quickly in a previously unknown situation.

4.8.16 It was also acknowledged that many of the contributory factors were in place before the pandemic; for example, the failure of the SW to engage partner agencies in the single assessment or subsequent review meetings, Harry's extended periods of non-attendance at school and

the repeated failure to secure respite services despite mother's requests from 2018 onwards. The historical concerns regarding Harry's anti-epileptic medication and possible parental neglect in 2015 were also considered significant.

4.8.17 Practitioners wondered whether mother's failure to engage with services and apparent attempts to prevent professionals from seeing Harry might be related to fear of him being exposed to Covid. However, it was not possible to explore this further with mother as part of this review.

Practice insights:

"It was hard to contact parents of children with complex needs on the phone; they were busy looking after their children's cares."

"We thought he was being seen but that was also virtual."

"Although we were seeing him [on a screen] we always saw him with a blanket, and we didn't recognise the weight loss."

5. Research and Learning from Previous Case Reviews

5.1 Little was written about the abuse of disabled children before the mid-1990s when the introduction of the Disability Discrimination Act 1996 and research published by academics[1] led to a national conference[2] and the creation of the National Working Group on Child Protection and Disability.

5.2 American research in 2000[3] estimated that disabled children are 3.4 times more likely to experience abuse or neglect, and ten times less likely to be referred to statutory agencies.

5.3 In January 2003, the NSPCC published 'It doesn't happen to disabled children' which identified a number of factors that may increase the risk to this group of children, including: -

- Diagnostic overlay – indicators of abuse are assumed to be as a result of the disability.

[1] Westcott, H 1993; Morris, J 1995; Westcott, H & Cross, M 1996
[2] Kennedy, M / Triangle: Violence against disabled children and adults, Oct 1999
[3] Sullivan and Knutson, 2000

- Rule of optimism – professionals delay intervention in the hope that the child's situation will improve on its own.
- Reluctance to challenge – also referred to as the 'halo' effect, professionals feel compassion for the parent(s) and tolerate inadequate/ poor parenting that would not be accepted from the parent(s) of a non-disabled child.
- Barriers to communication, including professionals feeling ill-equipped to talk to children using augmentative and alternative communication.

5.4 The Department for Children, Schools and Families issued non-statutory multi-agency advice, Safeguarding Disabled Children[4], in 2009. This identified that disabled children are more vulnerable to abuse as a result of social attitudes and assumptions about disability, learned compliance, a reluctance to challenge carers, barriers to communication and the skills gap in Children's Social Services. The guidance made a number of recommendations to local safeguarding children boards (LSCBs). The document remains live on the DfE website.

5.5 In 2012, Ofsted published a thematic inspection report[5] 'Protecting disabled children'. They found that disabled children account for 14% of all children in need but only 3.8% of children on a child protection plan and observed that "*In many of the child protection cases examined by inspectors, where neglect was the key risk, children had previously received support as children in need for a long time. Despite the lack of improvement for the child there were delays in recognising that the levels of neglect had met the threshold for child protection*." The same year, a DfE analysis of serious case reviews between 2009-2011 identified that 12% of reviews related to a disabled child[6].

5.6 NSPCC revisited their 2003 research ten years later[7] and concluded that insufficient progress had been made in relation to some of the factors that increase vulnerability; there was evidence that diagnostic overlay, reluctance to challenge poor parenting, lack of child-focused assessment and a skills gap between professionals who work predominantly with disabled children and those who work in child protection were still prevalent.

5.7 Serious case reviews and child safeguarding practice reviews published are now held on a national repository managed by the NSPCC; thematic analysis of these reports is produced periodically. In 2016, the NSPCC[8] published a briefing on cases since 2010 relating to deaf and disabled children which identified key issues which can impair professionals' ability to recognise abuse in this group:

- Parents can feel overwhelmed by the number of professionals working with them.

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[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf
[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419062/Protecting_disabled_children.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf

[7] https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/2014WeHaveTheRightToBeSafe.pdf
[8] https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/deaf-disabled-children

- Health professionals often had the best knowledge of a family's situation but saw child protection issues as outside their remit.
- Different information was shared with different professionals, resulting in no one agency having a complete picture.
- Barriers to communication, including reliance on parents to interpret what their children were saying.
- Signs and indicators of abuse and neglect were assumed to be related to the disability.
- Lower standards of care expected of parents and a reluctance to challenge.
- Focus on health needs to the exclusion of wider issues including safeguarding.
- The impact of high levels of dependency on parents.

5.8 Most of the themes identified in the above guidance documents and research findings are evidenced in this review. As described elsewhere in this report, Harry's poor weight gain and, at times, weight loss were attributed to his medical condition rather than a consideration of potential neglect. The positive impression of mother as a capable and attentive 'expert' carer led to an over-reliance on her assessments of Harry's needs and impeded professionals from applying critical thinking; for example, when two health services closed referrals within the same month due to mother's non-engagement, SW2 did not challenge this. Professionals received conflicting information about Harry's circumstances or needs but opportunities to verify the information were missed; for example, mother gave special school 2 a series of different explanations for Harry's non-attendance between September 2020 and May 2021 but the school made no attempt to contact health professionals or the social worker for confirmation. Some professionals were led to believe that others were having direct contact with Harry when this was not the case and the social worker's failure to invite health services to the CiN meetings resulted in no agency having a full understanding of Harry's life.

5.9 Of the 265 case reviews published nationally since 2019, 11 relate to a child with a disability (4%) although it should be recognised that the actual number of cases may be higher; the key word search relies on the child's disability being referenced in the report and, as noted by the DfE in 2012, this does not always happen.

5.10 "*Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement*" (Reder et al, 1993) and is identified as a contributing factor in 206 of the 1694 case reviews available on the NSPCC repository. In an NSPCC briefing paper[9] published in 2019 which analysed cases from 2014 onwards, typical behaviours included:

- Parents and carers can develop good relationships with some professionals whilst criticising or ignoring others. This can divert attention away from parents' own behaviour.

[9] https://learning.nspcc.org.uk/media/1334/learning-from-case-reviews_disguised-compliance.pdf

- Parents and carers may manipulate professionals and situations to avoid engagement or intervention.
- Sometimes practitioners are over optimistic about parents' and carers' progress and ability to care for the child or their promises to engage with services.
- Practitioners tended to accept information from parents and carers as fact without displaying appropriate professional curiosity and investigating further.
- In some cases, disguised compliance was suspected or discussed but no actions were put in place to tackle this.

5.11 Harry's mother demonstrated behaviours typical of disguised compliance; for example, she told the paediatrician that the school would not permit Harry to attend whilst informing the school that the orthopaedic advice had been that Harry should not attend, and told the social worker that she felt the paediatrician was not taking her concerns regarding Harry's weight seriously. There is also a significant pattern of requesting services and then not engaging, as with the sleep clinic and when the community team offered a home visit. The NSPCC analysis identifies that disguised compliance is sometimes suspected by agencies; however, professionals involved with Harry held mother in high regard and there is nothing to suggest that disguised compliance was ever considered.

6 Analysis

6.1 Inter-agency working and information sharing

6.1.1 We identified many examples of robust intra- and multi-agency information sharing during this review, particularly in relation to health partners. This was facilitated in some cases by shared digital systems. A shared digital system is not always a guarantee of effective communication but some professionals applied a robust approach to reading files and cross-checking the information they received; for example, GP8 who noted the historic information in the journal and safeguarding nodes of SystmOne during an appointment with Harry and his sibling.

6.1.2 The Bradford School Nursing Special Needs (SNSN) team is well placed to facilitate communication between school, home and partner health agencies, often being the most effective route for rapid information exchange; this is particularly the case with other health services using the same digital record, SystmOne. SNSN team members could and did clarify information with the GP, Nutrition and Dietetics Team, occupational therapy and others when needed. One example of this was in September 2018 when SNSN contacted GP for confirmation that Harry no longer had food allergies rather than rely on information from the mother. They then followed this up during a face to face contact with mother.

6.1.3 SNSN records indicate regular liaison with school staff at special school 1 and team members were proactively involved in writing the health aspect of Harry's education, health & care plan (EHCP) in 2018 and 2019. The team regularly updated the health care plan with new information from other health services and were responsible for updating the epilepsy care plan and asthma plan on an annual basis.

6.1.4 It appears that SNSN team had a very different relationship with special school 2. They were not asked to contribute to the EHCP review in January 2021. It is not clear where the school sourced the information to populate the health section of the EHCP; some of the information may have been provided by mother or from previous EHCPs. It may be that this different interface affects all children with health needs at special school 2 or it is possible that the issue was specific to Harry's extended period of non-attendance and the knowledge that mother was appealing for a different school. The school nurse did contact their equivalent in the preferred school to check whether they had any additional information.

6.1.5 BTHT records indicate that the physiotherapist was proactive in communicating with other health services, particularly paediatrician 1 and the sleep system company. They also made regular contact with mother.

6.1.6 On 21st April 2021 LTHT physiotherapist demonstrated good practice by contacting the BTHT physiotherapist to share observations of Harry during a clinic the previous day. It had been observed that Harry had pressure sores, an increase in seizures, he was in significant pain and there were concerns regarding his stature. The LTHT physiotherapist confirmed that this would be put in writing by the LTHT orthopaedic paeditatrician topaediatrician 1.. However, there was a significant delay in generating the clinical letter, which although was dictated on the day of the clinic appointment, was not sent out until 8th June 2021 due to significant challenges in administrative support at the time. The LTHT physiotherapist recorded that the outcome of the telephone call was that BTHT physiotherapist would follow up with the family and initiate support with their local team. The LTHT physiotherapist reflected later to have felt reassured that this would initiate increased support for Harry.

6.1.7 The BTHT physiotherapist did not communicate the information with any other health professionals at BTHT. The BTHT physiotherapy service holds paper records so the information was not available to heath colleagues via SystmOne.

6.1.8 The two special schools did not always communicate effectively with each other or with partner agencies, particularly where information was provided by mother. During the transition phase, special school 1 failed to inform special school 2 of Harry's status as a child in need, despite the schools having a shared digital recording system. Special school 1's explanation for this is that the Head teacher/ DSL was on long term absence and then left although the information from the local authority and contact from the SW had been received prior to this and could have been recorded and passed to the new school by any of the deputy designated staff.

6.1.9 Opportunities to verify mother's explanations for Harry's absences from school were missed; for example, when mother informed special school 2 that the orthopaedic consultant had advised that Harry could not attend school due to the fragility of his bones, the school did not contact LTHT to confirm this. This is likely to have been due in some part to the interface between special school 2 and SNSN.

6.1.10 West Yorkshire Police shared information appropriately with CSC following each domestic abuse incident they were called to. They also followed this up with requests for service when they identified concerns around cannabis use in the house and the impact this might have on Harry, the house being 'extremely untidy' and, on one occasion, recognition that mother was struggling and might benefit from respite or support.

6.1.11 It should be acknowledged that the last recorded incident of domestic abuse predates the introduction of Operation Encompass (OE) in the Bradford district. Current practice would be that each incident is notified to OE who then inform the school.

6.1.12 The medical supplies provider endeavoured to maintain robust communication with parents. However, given the level of concern they clearly had, it would have been good practice to escalate the situation to their own safeguarding team and/ or to inform the dietetics and nutrition service.

6.1.13 Too often, mother controlled the communication flow and was able to provide different information to different professionals without challenge. Once SW2 became involved in November 2019, she inadvertently facilitated this.

6.1.14 CSC did not demonstrate effective communication with partner agencies, either historically or during the period of this review. CSC received 15 notifications of domestic abuse, substance use and family support needs from the police over a ten-year period but there is little evidence that this information was triangulated or shared with professionals working directly with the family or that duty social workers sought contextual information from health professionals on any additional risk or impact the home circumstances might have on a child with complex needs. Similarly, CSC did not share information with partner agencies before closing the referral in 2015.

6.1.15 SW2's failure to engage partners in the single assessment or subsequent CiN meetings is inexplicable. As a social worker in a team working with children with complex health needs, she should have been well aware of the critical importance of a holistic assessment. Unfortunately, SW2 was not available for the learning together event so the opportunity to explore this further was not presented. Similarly, the CCHDT team manager should have sufficient experience to recognise the importance of inter-agency communication, particularly in cases of complex

need, but supervision records indicate that SW2 was never challenged on the failure to involve professionals involved with Harry and his family.

6.1.16 It seems reasonable to conclude that, although there were other contributory factors, failures in inter-agency communication hinged on the fact that professionals involved with Harry were unaware of his status as a child in need. SW2 did make contact with individuals in order to pursue specific tasks but did not make clear the nature of her involvement; it is also noted that professionals did not ask for this information. If professionals had been involved in the CiN meetings, they would have been able to contribute to a holistic assessment, provide clarity regarding some of the information provided by mother and ensure the subsequent plan was robust.

6.2 ***How professionals understood and responded to the wider concerns of domestic abuse and drug usage within the relationship and the impact of this on the children.***

6.2.1 It is clear that, with the exception of CSC and one GP, professionals were unaware of the history of domestic abuse within the family. Mother's experiences of verbal and physical abuse perpetrated by father and other members of her family, including during both pregnancies, had the potential to disrupt her attachments with her children and to impede her coping strategies and support network but this was never addressed in assessments.

6.2.2 It is known that Harry and his sibling were present during some of these incidents but there appears to have been no assessment of the impact this might have had on the children. Harry's profound learning disabilities make it impossible to seek his views on those incidents although he would have been aware of and reactive to negative stimulus. Although his sibling shows none of the indicators often associated with children living with domestic abuse and appears to have a strong bond with both parents, there has been no opportunity for professionals to explore this with her; for example, through the safeguarding curriculum at school.

6.2.3 Mother states that Harry and his sibling have no relationship with their maternal grandmother due to the violence and aggression perpetrated towards mother in the past.

6.2.4 The CSC case records include nine notifications of domestic abuse from WYP, members of the extended family and, in one case, a member of the public. It is expected that SW2 had access to this contextual information yet there is no evidence that it was taken into account during the single assessment or discussed with the CSC manager in supervision.

6.2.5 Professionals working with the family during the period covered by this review had no knowledge of the concerns around cannabis production and use in the family home and at father's address. There is no evidence in police records or CSC case files that WYP informed CSC of the incidents.

6.2.6 In the CSC case file, there is one contact in August 2014 from maternal grandmother who alleged that father was growing cannabis and taking drugs in the family home. The outcome was recorded as no further action. On the same date, Family Health services noted in the sibling's health record that there had been a discussion with a social worker during which reference was made to mother's partner allegedly growing cannabis.

6.2.7 School staff at the learning together event commented that they had never smelt cannabis on Harry.

6.3 ***Application of the "think family" concept***

6.3.1 Working together to safeguard children (DfE 2018) says: "*Research has shown that taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment … (including) the capacity of parents or carers (resident and non-resident) and … the impact and influence of wider family and any other adults living in the household*." The Social Care Institute of Excellence (SCIE) presents 'think family' as an opportunity to take a holistic view of the strengths and needs of all family members and how these inter-relate; for example, parental mental health and a child with disabilities or health conditions.

6.3.2 'Think family' was not evident in Harry's case. Professionals' focus was on mother's needs and/ or the needs that she described on Harry's behalf. Professionals rarely interacted with Harry's father and there is very little information relating to his sibling in case files or records. Mother was the recorded main contact, attended appointments and contacted agencies when Harry was ill or needed services.

6.3.3 Most professionals understood mother to be a single parent and lone carer, including those who had regular contact with father; this is how she described herself. It appears that professionals, for example at special school 1, formed a view of the family structure based on what they were told rather than what they were seeing. The exception was sibling's primary school who had regular contact with both parents and understood them to be in a relationship.

6.3.4 Research has existed for many years around the barriers that inhibit professionals from engaging with fathers as carers and, specifically, the role of fathers in family assessments. Properly embedded, the 'think family' approach should resolve some of these barriers but SW2 made

only two attempts to contact father between November 2019 and May 2021, both of which were unsuccessful. Parents cannot be required to engage with a single child and family assessment under s17 of the Children Act 1989; however, SW2 recorded in the case file in January 2020 that father was "very much involved" and should have made robust attempts to engage him.

6.3.5 Paternal grandmother has a significant supporting role to mother and the children; this was noted by SW2 although she did not go on to involve grandmother in the single assessment.

6.3.6 In 2018, a SW contacted the sibling's school to make enquiries as a result of the referral from the occupational therapist. The school has never had contact from SW2. There is no evidence of the single assessment addressing how Harry's sibling may be impacted practically or emotionally by growing up with a brother with such profound needs. The primary school DSL states that this has been a common theme since May 2021 and that multi-agency conferences and review meetings have barely touched on any needs the sibling might have. It is significant that the primary school was not included in the original scope for this review and therefore did not have the opportunity to contribute to the learning together event.

6.3.7 Hospital staff demonstrated good practice in collecting the details of all family members on two occasions when Harry was admitted. The GP practice had recorded father's details although he was registered with another practice.

6.3.8 Professionals at the learning together event were not confident about the 'think family' approach and few had received training on this, designated health professionals for safeguarding and LTHT attendees being the exception. The education safeguarding team states that 'think family' is not covered in the two-day DSL training in Bradford.

6.3.9 It was noted that Bradford has, for the last four years, bought into the 'signs of safety' approach and that this may have drawn professional practice away from 'think family'; however, there is no evidence that SW2 was applying signs of safety principles to Harry's assessment.

6.4 ***Single and multi-agency training on safeguarding children with disabilities***

6.4.1 All LTHT professionals are provided with specific training on safeguarding children with autism and learning disabilities, which includes information regarding the specific risks faced by children who are non-verbal.

6.4.2 The Bradford Partnership has, until 2020, offered two levels of face to face multi-agency training relating to disabled children – a general awareness course and 'safeguarding disabled children – working in the margins', a more in-depth content for professionals who work specifically with children with disabilities. The higher level training addressed learning from serious case reviews and research. It is not clear whether those training courses are available post-Covid.

6.4.3 The education safeguarding team does not offer specific training, either to staff in mainstream settings, special schools or to DSLs. Neither special school 1 or 2 provide staff training on the specific risks faced by children with disabilities and complex needs.

6.4.4 Social workers in Bradford access regular staff training. However, the CCHDT manager states that training on the specific risks faced by children with disabilities and the challenges of supporting these children is not currently available to social workers in that team.

6.4.5 Most, if not all, practitioners at the learning together event were aware of the risks associated with disguised compliance. However, responses to the presentation indicated that many were not aware of the research relating to disabled children and increased vulnerability, or the themes of diagnostic overlay, the expert parent and the 'rule of optimism'.

6.4.6 If training has been available, the evidence of this case is that learning from research and previous case reviews has not been embedded in practice.

6.5 ***The lived experience of Harry, including observations of the parents' interaction with Harry and whether there was an over reliance on the self-reporting or so called "expertise" of the parent(s)***

6.5.1 Professionals had high regard for mother's ability to meet Harry's needs; she was seen as a proactive advocate who sought help and advice when needed. Mother was directly observed, by the physiotherapist and school staff, to be proficient in managing Harry's medical and care needs such as lifting and turning and, during the pandemic, her judgment that Harry might have an infection or be in pain was at times considered sufficiently reliable for doctors to raise a prescription including, in February 2021, for Oramorph.

6.5.2 Professionals continued to hold this positive view even when faced with evidence to the contrary; for example, SW2 recorded that mother "is a proactive mother and engages well with professionals to advocate Harry's needs," in the same month that two services informed her that they were closing their case due to mother's lack of engagement. The SW became focused on finding solutions for the challenges that mother was describing rather than on what life is like for Harry.

6.5.3 There was an over-confidence in mother's ability to coordinate services and equipment; it was recognised that Harry had unmet needs over a sustained period of time but professionals accepted mother's narrative that another agency was following this up or that delays were unavoidable.

6.5.4 As a direct result, Harry became invisible to services, particularly during the pandemic although there was some evidence of this pattern of behaviour prior to March 2020. Mother requested services or support but declined home visits or assessments, for example, for support from the sleep clinic or when the CCNT offered to visit the home to weigh Harry. He was removed from the orthotics service caseload twice due to not being brought to appointments, first in August 2018 and again in March 2020. There was no evidence in case files that the orthotics service tried to contact mother to clarify the reason for non-attendance or considered what impact the failure to provide orthotic support might have on the child.

6.5.5 Harry's non-attendance at school due to the lack of a suitable wheelchair was a recurring theme during the period of this review. In March 2022, the Ofsted/ CQC joint area review of SEND provision in Bradford identified provision of equipment as an area of development; "*The coordination and oversight of access to specialist children's equipment, such as wheelchairs, is poor. Parents and carers often have to chase services to make sure that children and young people with SEND receive much needed equipment in a timely manner.*"

6.5.6 Paediatrician 1 made an initial referral for a wheelchair assessment in November 2019 and then repeated efforts to chase this up; the chair was received in August 2020. Other professionals, including special school 1 and SW2, were aware of the lack of wheelchair but there is no evidence that the practical implications of this for Harry were considered – he spent most of those nine months in the house – or the increased pressure this was placing on a parent who had already been asking for respite for over a year. Following a period of non-school attendance due to mother indicating that she would appeal the placement, she informed SW2 and special school 2 in February 2021 that Harry could not attend due to the fragility of his bones and the unsuitability of his new wheelchair. Neither the SW nor school contacted the orthopaedic consultant to confirm this.

6.5.7 Harry was known to be susceptible to pressure sores. Health professionals believed that mother was adept at recognising and treating these; when she rang the community nursing team for advice, they offered a home visit but she declined this, assuring them that Harry was fine. Over a period of months, she told professionals that an air mattress was being ordered or was arriving imminently; it was hoped that this would reduce Harry's frequent pressure sores and make him more comfortable. Professionals accepted this information at face value and did not follow it up.

6.5.7 Harry is very small for his age and his medical diagnosis causes poor weight gain although he should not lose weight if feeding well. Prior to the pandemic, his weight was carefully monitored by a range of services including the SNSN team and at hospital clinics. When weight loss was identified, professionals accepted without challenge mother's assurances that he was feeding well orally in addition to the feeds. From March 2020, remote appointments meant that the paediatrician and others had to rely on mother's verbal reports of Harry's visual appearance; for example, in July 2020 when mother reported that she believed he had put on weight because she had to loosen the waist on his trousers. In November 2020, when mother advised the CCNT that they would not be able to enter the house to weigh Harry due to a problem with the door, it was agreed that mother would weigh him herself and her report of his weight at 14kg was accepted as reliable.

6.6 ***Diagnostic overlay***

6.6.1 When CSC accepted the referral from paediatrician 1 in November 2019, SW1 expressed a view to the special needs school nursing team that Harry's needs were medical rather than social. This view persisted throughout the period under review.

6.6.2 Mother informed SW2 when Harry had pressure sores, that he was waking up hungry during the night, that she believed he may have lost weight. SW2 does not appear to have challenged mother or sought confirmation that she was seeking appropriate medical attention at these times. It seems likely that SW2 felt she had less expertise than mother and that the symptoms and indicators were unavoidable effects of his disabilities.

6.6.3 Health practitioners also accepted the potential indicators of neglect as symptoms of Harry's complex diagnoses. The BTHT case files indicate that an increase in seizures led to a change in his anti-epileptic prescription; there appears to have been no consideration of the referral made by paediatrician 1 in 2015 when it was realised that mother had not been administering Harry's anti-epileptic. Similarly, the paediatrician and dietician were both aware of his lack of weight gain and sometimes weight loss but were reassured by mother's reports that he was feeding well.

6.6.4 A number of professionals, including the social worker, paediatrician and dietician, only had remote visual contact with Harry or telephone contact with mother. If they felt any disquiet regarding the information that mother shared regarding Harry's deteriorating health, they were under the impression from mother that other professionals were having direct contact and would be able to complete physical checks.

6.6.5 When Harry was seen in person at Leeds on 20th April 2021 he was described as 'emaciated' and 'in obvious discomfort'. The practitioner recalled later that mother 'looked like she had given up' although this was not recorded at the time; an offer was made to admit Harry as an

in-patient but mother declined this. It was agreed that Harry would be referred back to community services and that LTHT would make contact with Bradford colleagues the following day. The Leeds physiotherapist made contact with her Bradford colleague on 21st April 2021 as agreed with mother. The LTHT orthopaedic consultant wrote to the GP and paediatrician 1 flagging Harry as a possible 'child in need' but no safeguarding concerns were identified. At this point LTHT were unaware that Harry was already identified as a 'Child in Need' by social care due to other reasons. The letter was received at the GP practice on 11/06/21.

6.7 ***The voice of the child***

6.7.1 Based on agency records shared during this review, it is clear that Harry had no voice despite coming into contact with a range of professionals experienced in working and communicating with disabled children. Although he is non-verbal, Harry can communicate pleasure or pain and is able to recognise known carers but his mood is rarely recorded in his case files following health appointments, social work visits, etc.

6.7.2 Some professionals did not routinely record Harry's physical presentation – his clothing, hygiene, alertness, whether he looked comfortable, felt warm or cool - unless there were concerns; when pressure sores were being assessed, for example. One notable exception was the SNSN team, but they were unable to make any direct observations once he stopped attending school in February 2020. Remote appointments as a result of the pandemic also impeded professionals' opportunities to observe Harry directly; as noted by a practitioner at the learning together event, he was often covered by a blanket and mother's reports of him being well were accepted rather than asking for the screen to be brought close to him.

6.7.3 Harry does not have the cognitive ability to make choices or express his wishes; professionals should therefore have demonstrated in their records how they determined his best interests. This rarely happened during the period of the review, partly due to the lack of face to face interactions and an increasing reliance on mother's assessment of Harry's needs. This is particularly relevant to SW2 as there is no evidence in the CSC records of the voices of Harry or his sibling being taken into account during the single assessment.

6.7.4 The paediatric dentist was the last professional to physically see Harry prior to his admission to hospital on 21st May 2021. There is no record of Harry's physical presentation at that appointment; if he was in discomfort as he had been days earlier at the orthopaedic clinic, this was not recorded.

7. Recommendations

In addition to the recommendations made and actions taken by individual agencies as set out in section 8 below, this report makes six further recommendations.

During the writing of this report, NICE has published new guideline NG213[10] on working with disabled children and young people with complex health needs. The guideline includes 18 recommendations and a baseline self-assessment tool.

Recommendation 1 – Heads of service/ senior managers of education, health and care services working with disabled children with complex needs should ensure that the recommendations in NICE NG213 relevant to their service are implemented, specifically recommendation 1.1.

Recommendation 2 – Safeguarding training for all professionals who work directly with children with disabilities and complex needs takes into account the research and learning from safeguarding reviews on how and why disabled children are more vulnerable to abuse.

Recommendation 3 – The Bradford Partnership should promote the importance of 'thinking family' via a campaign aimed at all professionals in Bradford involved in assessments and/ or with designated safeguarding responsibilities in their setting.

Recommendation 4 – All agencies should review their existing training programmes to ensure that it is clear to practitioners that all children should have a voice, including those who are pre- or non-verbal.

Recommendation 5 - The Bradford Partnership should review the CSPR arrangements to ensure all relevant services are included in scope even if they were not initially involved in the rapid review.

Recommendation 6 – The Bradford Partnership should undertake a systems review to ensure a robust approach to Child in Need arrangements.

Appendix 1 – Glossary

Acronym / term	
CCHDT	Children's Complex Health & Disabilities team
CCNT	Children's Community Nursing team
CCST	Children's Community Support Team
CCT	Continuing Care Team
CIN	Child in Need/ s17 of the Children Act 1989
CNS	Clinical Nurse Specialist
CPOMS	Child Protection Online Management System
CSC	Children's Social Care
DASH	Domestic abuse, stalking and harassment risk assessment
DSL	Designated Safeguarding Lead
EHCP	Education, Health & Care Plan
SNSN	School Nursing Special Needs Team
WYP	West Yorkshire Police