Nottinghamshire Safeguarding Children Partnership

Local Child Safeguarding Practice Review

Child RN19

29/09/20

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Content

Introduction

This Local Child Safeguarding Practice Review (LCSPR) was commissioned by the Nottinghamshire Safeguarding Children Partnership (NSCP) on 16th September 2019. The decision to conduct a LCSPR was made following a rapid review of the circumstances of the case and advice from the National Child Safeguarding Practice Review Panel that the criteria had been met for a LCPR to be commissioned in line with Working Together 2018.

The catalyst for this review was that a 15-year-old child, who will be known as Child R, had become unresponsive at home and tragically died soon after being taken to the hospital. The child was found to be emaciated but otherwise appeared well cared for. A coroner's inquest took place on 24th and 25th September 2020 with a narrative verdict. The review author attended the inquest, gave evidence and was present throughout, and any additional relevant information gathered as a result has been added to the report for completeness.

At the time that Child R sadly died she was being electively home educated (EHE). The child had enjoyed ice skating as a hobby and loved the family pet dogs.

Following the death of the child a police investigation into possible neglect issues was commenced. The police report that after a full and thorough investigation, no evidence of neglect has emerged and with no criminal charge being made.

The key learning themes identified in this review include***; eating disorders in adolescence; engaging adolescents in their own health care and promoting child welfare in the school and elective home education settings;***

Methodology

This review was carried out using the systems model approach to learning as outlined in the Child Practice Review process provided by "*Protecting Children in Wales Guidance for Arranging Multiagency Practice Reviews"* (Welsh Government 2012).

The overall purpose of the LCSPR model was to enable consideration of what happened in this case and explore why services were delivered as they were. Also, to consider how practice can be improved through changes to the system to improve outcomes for children.

The process involved a review panel of representatives made up of senior managers and safeguarding leads who were from the organisations involved in providing services for the child and family. The role of the review panel was to provide relevant information and analysis of their organisation's involvement in order to capture service/practice issues and to agree the key learning themes and actions required for multiagency practice improvement.

Local Child Safeguarding Practice Review - local authorities are required, under a statutory duty, to conduct an independent review of serious case where they know or suspect that a child has been abused or neglected and a child has died or been seriously harmed.

Safeguarding Children Partnership - provides the safeguarding arrangements under which the safeguarding partners and relevant agencies work together to coordinate their safeguarding services.

National Child Safeguarding Practice Review Panel - Are an independent panel commissioning reviews of serious child safeguarding cases.

There was appropriate representation at the panel meetings and participants were knowledgeable about their own area and safeguarding arrangements. They were keen to submit and consider learning issues.

A composite timeline which included all agency interactions between 25/08/17 and 25/08/19 was scrutinised by the Independent Reviewer and together with the review panel to identify the key themes of learning.

The key lines of enquiry for the review included:

1) The review should explore the way that professionals assessed and responded to the child's emotional and physical health and well-being and safeguarding during the following key practice episodes.
    a. Presentations to health professionals
    b. Relationships and behaviours in school
    c. Transfer from school to EHE
    d. Support offered to the young person and family by agencies during the period of EHE.
2) Examine the impact of language, ethnicity and culture on the way services responded to the needs of the child and family.
3) Was there evidence of child focus and the "voice of the child" influencing services?
4) Were there any gaps in service that may have led to a different outcome?

Family involvement

Family involvement in the reviewing process was key to understanding the nature of services provided to the individual family. This provided an understanding of how helpful practitioners / services were perceived by the family members on a day to day basis.

The Independent Reviewer and NSCP Development Manager visited Child R's mother at home but Child R's father was not available at the visit and was therefore, seen separately. The home environment was seen to be conducive to home education and everyday family life. Mother demonstrated how well home education had been progressing in terms of meeting Child R's education needs and examples of the child's academic work was seen by the Independent Reviewer and NSCP Development Manager.

The Independent Reviewer was of the view that Child R had produced some beautifully well-presented academic work which was well detailed.

Following a period of reflection with Child R's Mother she was of the view that:

- More direct contact is needed between professionals, children and the families they are working with.
- More direct contact was needed from school to parents when children were moving into EHE or if they have concerns about a child's appearance in school.
- GPs should follow up when children do not attend for planned tests and provide an opportunity for adolescents to be seen alone.

Child R's father was invited to meet the Independent Reviewer and NSCP Development Manager separately. Father was very reflective and emotional about what he felt had been the issues. Home education had been left to Child R's mother who had a very close relationship with their child. He was self-employed and often away from home on business so often left mother and child to make decisions for themselves.

During discussions about agency involvement he expressed that had been very grateful for the support of the Ambulance Service, Police and Emergency Department who had received his daughter and done everything they could.

Father's messages to other parents were that:

- Parents cannot always see what is happening before their own eyes
- Parents cannot do everything alone.

Further views and reflections of both parents will be used throughout the narrative of the report.

The Reviewer had access to a number of documents as follows:

- Rapid review information gathering po-formas
- Individual agency individual management reports (IMRs)
- Joined multiagency timeline of significant events/analysis
- Policy for Elective Home Education (Sept 2013)
- Elective Home Education dashboard – data
- Child R's – Progress Report – Year 9

Research evidence and national statutory guidance was considered and used throughout this review.

Family composition and context at the time of the child's death.

Child R	Age 15 years. White British. An only child. Described as happy, friendly, sensitive and loved animals. Child R had a fascination for ice and snow which built into the love of ice skating. Child R was an accomplished student who was expected to achieved good things in adult life.
Mother	Age 50 years. White Russian. Professional dog walker who had previously been employed as a Scientific Chemical Engineer. Enjoyed being a stay at home mother. Took the lead for educating Child R at home and for addressing health care concerns. Mother speaks good English with a strong Russian accent. It was not clear if mother always fully understood all the nuances of a lengthy conversation.
Father	Age 62 years. White British. Self-employed contractor. His work involved travel and evening work and he was in and out of the home during the day/evening.

Circumstances and significant events (25/08/17 till 25/08/19)

Information outside the timeframe

Child R left Primary School in 2015 and was described by the school as having exemplary behaviour, was hard working and making good progress when leaving the school. Child R had a good group of friends who were supportive.

Primary school held two notes of concern. In May 2012 mother had written to school complaining about bullying and during the child's final year at school their attendance had been 313 out of 353 (89%) which was less than expected and should have been referred to the secondary school in transfer record.

Child R moved to the local secondary school in September 2015 transferring with close friends where the child made very good academic progress. The only concern at school was around the child's school attendance levels which was at 91% for the first year. All absences had been authorised by the parents contacting school. This level of attendance triggered a standard letter being sent to parents about the importance of good attendance.

Father responded by email to confirm the child's illness and challenged the school welfare manager about their competence to question the child's medical fitness to attend school. In Year 8 school attendance improved to 96.3%. The child was weighed as part of the National Child Measurement Programme (Gov.UK 2013) and was found to be within the normal range.

Year 9 at secondary school - (September 2017 till February 2018)

In Year 9 commencing September 2017 school attendance became a concern at 87.2%. The absences were all authorised by the parents for medical reasons. In January 2017 the school First Aid and Wellbeing Co-ordinator wrote an email to colleagues highlighting concerns that the child had requested mother to pick up Child R from school early. The email stated that *"this is getting more and more regular and got a feeling there's more to it than illness".*

The following day Child R's joint form tutor shared their views which resulted in an entry being made on the schools "my concerns" computer system referring to Child R *"extreme difference in appearance. Gaunt/pale. Keeps feeling sick".* The form teacher phoned home to share concerns and mother said that the child's appearance was due to illness and anxiety about sitting grammar school exams.

Following this conversation Child R only attended school for two more days after which the child was recorded as authorised absent from school for a further 6 days. On the following day school were notified by email from the Local Authority - Elective Home Education service that Child R had left school to commence EHE.

The student welfare manager was unable to reach the parents by telephone and asked by email the reason for their decision. Mother replied that Child R was not happy at school and

had passed the grammar school entry test (February 2018) and would be home educated while waiting for a grammar school place.

Child R was seen by the GP on five occasions during this period and there was one significantly delayed presentation to the local hospital Emergency Department following advice from the Out of Hours (OOH) service. Presenting concerns were primarily reported to be for a chest infection and then mainly for chest pains reportedly brought on by eating fatty food and stress. Medication for gastric acid reflux was appropriately prescribed by the GP. Treatment for anaemia was also commenced which was attributed to Child R being unwell and having heavy periods.

There were two episodes of not attending GP follow-up appointments. There were also two episodes of blood tests not being undertaken, where there was a reliance on the child's family making the necessary arrangements for the tests to take place.

Transition into Elective Home Education (EHE) (February 2018 till March 2018)

The EHE administration team received an email from mother informing them of her wish to EHE her child and to remove the child from the school roll. School were informed the same day by the Local Authority EHE service. The school were asked to complete the standard pro-forma giving information about Child R. The student welfare manager at the school did not complete all the sections of the proforma and edited it to remove sections intended to pass on additional information. The completed form stated "There are no safeguarding concerns about this pupil being removed from school roll to be electively home educated".

On receipt of the pro-forma the EHE Programme Manager approached one of the EHE advisors to offer advice to the family. This was agreed and the family was informed of future contact arrangements. EHE administration emailed school to inform them they could remove the child from roll and requested that they send the child's school file. This file was never sent and was not requested a further time.

Application to grammar school (February 2018 till August 2019)

Confirmation of Child R's success on reaching the appropriate standard in the grammar school advanced entry tests was received in February 2018. Following this mother emailed the grammar school for assurance that Child R would be able to start school in September 2018. A return response was received explaining that there were currently no places available. The following day an email from Child R's personal account replied "please I'm begging you" to which the school replied there were no vacancies at present.

Elective Home Education (March 2018 till August 2019)

In March 2018 the first EHE advisor visit took place. Mother explained her concerns at secondary school and hoped for a place at grammar school. The expectation was that the EHE would be a short-term provision and the need to avoid social isolation and the importance of maintaining friendships were discussed.

Mid-March 2018 mother made a call to the OOH GP services (02.30hrs) and voiced concern about Child R having chest pain and upper back pain and the child was refusing to take Paracetamol offered by mother. OOH advised that the child should attend the local Emergency Department within 6 hours, but the child was not presented until 13 days later. Investigations at the hospital did not find anything abnormal.

A further three appointments took place in April 2018 with a GP within a three-week period. All appointments were concerned with chest pain made worse with eating fatty food. On the third visit the GP checked the child's height and weight and requested a blood test. However, the blood test did not take place and a follow appointment was not arranged. Child R did not see the GP again.

The EHE advisor made a second visit in July 2018. It was normal to re-visit EHE pupils three months after the initial visit. The home education plan was judged to be good and a discussion around post 16 education took place. Again, the need to avoid social isolation was raised. In line with local practice the next visit by the EHE advisor was planned to take place one year later.

Between July 2018 and August 2019 (13 months) there was no agency involvement with the child and family.

One week before Child R died. The child texted a friend to say that they (Child R) thought they had an eating disorder. The friend who was not previously aware of this, texted back and advised getting support.

5 days before Child R died. Child R's mother made a GP appointment for the child but the mother attended the appointment alone. Mother was reported to have discussed her daughter's poor eating. She reported Child R was eating healthily, but eating less than before. She was advised to encourage Child R to attend the practice for a review.

4 days before Child R died. The child telephoned Beat (support charity for eating disorders) helpline. There was a 24-minute-long anonymous call. Child R was worried about having to go out to a family meal and wanted to know what to eat without putting on weight. Advice about seeing a GP was given. Following this, Child R made an extremely short call to NHS 111. The child requested to speak to someone anonymously and hung up after only providing a date of birth and confirming age (15).

3 days before Child R died. The EHE advisor visited the home to review the child's education programme. There was good evidence that this had been progressing well. There was talk about post-16 and post-18 education and Child R had been keen to hear all the options available. Following the death of the child the EHE advisor has reflected that at the final visit Child R was seated on the sofa throughout the visit and was wearing layers of thick clothing despite the hot weather. The child's long hair was worn down and covered most of the face.

2 days before Child R died. The child contacted an Eating Disorder Charity helpline to find out what they could eat without gaining weight. Child R told the call handler that they were worried that they would have to eat a family meal and did not want to put weight on. Child

R was advised to speak to their GP. Shortly after this call the child contacted 111 service but ended the call after only providing their date of birth, age and postcode.

Incident – (August 2019)

The local ambulance service received a call at 12.52. The child had been sleeping all morning but was now unconscious and not responding. The caller confirmed the child was breathing and that they had worries about the child not eating properly for some time.

The caller confirmed that the breathing had become very shallow. Advice was given around maintaining an airway after which the caller stated there was no breathing and instruction on CPR was given.

As soon as the ambulance crew arrived, they commenced advanced life support until handover to hospital staff. The crew described the child as looking "skeletal". Mother was very distressed and said she had been trying to get her child to see a GP that week. Hospital staff continued with resuscitation for a further 45 minutes to no avail.

A Police investigation was commenced as part of the Rapid Response Procedure and the conclusion was that the case did not meet the evidential threshold for the case to proceed to criminal charges. It was concluded that the adolescent child had clearly been hiding their condition from the parents.

Analysis of practice and organisational learning

There were three main learning themes which emerged during the reviewing process as follows:

- **Eating disorders in adolescence.**
- **Engaging adolescents in their own healthcare.**
- **Promoting child welfare in school and elective home education settings.**

Eating disorders in adolescence.

As previously stated, a Coronal Inquest has taken place with a narrative verdict which indicated that the child died of natural causes and that undiagnosed and untreated Anorexia Nervosa had been the causative factor.

Anorexia Nervosa is a type of eating disorder. Eating disorders have increased nationally by 37% in two years. NHS Digital data for England shows there were 19,040 hospital admissions among all age groups in 2018/19, up from 13,885 in 2016/17. The figure includes 4,471 admissions for young people aged 18 and under with an eating disorder which is up 8% in a year. More than half of those requiring admission to hospital were due to anorexia nervosa.

Rapid Response Procedure - relates to unexpected deaths of children up until the age of 18 and sets out the roles and responsibilities for those agencies who are involved with responding to unexpected deaths as part of the child death process (police, health professionals and children's social care) and reflects roles and responsibilities set out in Working Together to Safeguard Children.

Anorexia Nervosa is a type of restrictive eating disorder where individuals consume very restrictive quantities of food which leads to starvation. Eventually they become dangerously thin and malnourished, yet they still perceive themselves as being overweight. (NHS website). It has the highest mortality rates of all the psychiatric disorders with reported mortality rates in adolescents and young people of up to 20%. (Jon Arcelus, Alex J Mitchell et al. (2011).

In addition to food restriction, some people with anorexia may also make themselves sick, do an extreme amount of exercise, or use medicine (laxatives) to help speed up the digestion process to stop themselves gaining weight from any food they do eat.

The complexity around extreme exercising is that exercising is seen as a virtue and is often seen as providing significant health and mental health benefits. However, for those with eating disorders, excessive exercise is a common symptom and can play a role in the development and maintenance of the disorder. (Muhlheim.L. 2020)

Although eating disorders can occur at any age there is a higher risk for young people (both boys and girls) between 13 and 17 years of age. Those with an eating disorder may find it difficult or distressing to discuss their eating disorder with a healthcare professional and others. Poor insight into eating problems, lack of motivation to tackle the eating problem, resistance to changes required to gain weight are all features recognised in anorexia nervosa. (NICE 2018)

Triggers for the onset of eating disorders vary from person to person. Triggers have been known to include the internalisation of the thin ideal, healthy eating education, sports performance motivations, weight-related teasing and wanting to exert control in particular circumstances. Non-specific factors included general preoccupations about weight, shape, and healthiness (Chen. A & Couturier. J, 2019).

The illness can affect people's relationship with family and friends, causing them to withdraw; it can also have an impact on education. As with other eating disorders, anorexia nervosa can be associated with depression, low self-esteem, alcohol misuse and self-harm.

The seriousness of the physical and emotional consequences of the condition is often not acknowledged or recognised, and sufferers often do not seek help. They may go to great lengths to hide their behaviour from family and friends, and sometimes might not realise that they're ill. Getting help is often reliant on friends, professionals and family members. Early identification by GPs and referral to specialist treatment services are recommended.

A recent study by the charity Beat demonstrated that, on average, there was an 18-month period before those under 19 years recognised themselves as having an eating disorder, with a further 9 months delay before seeking help. Boys were found to take longer than girls for attending a first visit with a GP or specialist service. Following a first visit it can then take another 4 months until the sufferer receives a specialist assessment. In other words, it takes approximately 2.5 years from the onset of the eating disorder to receiving specialist therapy to address the individual child or adolescent needs. (Beat - published 2017)

Beat have suggested that Clinical Commissioning Groups should extend their focus on early intervention to include earlier stages of the illness, ensuring attention and resource are applied to reduce the delay between the onset of an eating disorder and the individual seeking help. Also, increasing measures around awareness for GP's and other relevant healthcare professionals.

Information heard at the Coroner's Inquest revealed that the parents became aware of their child's interest in healthy eating from the Christmas of 2017. Father recognised that Child R was checking food packaging for the food values to ensure low carbohydrates and calories. By Christmas 2018 Child R would only eat the turkey at the Christmas meal.

Mother was worried that Child R was not eating enough but respected the child's wishes to eat healthily. There was evidence that mother was trying to get Child R to eat more and to see the GP. One week before the child died mother purchased a book on Anorexia Nervosa and this appears to be the catalyst for mother attending the GP on the final visit.

The Reviewer, supported by the NSCP Development Manager has met with both of the child's parents in this case, to gain insight into the homelife. The first observation was that Child R appeared to be a very much loved and treasured child. Mother and child were said to have a very close bond and went on many adventures (outings) together.

The child's bedroom and study room were still intact and was seen as being warm and possessing all the resources that a child would need for a comfortable life and home study. Mother was the lead parent in Child R's education and care. Father who was in and out of the house most days appeared to have little influence over their activities.

There were a number of dogs at the house which reflected mother and child's love of animals. Child R's much-loved Golden Retriever dog died in May 2019 and the child was said to be very upset about this. We now know following the Coroners Inquest that the impact of this loss on Child R and mother was profound and both mother and child lost weight during this period of grieving. Mother purchased another Golden Retriever to take the previous dog's place.

The parents explained that Child R would have been home alone for various parts of the day when mother and father were out working. The reviewer was told that Child R prepared all of their own meals and that Child R liked chicken, vegetables and insisted on having a very healthy diet.

Prior to leaving school Child R was seen eating normally (usually Panini and Coke) at lunchtime and no one in the friendship group had noticed any weight loss. The termination of Child R's school placement came out of the blue for Child R's school friends. Changing schools had never been discussed with them.

Clinical Commissioning Groups - are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Once Child R left school the child gradually started to lose contact with friends and as a result would have become socially isolated, although the child did continue with weekly ice-skating lessons until June 2019. Child R also, experienced a range of visits with mother including visits to museums, art galleries and had a family stay at a holiday leisure park.

Child R was taken to see the GP on several occasions during the first few months of EHE and the child's healthcare issues and treatment will be discussed later in this report. One of the GPs was aware that the child had an EHE status but did not recognise the significance of this in terms of the child not being regularly monitored by other professionals.

The Child Safeguarding Practice Review Panel (CSPRP) have identified that there is a consensus that attending school is a protective factor for children. This is because children are seen regularly by many different professionals and by peers and other families. This enables any early indicators of concern to be identified and for decisive action to take place.

In understanding what happened in this case and as part of the police investigation, the child's electronic devices have been interrogated and it is the police opinion that this material provides an insight into the voice of the child. Child R used the notes section of the mobile phone as a diary and noted eating habits and extensive workouts.

Child R may have been confident in not being found out by their parents because mother had been firmly of the view that a personal mobile phone was private and not to be seen by others. Mother told the reviewer that she had a very controlled up bringing herself and she did not want this for her child.

The mobile phone extracts below are taken from April to August 2019.

- *Pretend eggs breakfast have one egg white only basically and say it's a "meal"*
  Go to Sherwood pines walk have the jelly maybe sometimes then 2 egg yolk and yogurt and a bit of cucumber or salad dinner

- *Toast and something one day for breakfast maybe and say egg thing low calorie*

- *Don't eat a lot out maybe bring a clementine or something - when back don't eat a lot only cucumber or something like that small not anything else*

- *I love how I look and feel right now* 💞💗
  Finally I feel confident, I can wear clothes I have always wanted to, look how I've always wanted to, feel amazing and do all the things I've wanted to do. My habits and my workout is perfect and I couldn't feel happier. So why does she hate it. Don't change for anyone do what you love and enjoy and don't do anything for anyone
  ✨💝✨💝✨
- *Drink tea then just eat cucumber and yogurt ONLY FOR DINNER*

- *Center Parcs don't eat lunch*
  Bring big tub of yogurt and a few small and say it's for snack

- *Work out as much as possible without eating / collapsing then have breakfast then workout again*
  Love handle
  Ab workout
  X4Thigh workouts
  Sanne vander vs and thigh Molly dolke ab
  Chloe ting ab and alexis ren ab
  Through the day try a few arm ones quick

- *Before mum goes do thigh ab and sanne vander*

- *Only one small meal maybe one orange*

(Names mentioned are all models on YouTube offering workout and wellbeing advice)

The mobile phone extracts suggest that the child was significantly restricting their diet intake and using extreme workouts to burn off calories in order to reduce their weight. This appears to have been done in secret when the parents were out of the house.

Within the same device, in addition to the written notes there were a number of selfies showing images of the child's "progress". It was evident that in April 2019 the child appeared as slim. However, following on from this date there was a rapid deterioration in appearance and weight. Police report that these images were distressing to view. This period of deterioration coincided with the loss of the Child R's dog and this may have been a trigger for the rapid weight loss.

The device also disclosed that during this period there was limited contact in respect of socialisation. Child R's main contacts were with parents and with grandparents who lived in Russia. This would appear to support the view around social isolation and its negative impact.

Child R did reach out for support in the last days of life. Child R texted a school friend saying they thought they had an eating disorder and the friend texted back advising that the child should get support.

At some point Child R visited a different GP practice to possibly enquire about a Teenage Clinic which was held there. Child R told mother that she had been to the Practice but had only spoken to the receptionist. What was said is not known. It is possible that Child R had been looking for help.

Child R made a call to an Eating Disorder Helpline requesting advice about what food they could eat without gaining any weight. Child R was worried about a family meal that was being planned and didn't want to gain weight. The call handler managed to keep the child on line for several minutes and tried to convince the child into seeing their GP.

Following this call Child R contacted 111 and asked to speak with someone anonymously although the child did confirm their date of birth, age and postcode. The call handler asked

for the child's address at which point the child ended the call. This should have resulted in a call back to the patient but due to worker failure this did not happen. This has been addressed by 111 internally. There is no evidence to suggest that the child would have responded to a return call.

Child R did not have the checks and support of professionals that children have when they are routinely attending school. Neither did Child R have a friendship or peer group for support and feedback. Child R appears to have been aware that they needed support but did not want to gain weight and was therefore reticent about allowing any help available.

According to the data found on the child's mobile devices, it is clear that Child R was hiding the full extent of their illness from their parents. It may be that the child was not aware of the danger they were in at the time. Despite both parents loving their child wholeheartedly neither parent appears to have fully recognised or been able, for whatever reason, to adequately deal with the situation around their child's eating disorder.

Practice learning for parents and professionals

- Eating disorders are becoming more prevalent in England.
- Anorexia nervosa is very complex and has significant effects on physical, psychological and emotional growth and development.
- Parents do not always see what is happening in front of them – it is a well-recognised symptom of eating disorders to cause the sufferer to be secretive and the potential for the disorder to deceive and manipulate can be extensive. This extends to the sufferer themselves who often lack insight.
- Parents and professionals need to remain "curious" about what their children are thinking, feeling and accessing on mobile devices.
- Parents need to be aware of the positive aspects of technology and internet use for their children as well as the risks and follow guidance to help them keep their children safe on line.
- Parents need to understand the signs of an eating disorder and get support early for children demonstrating these whether or not the child accepts they may need help.
- Social isolation can have a negative impact on emotional and psychological health
- Know what to do to help parents when children refuse to attend GP appointments. This can sometimes be complex where children have capacity to make their own decisions and do not consent to comply with medical care.
- Beat (Eating Disorder Charity) Youthline is available to local young people
  Tel: 0808 801 7110
  email: fyp@bateatingdisorders.org.uk

The local picture relating to eating disorders

The Nottinghamshire Child Death Overview Panel (CDOP) Co-ordinator has confirmed that this is the first case of the death of a child (normally resident in the Nottinghamshire Local Authority area) due to an eating disorder since CDOP records began in line with statutory guidance in April 2008. Learning from this review will be shared with CDOP to support future practice improvements for children and young people across the county.

The county where the child lived has a well-established Child and Adolescent Mental Health Service (CAMHS) Eating Disorder Team. This service has a role to assess and provide treatment for children and young people up to 18 years with significant eating disorders.

There are a number of CAMHS bases across the county for easy access and a helpful web-page with contact numbers and email addresses for those who need help. Referrals from professionals and self-referral is accepted either on line and by telephone. This service, given the opportunity would have been available to help the child which makes this child death all the more tragic.

Engaging adolescents in their own local healthcare.

The World Health Organisation (WHO) recognised that adolescents have significant needs for health services. They pose different challenges for the health-care system than children and adults, this is due to their rapidly evolving physical, intellectual and emotional development. WHO recognises that school health services bring health care closer to adolescents and they may have advantages in terms of access, equity and responsiveness to help meet their unique health care needs.

Local school health services form part of the local 0-19 years health services and are commissioned by the Local Authority Public Health service. The 0-19 service is provided by a local Community Health Trust provider. The 0-19 service have local involvement with schools and a Healthy Child Programme for 5 -19-year olds. School nurses are part of the school health service and are trained to identify and support children with additional health needs.

There may have been an opportunity for the school to consider making a referral for Child R to the school nurse when they had concerns about the child's change in appearance and behaviours around contacting mother to leave school early.

Involving a school nurse at an early stage of concern may have provided an opportunity to engage the child in early healthcare. The school nurse would have had easy access to the child's weight taken as part of the National Screen Programme should this have been relevant at the time. However, there has been nothing to suggest that the child was underweight at this point in time.

World Health Organisation - primary role is to direct international health within the United Nations' system and to lead partners in global health responses

Practice learning – school staff should act on healthcare concerns by engagement with parents and offering referral to appropriate services for example the school health service who are well placed to assess healthcare needs of children. Spotting the signs of an eating disorder is essential for early treatment and better outcomes for children.

At the time when Child R was receiving EHE, the school health service was not being routinely informed about children who were being EHE and this was due to local concerns about parental consent.

The school health services were therefore, not aware that Child R was receiving EHE. This situation was resolved prior to the death of Child R and a new information sharing process was already established prior to this review being completed.

The school health service and EHE programme manager had established the improved process by working together to develop an information sharing agreement. Further to this, in August/ September 2019 the EHE service wrote out to all parents registered as receiving EHE for consent to share information with the 0-19 service giving them an opportunity to opt out of the service offer as is their right to do so. From the end of October 2019, the school health service started to receive a list of all children and young people registered with EHE which goes to a secure NHS email address for the information of the local school health service.

The local school health service will be contacting all families who have chosen to EHE their children to ensure they are aware that their child is still able to access a universal healthcare services which are readily available to all children and young people who attend school. This will be done via the EHE advisors who are in contact with the families concerned.

Practice learning – it is important that EHE and school health services work together and share relevant information with one another about issues and concerns relating to EHE children in their area.

As previously stated, eating disorders have the highest mortality rates of any of the psychiatric disorders. This, along with the potentially irreversible effects of eating disorders on physical, psychological and emotional growth and development, require early recognition and intervention of these young people.

It is important that primary care providers, such as GPs, along with other health professionals who may come into contact with young people, recognise their important role in the early identification of an eating disorder, and that they recognise that anorexia nervosa is a serious disorder with life threatening physical and psychological complications.

Child R was seen by the GP on five occasions between July 2017 and April 2018; this was primarily for a chest infection followed by complaints about chest pains linked to eating fatty foods and stress. Medication for gastric acid reflux was appropriately prescribed for two weeks with a request to see the GP again to monitor progress.

The cause of the stress was not explored by the GP although the mother did explain that stress was related to school attendance. She informed the GP that Child R was now receiving EHE which could have suggested that the child's stress would now be alleviated. The relevance of the child being EHE was not explored further by the GP and there was no flagging system in place to record the child's educational status. Child R was reported as appearing pale at the majority of appointments and treatment for anaemia was commenced and was attributed to being unwell.

Practice Learning – The flagging of EHE status on the GP record keeping system may give rise to alerting the GP that the child is not in regular contact with other professionals and this information can be factored into any clinical or psychosocial assessment required.

There were two missed GP follow-up appointments, two missed blood tests and one delayed presentation following advice from OOHs that the child should attend the local Emergency Department. It took thirteen days for the child to attend the Emergency Department, where investigations for chest pain were explored with no concerns being found, the discharge letter from this attendance was sent to the GP.

The reasons why Child R did not attend the emergency department, as advised, was never explored. There was no professional curiosity by the GPs in terms of questioning around non-attendance and given mothers Russian accent no professional curiosity to check that mother fully understood the importance of the blood tests and follow up appointments.

The 3 in 1 routine vaccination was offered by the school age immunisation service however, consent was refused with no reason for this being specified. Previous vaccinations had been up to date with no issue. There was no professional curiosity around why consent had been withheld given the importance of the vaccination programme.

The child's final appointment with the GP took place in April 2018 which was sixteen months prior to the child's death. At this appointment the child was weighed and measured and a blood test requested. Child R was weighed as part of the GP assessment at 45kg with a height of 1.67m which gave a BMI of 16.14 kg/m. At the time the GP weighed the child the GP was unaware that the child had previously been weighed by school health service in 2015, three years earlier, 45.4kg. This information was available as part of the wider record available to the GP, but they were unaware of this at the time of the consultation.

Reports of Child R having problems with heavy periods, may have distracted clinicians from considering an eating disorder, as periods often stop in those who are severely underweight.

Centile Chart - Centile charts are used in child growth assessment and show the position of a measured parameter within a statistical distribution. They do not show if that parameter is normal or abnormal. They merely show how it compares with that measurement in other individuals and over time.

Faltering growth - Faltering growth (also known as failure to thrive or under-nutrition) is a term used to describe a lower weight, or rate of weight gain, than expected for age and sex in childhood.

BMI – Body Mass Index is a value derived from the mass and height of a person. The BMI is defined as the body mass divided by the square of the body height, and is universally expressed in units of kg/m^2, resulting from mass in kilograms and height in metres.

It is recommended that when height, weight and BMI is taken in a child or young person it is plotted on the relevant centile chart. This allows the professional to review the child's metrics in the context of any other previous measurements and in comparison, with their peers. If the chart had been reviewed and both weights plotted by the GP, this would have provided valuable information about the child's growth which had plateaued.

The blood test never took place. It is difficult to extrapolate what actions may have been taken if these blood tests had been obtained. Had these blood tests been reviewed in the context of a young person with faltering growth then, even if they were normal, they may have prompted exploration of other causes for faltering growth, including an eating disorder. The simple fact that a family who were presenting as worried, but had not attended for the recommended blood tests, should be a highlight that further assessment was warranted.

Mother told the Independent Reviewer that blood tests did not take place because the child refused to attend hospital due to the child developing a needle phobia, although this was never discussed with a healthcare professional at the time. If needle phobia had been recognised then the GP could have referred the child to the Community Children Nursing service for support around vaccinations and blood tests and engaging the child in healthcare.

The issue of missed investigations such as blood tests being a warning sign to professionals was an issue raised by father who felt that children who miss out on investigations should be reviewed to ensure they are not missing out on vital healthcare.

It was apparent that the GPs who saw Child R were not given an history of an eating disorder and had not detected any physical signs that the child may have an eating disorder, apart from the faltering weight which was not recognised on the one occasion that the GP weighed the child.

Five days before Child R died, mother attended alone to a GP appointment which she had made for the child. Mother voiced concern that she thought her child had eating problems and was worried about this, but went on to describe a healthy diet. The GP advised mother to bring the child to see a GP at the practice.

Given the situation that mother had already attended the appointment without the child it may have been helpful for the GP to check with mother if she would be able to get the child to attend an appointment. Being professionally curious about why the child had not attended with mother and how the mother was going to get the child to attend an appointment if the child refused to attend were not addressed. Consideration of use of the Community Children Nursing Service and School Health Service would have been useful should the GP have required clinical support.

Professional learning –Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This is an important skill which would have helped in the early identification of an eating disorder or other clinical diagnosis.

Following the death of the child the GP practice have worked with the local Named and Designated Professionals to consider learning from the child in this case and there have been a number of practice issues identified and implemented which will improve clinical practice and outcomes for children in the future.

The practice areas identified and progressed are relevant to all GP Practices and should be considered by all GP's in the area as set out below:

"Was not brought" (previously known as "did not attended").

Child R was not brought for follow up to the GP despite the GP requesting an appointment. Also, relevant blood tests were not taken up as requested. At the time the GPs were reliant on parents' ability to bring the child as requested.

Reasons why there had been a failure to attend follow up appointments and blood tests were not addressed following the non-attendance, or at subsequent appointments. There are multiple reasons why children and young people may not be brought to attend medical care. One reason may be that young people do not wish to attend. It is important that healthcare professionals including GP's understand issues of consent and capacity in relation to young people so that they can work with parents to support a young person to engage.

There was a local policy which indicated that if a child "was not brought" for an appointment for three times in twelve months then the GP would chase up reasons and issues for none attendance. This set criteria did not apply to Child R because only two appointments were missed.

Progress – The "was not brought" GP policy has been reviewed and appointments will be considered for non-attendance every time and followed up as necessary. Blood test requests for children will be monitored through scheduled tasks on the practice web-based system to ensure children are followed up when any referral and investigation requests are made. This will promote GP professional curiosity around why children miss their GP appointment and any request for medical investigation.

Continuity of care.

Child R was seen by seven different GPs. This lack of continuity of care has been attributed to the requests for GP appointments being made at short notice and the practice efforts for children to seen as soon as possible.

Appointments with the same GP may have led to a stronger relationship between the adolescent child and GP being formed and may have helped assessment over the eight months that the five appointments took place. Child R did have a usual GP but because the child did not attend for follow up appointments the child did not see their usual GP.

Progress – The GP practice are formalising a process in order that patients are seen by the same GP at consultations where possible. This will promote and improve opportunities for continuity of care.

Faltering weight in children.

It is recommended that height, weight and BMI are plotted on an appropriate centile chart to allow comparison with peer group and subsequent or past measurements. If this had been done the GP would have seen a worrying trend that the child had crossed from 91st to 25th centile over three years. This may have alerted the GP to the fact that the child was not gaining weight at a time when the child should have been as part of the child's natural development and may have resulted in an assessment for faltering growth including a referral to specialist paediatric services.

Sadly, the child did not attend for a GP appointment again and the child died sixteen months later. There was a clinical tool available on the GP record system which plots height and weight on growth charts for children. These had not been routinely used by GPs in the practice at the time.

Progress - The GP practice is developing an electronic record template to document weight, height and BMI in children (up to eighteen years) and will use growth charts to guide their plans and follow up children where these charts identify concerns. Furthermore, local guidance is being developed to highlight faltering weight by making use of existing software which is based on NICE guidance on eating disorders (2017). This will be shared with the wider GP community and will promote and improve the early detection of faltering weights in children.

Importance of providing opportunity to see adolescent children alone.

Offering to speak to adolescent children alone is an important factor in healthcare. Child R attended all appointments with mother, and it was recorded in the GP record that mother had reported that Child R had been stressed at school and was being home educated until a place at grammar school became available.

Offering the adolescent child, the opportunity to be seen alone without mother would have given an opportunity to explore the adolescents' perspective but also to ask psychosocial questions which may not be answered truthfully in front of parents. This can often give an insight into the young person's medical presentation.

Children receiving EHE may have no other time to speak in private with a professional without their parent being present. EHE children having lost daily contact with school staff and potentially with friends can become isolated and may not feel able to tell their parents what is worrying them. We know that some children and young people will disclose to friends or a trusted professional rather than parents, often to avoid upsetting them. As previously mentioned, Child R did disclose to a friend by text the week before the child's death.

Progress – The GP practice recognise there was a potential gap in the way they engage with adolescents and will be mindful in future about additional risks for those who do not attend school and the need to offer an opportunity for the child to be seen alone. It is hoped this

will promote professional curiosity and provide an opportunity for the adolescent to speak in private about any concerns.

Practice learning – It is important that GP's use tools available to recognise faltering growth and that eating disorders are part of the differential diagnosis for this. It is important that once recognised appropriate referrals are made to secondary care services. Young people should routinely be offered appointments alone, and practices should provide clear communication about this in public areas. They should be asked screening questions as part of a brief psychosocial assessment such as HEADSSS.

- HEADSSS is an interview prompt or psychosocial assessment tool to use with young people to understand their situation and concerns around **H**ome / **E**ducation / **E**mployment / **A**ctivities / **D**rugs / **S**ex (& relationships) / **S**elf harm (& depression) / **S**afety (&abuse). Royal College of Paediatrics and Child Health, 2003.

Promoting child welfare in school and elective home education settings

National guidance in 2017 made clear that parents had a right to decide to home educate their child at any stage up to the end of compulsory school age (5 – 16 years). This right applies equally to parents of children with special educational needs. Home education may also be used to meet the requirement to participate in education or training up to the age of 18 years.

In England, education is compulsory but schooling is not. Under section 7 of the Education Act 1996, the responsibility for a child's education rests with their parents.

Parents who home educate their children have the ultimate responsibility for ensuring that the education provided is efficient, full time and suitable to the child's age, ability aptitude and any special educational needs that they may have. Parents are not required to provide a broad and balanced curriculum and do not have to follow the national curriculum.

Local authorities have no duty in relation to the monitoring of the quality of home education on a routine basis. However, they do have duties to make arrangements to identify those children not receiving suitable education and to intervene if it appears that they are not. Intervention could take the form of issuing a School Attendance Order via the magistrate's court.

Local authorities also have a duty to make arrangements to ensure that their education functions are exercised with a view to safeguarding and promoting the welfare of children. (Education Act 2002, Section 175(1)). This section does not extend existing powers to make home visits for the purpose of seeing and questioning children about the suitability of their education. As part of their safeguarding duties, local authorities have powers to insist on seeing a child to enquire about their welfare but this is separate from the purposes of establishing whether they are receiving a suitable education.

Updated elective home education guidance (2019) para (7.2) clarifies the EHE service role to share relevant information about individual children and para (7.4) clarifies local authorities es approach to considering “suitable education” and states that local authorises should be ready, if a lack of suitable education appears likely to impair a child’s development, to fully exercise their safeguarding powers and duties to protect the child’s wellbeing.

The structure of the local EHE service since 2016 had been that there was an EHE Officer sitting within the School Place Planning Team. Home visits were made by a group of associates who were self-employed professionals with a teaching or other education background. Their work was administrated by two members of the business support team. At the time this structure was consulted upon EHE numbers were significantly lower than they are at present. The structure was designed to provide parental guidance about their responsibilities and to monitor the appropriateness of the education plans.

As previously stated, the EHE service had no information sharing links with the school health service and this area has since been addressed.

In relation to Child R there are a number of school/EHE practice learning areas identified as follows:

Transition from school to EHE.

Prior to being home educated Child R attended a local secondary school where the child was seen as being quiet, hard-working and making good academic progress. The child had one particular close friend and a number of other friends in the child’s school year. There had been some concern around less than optimal school attendance in Year 7 and 9 and this was appropriately managed by the school by contacting the parents.

Immediately prior to Child R leaving school staff had raised some concerns about Child R which were recorded on the schools “my concerns” IT system. This system was used in school for sharing concerns about pupils with other members of staff. Concerns related to the child phoning home to be collected early and appearing “gaunt and pale”. It was agreed that school staff would monitor the situation in school. However, Child R only attended a further two days and the opportunity for school to monitor the situation over time was lost.

The concerns identified were shared with mother who reported that Child R had been ill and was anxious about sitting the exams for Grammar school. This was the first time that school were aware of the parent’s intention to change schools. Following Child R’s death, the teaching staff have reflected and report that there had been no signs that the child had lost weight and there were no concerns about anorexia. Apparently, the school has a number of pupils with eating disorders in school and feel confident in recognising early physical signs and behaviours.

Around a week following mothers’ conversation with school about concerns relating to Child R, mother notified school via email that Child R would be home educated pending a place at Grammar school. This came as a complete surprise to school who had not been approached about any parental concern or issues around the level of education and support offered to

the child. Child R had been making good progress and had received a very promising Year 9 report outlining good academic progress.

The reviewer has seen Child R's progress report for Year 9. It is clear that the child was making good progress and there were a number of positive comments from teachers including, *Child R is a lovely child with a good attitude; polite, considerate and growing in confidence; shown amazing skills so far; putting 100% effort into their work; making above expected levels in some subjects*. Child R was advised to engage a little more in class discussions which was a theme which ran throughout the report.

Given the circumstances, there was no professional curiosity about why Child R was being abruptly removed from school roll and no face to face resolution meeting with the parents to allow the school to address any concerns. As a result, there was no opportunity to respond to concerns about school and to work with the child and parents to alleviate any problems.

Practice learning – The importance of professional curiosity - Schools need to make efforts to understand the reasons why parents choose to remove children from their school roll to home educate in order to address any issues concerning individual children and to identify any school wide issues which need attention.

Mother was asked by the Independent Reviewer the reason why the child left school and how she knew about home education. Mother shared that Child R was unhappy in school with the suggestion that the child had concerns about the standard of education they were receiving. According to mother the child had experienced some level of bullying and had become unsure about her friendship group. Mother was aware of home education from a local friend who was successfully home educating their own children.

School were asked to reflect on whether they had been aware of any bullying or any dissatisfaction with the standards of teaching at the time. The school was not aware of either issue and were surprised that bullying had been suggested as this had not been recognised or indicated. The school in question has a robust anti bullying policy and procedure in place.

Once the child had left school, the child was registered with the EHE service who requested transfer forms to be completed. The school returned an older version of the form rather than the form that they had been sent. This older form collected less detail than the revised form, and although the response received did state that there were no safeguarding concerns in relation to this pupil, there is no evidence that the school were contacted to complete the full form they were originally sent, as requested. Therefore, recent concerns identified in school were not shared with EHE which was below the level of expected practice.

The programme manager for EHE at the time has reflected that had EHE been aware of the concerns identified in school he would have allocated a tutor with specialist experience in working with children and young people with mental health issues. The programme

manager would also have requested an "intervention meeting" to get to the bottom of the situation and seek a suitable resolution.

Practice learning- Schools have a duty of care for children on their roll. Parents have a right to remove their child from school and educate them at home. Nevertheless, although it is not a legal requirement, it would be best practice for schools to consider what is in the child's best interest prior to removing children from school roll. Schools should work with parents and the local authority to make sure that all issues are understood and addressed prior to removal from school roll.

Practice learning – Schools and EHE services must share information about any concerns, even if they appear low-level and should ensure these matters have the opportunity to be addressed and to be continually monitored.

Delivering EHE services

At the time of this review the EHE service was experiencing an increase in the number of EHE students to be monitored while at the same time experiencing pressures to reduce expenditure.

Numbers of students requiring EHE services was as follows:

- **April 2017** = 591 / advisor refusal = 29
- **April 2018** = 674 / advisor refusal = 21
- **April 2019** = 834 / advisor refusal = 199

There was also in increase in parents who refused the services of the EHE advisor which is of concern because it may be leaving children even more vulnerable. This area of service concern should consider a review for this aspect of the service to better understand the context of this issue if not already known.

In this case, the child and parents were allocated an experienced EHE advisor who made an initial visit to the home and then provided annual reviews. The EHE made a total of three visits and found the education programme being provided to the child was of good quality. The reviewer has seen some beautifully well-presented work which was produced by Child R during home education.

During the EHE visits the advisor saw and spoke to Child R at length. Their impression was that mother and child had a good relationship and that home education was well planned. There were no concerns raised in relation to Child R's welfare and the advisor had no concerns. The advisor knew how to report any welfare concerns to the EHE manager and had done so in the past in other cases.

Following Child R's death, the EHE advisor reflected on the child's appearance at the last annual visit. He observed that the child was seated of the sofa throughout the visit and the child was wearing several layers of clothes in hot weather. The child wore their hair down which covered most of the child's face. The child had sounded optimistic about the future

and was looking forward to post 16 and post 18 education. In hindsight, there may have been some physical clues of the child's weight loss but the advisor had no reason for concern at the time.

Practice learning – Importance of professional curiosity for EHE advisors when working with parents and children at times when children are presenting differently from previous visits. Change may present in many forms including physical, emotional, behavioural or educational.

What we now know from the police investigation of Child Rs mobile phone is that the child was spending a lot of time working out and exploring how to lose weight on YouTube when parents were out of the home working. It is not uncommon for sufferers of anorexia nervosa to cover their body with several layers of clothing to prevent others from noticing their weight loss and too conceal their condition as previously stated. Also, wearing hair over of the face can be a sign of trying to hide away.

Practice learning - EHE advisors need to develop a focus on contextual safeguarding and to think more broadly about the home educated children and young person in the context of the environment and circumstance they are in. This should include wider questioning and use of professional curiosity beyond educational planning.

Selective Grammar School

Parents want the best for their children in terms of their education and happiness. A place at a selective Grammar school is an option that many parents wish to pursue in the belief that this is in their child's best interest.

When Child R became unhappy at school mother tried to secure a place at a Grammar school with an excellent reputation, which was approximately thirteen miles away. Mother was willing to take the child to school every day and as long as the child could pass the entrance exam there did not appear to be a problem.

The child passed the entrance exam and was placed on a "reserve" list to attend the Grammar school if and when a place became available. *"Congratulations on what, I am sure you must regard as good news".* "*Please note, however, that reaching the standard in the tests does not in itself guarantee your child admission to the schools Year 9 is currently full. Your child will now be placed on the reserve list, and we will contact you should a place become available".* Mother and possibly the child initially sent begging emails for a place at the school but the school had no place for the child and a brief response was provided.

What the parents and child did not understand and were not told, was that it was highly likely that Child R had zero chance of ever getting a place at the school because of the school's admission criteria. The child was left in limbo whilst waiting for a school place which was never going to materialise and the opportunity was then lost for other school options to be explored.

Practice learning- When popular schools have children on waiting lists parents and other relevant agencies should be provided with realistic advice on the likelihood of a place coming available. In this way parents or services such as EHE can discuss an alternative school placement if appropriate.

Initially, EHE was seen as an interim arrangement whilst awaiting a place at Grammar school. This position was left to drift without being reconsidered in terms of whether EHE was still the best course of action for the child. A system for more radical review of EHE placements would have been helpful. For example, the decision of where and when the child would sit GCSE's was never fully addressed.

What was needed was a broader review around the appropriateness of her home education not simply a review of whether or not home education was being adequately provided.

Practice learning – EHE should develop a system to ensure that interim and short-term home education arrangements do not drift without appropriate review of a return to school as a viable option.

EHE Progress

Since September 2019 the safeguarding training of EHE advisors has been monitored by the EHE administration team. Further training on contextual safeguarding and learning from this case has been provided.

In September 2019, the responsibility for monitoring EHE transferred to the leadership of the Team Manager for Fair Access who is the responsible person for children missing education in the area. A new full-time officer post has been appointed to co-ordinate the work of three of the most experienced EHE associates available, these associates are now employed on a higher rate to act as programme managers to improve co-ordination of the service. The team of associates and the two business support staff continue to fulfil their original roles, and additional associates have been engaged to meet the growing need for home visits.

Practice learning – All public services working with children should regularly review the level of service and quality of service provision in order to keep pace with the changing requirements of children and young people.

Good Practice

There was a number of good practice examples recognised across the time period of this review as follows:

- "My concerns" IT system in school for monitoring and sharing low level concerns for individual children appeared to work well and was used appropriately.

- GP same day availability for children – the practice worked hard to ensure that children are seen as soon as possible

All agencies have worked hard to follow up on any practice issues which needed resolving as addressed in this review. in particular, the GP Practice has highlighted practice areas where progress has been made. These practice areas may have relevance for all other GP Practices in the area.

Practice Issues

There were a number of practice learning issues identified by the individual agencies and these have already been addressed to reduce the chances of this situation ever happening again. A lack of professional curiosity is a golden thread which was a feature in all agency reports. The barriers to professional curiosity and how systems are used to support professional curiosity need to be considered across the partnership.

The reviewer got the impression from the reports that agencies were presented with what could be called a “normal, average family” and were too willing to take everything which happened at face value. This resulted in a lack of understanding about the needs of the child and family and may have allowed opportunities for recognising the signs of social isolation and eating disorder to go by undetected.

Conclusion

This CSPR outlines the tragic death of a child who was receiving EHE. The child and family did not pose any particular “problem” to any of the agencies involved and professionals did not seek to fully check out what was happening in the life of the child.

There was a thirteen-month period when the child did not see any professional at all and this raises the question about what more can be done to identify those children who may be at risk of harm and are effectively lost from the view of professionals.

National EHE guidance (2018) reflects on areas of safeguarding and the role of social care but it does not provide any robust focus on promoting the child’s welfare. With more children than ever before becoming EHE, there should be a national consideration for future amendment of the EHE guidance.

This CSPR provides insight and reflection for the Nottinghamshire Safeguarding Children Partnership. The majority of required improvements have already taken place as identified in this CSPR. Perhaps the key learning theme throughout this CSPR was one of professional curiosity and the importance of asking questions to better understand children and families even when on the surface there are no apparent concerns.

This review should be shared to promote learning across the safeguarding partnership.

Recommendations

The following recommendations are for the consideration of NSCP as follows:

Recommendation 1
NSCP should review the material available to parents to help them recognise the signs of Anorexia Nervosa and the importance of early diagnosis in children.
Intended outcome *– To improve parental awareness of Anorexia Nervosa and importance of early intervention.*

Recommendation 2
NSCP should progress work to raise awareness across the partnership in the following areas:

- Early recognition of children with eating disorders.
- Professional curiosity and how to promote this within systems.
- Increased vulnerabilities such as social isolation of children and young people who are EHE and the role of the EHE service.

Intended outcome *– To increase the awareness of the frontline workforce across the partnership.*

Recommendation 3
NSCP should request quality audit evidence from the local authority that the recently reconfigured EHE service has the capacity to function appropriately and that EHE advisors have increased their role to consider individual child welfare as part of their routine visits.
Intended outcome *– For NSCP to be assured that the EHE is functioning appropriately and individual EHE children are having their welfare promoted.*

Recommendation 4
NSCP should request quality assurance evidence from the local authority that all schools in their area are taking steps to identify and support children and parents during decision making about moving from school into EHE.
Intended outcome *– For NSCP to be assured that schools are considering the best interests of children prior to moving into EHE.*

Recommendation 5
NSCP should explore the possibility of agencies flagging their children records to identify those who are receiving EHE on their systems.
Intended outcome *–. To ensure professionals can quickly ascertain the educational status of the child and factor this into their clinical assessment.*

Recommendation 6
NSCP through its links with the National Child Safeguarding Practice Review Panel, should consider requesting a National Review on EHE to change non-statutory guidance to improve opportunity to promote the welfare of children receiving EHE.
Intended outcome: *To better promote the welfare of all children receiving EHE.*

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The Independent reviewer would like to especially thank….
Dr Rebecca Sands – Consultant Paediatrician with special interest in child eating disorders for her expert contribution throughout this review in relation to helping the panel to understand the complexities of adolescent eating disorders.

Also, Bob Ross – NSCP Development Manager for his organisational expertise and for his support when visiting the parents.

Statement of Reviewer Independence

The reviewer, Kathy Webster is independent of the case and of Nottinghamshire Safeguarding Children Partnership and its partner agencies.

Prior to my involvement with this Local Child Safeguarding Practice Review;

- I have not been directly concerned with the child or any of the family members or professions involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigours analysis and evaluation of the issues as set out in the Terms of Reference.

Signature:

Name: Kathy Webster – Independent Reviewer

Date: 29th September 20