



# Practice review report: Child DS

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularly around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

## Context and background of review

The concise child practice review published by Pembrokeshire County Council in July 2016 concerns a young child who tragically died, aged eight years old, in December 2011, and was educated at home by his parents. The child lived with his mother, his father and an older sibling.

The post-mortem examination found that the child appeared to have been suffering from gross anaemia, dental abnormalities and soft tissue haemorrhage in the lower legs. There was no evidence of any medical input regarding the deterioration of the child's health.

The child was educated at home and had no direct contact with any agency from the age of 13 months. The child was not initially registered with the local authority as an electively home educated child, where the family resided.

A formal practice review was not held until the outcome of a criminal justice investigation and the coroner's report had been concluded.

In November 2014, following a detailed review of the case, the Crown Prosecution Service decided not to proceed with the case as it was felt that it was not in the public interest to pursue a prosecution.

The inquest into this matter reached a verdict of open conclusion on 29 January 2015.

## Circumstances of, and challenges faced by, the individual

The family lived in a remote rural area and actively avoided contact with authorities, both parents had reluctant involvement with local health services. Although services were involved with the parents, the children had not had formal contact with outside agencies and no opportunity to be heard. Even when formal contact was made in relation to their education, without parental consent and in the absence of any allegations, authorities had no legal right to insist on seeing the children.

## What happened?

Between July 2003 and July 2004, all appropriate immunisations, including MMR, health checks and visits were satisfactorily carried out. The three-year developmental check was declined by the parents in 2006 and, despite re-offering the appointment; the parents did not want any further contact.

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The local authority education directorate were first made aware of the family in June 2010, after a headteacher at a school in a second local authority contacted the education directorate, with a notification of a family with two children being educated at home.



Due to the children not being on the elective home education database, the manager of the pupil support service assigned two pupil support officers to undertake a home visit to the family to clarify the context of the education provision. This is routine practice and relates to the local authority elective home education process. The home visit was undertaken in early July 2010, but entry to the household was denied with the father stating that the family did not wish to engage with the local authority in any capacity.

Between August 2010 and October 2011, further attempts were continued by the education directorate to establish meaningful contact with the family. However, all communications with the family remained unsuccessful.

In December 2011, following an ambulance request to the family home the child was found unconscious and subsequently died in hospital.

The post-mortem examination found that the child appeared to have been suffering from gross anaemia, dental abnormalities and soft tissue haemorrhage in the lower legs. There was no evidence of any medical input regarding the deterioration of the child's health.

## Why it happened?

Parents have a right to educate their child at home provided that they fulfil the requirements under Section 7 of the Education Act 1996. This places a duty on the parent to ensure that his/her child receives an efficient full-time education suitable to his/her age ability and aptitude either by regular attendance at school or otherwise.

Under Section 437 of the Education Act 1996, the local authority has a legal duty to intervene if they have concerns, from whatever sources, about any aspect of home based provision. The authority does not, however, have the right to insist on seeing education in the home and some parents may not feel comfortable in allowing an education officer access to their child or family home. Where a parent elects not to allow access to their home or family this does not of itself constitute a ground for concern about the educational provision.

The guidance is clear that when there is an allegation or report of neglect where there are concerns about the child's welfare an initial assessment must be undertaken and Section 47 enquiries made, either by social services or jointly with the police if more serious neglect is suspected.

Where there are no immediate safeguarding concerns, a referral of a 'child in need' of help, requires parental consent in order for an assessment to be undertaken.

This did not happen in relation to this child as those practitioners who were aware of the children in the family did not have any reason to suspect the child may be at risk of harm or likely to be suffering as a result of neglect. The practitioners involved with the family were very much focused on the health needs of the parents. The only child care practitioners who visited the home were those related to the elective home education arrangements. They were not given access to the home and therefore did not see the child.

He was not seen by any health, education or child care practitioners from the age of 13 months, when he had his childhood immunisations. At that point there was no cause for concern noted. He appeared to be a healthy normal child. There was no further opportunity to assess whether his health was in any way impaired. Advice given about diet and nutrition during previous engagement in relation to the family's choice of having a strictly vegetarian diet appears to have been acknowledged.

The parents did not seek any further medical help for their child as they did not believe it was required.

It is possible that had the child been seen or spoken to by a childcare or health professional in the later stages of his life they may have been alerted to the fact that he had some health issues that the parents were not seeking appropriate help for, particularly his dental health and aching limbs. It could be argued that in failing to seek such advice and assistance for their child the threshold for neglect would have been met and any lack of co-operation by the parents once concern was raised could have been dealt with under the child protection procedures.

In this case the family remained isolated from mainstream universal services. They lived in a remote community and chose to adopt a private and secluded lifestyle that included home educating their children. That does not mean the children were at risk of harm. Not seeing children through their access to universal services is not an indicator that all is not well. Understanding all the dynamics in this child's family was needed in order to understand if there were any risks to the children.



## Report recommendations

- 1.** Write to the Welsh Government, asking for changes to the legislation and statutory guidance on elective home educated children, to incorporate a requirement that parents and guardians annually register all such children with the local authority. In addition to this, that all such children should have to be seen and spoken to and their views and wishes are recorded annually. The legislation should state that the information held is also to be shared with the family GP and other relevant professionals.
- 2.** Children and Youth Safeguarding United Regional board (CYSUR) to further develop a regional multi-agency protocol for safeguarding children educated at home, incorporating the following key elements:
  - to outline procedures for identifying those children who are being educated at home
  - to describe levels of support and advice available from professionals to parents/carers and children and young people who are considering or who are already educating their child/children at home
  - to ensure that all professionals involved with the family have the necessary skills to identify safeguarding concerns.
- 3.** Write to the National Independent Safeguarding Board to ensure there is consistent training for all practitioners working with children, adults and families on the implications of the new guidance for the Social Services and Well-being (Wales) Act 2014 to ensure that assessments on individuals also consider the wider family context, including the impact on parenting and the needs of carers.
- 4.** CYSUR to review the provision of multi-agency training and practice that supports practitioners in knowing how to deal with challenging and complex, resistant families and ensure there is evidence of professional management support.

**Citation** Rhodes White, G. (2016) Concise child practice review:  
re: CYSUR 2/2015.

[Pembrokeshire]: CYSUR Mid and West Wales Safeguarding  
Children Board.