Executive Summary – Child M

1. This is an executive summary report of the Local Child Safeguarding Practice Review (LCSPR) concerning Child M. The review was commissioned by the Enfield Safeguarding Children Partnership following a Rapid Review. Child M was a school-aged child with additional health and developmental needs who was admitted to hospital in a profoundly unwell state and found to be severely malnourished. No medical explanation was identified that could account for the extent of Child M's presentation. The review identified hidden harm, fragmented professional oversight and missed opportunities to recognise and respond to safeguarding concerns at an earlier stage.

2. About Child M

2.1 Child M was a child with autism, significant communication needs and additional health vulnerabilities. Child M was largely non-verbal and relied on adults to understand and respond to health, developmental and safeguarding needs.

2.2 Child M received support from a range of NHS, private and alternative providers and was electively home educated. This resulted in no single professional having a complete understanding of Child M's circumstances, needs and daily lived experience.

2.3 The review identified concerns relating to missed appointments, fragmented healthcare arrangements, restrictive dietary practices, limited professional oversight and a lack of coordinated information sharing. Child M became increasingly invisible to services despite a range of indicators that additional support, assessment and safeguarding scrutiny may have been required.

2.4 Although agencies held pieces of information suggesting vulnerability, concerns were not consistently brought together into a holistic understanding of Child M's lived experience, wellbeing and risk.

3. The Review

3.1 The review examined how agencies worked together to understand Child M's needs, hear the voice of a non-verbal child, assess safeguarding concerns and provide oversight where care and education were largely taking place outside of universal services.

3.2 The review identified examples of good practice, including efforts by some professionals to raise concerns, positive adaptations by hospital staff to communicate with Child M and reflective engagement by agencies throughout the review process.

3.3 However, the review found significant learning regarding visibility of children electively home educated, coordination of services for children accessing multiple providers, understanding the needs and experiences of non-verbal children, and maintaining professional curiosity where presentations are complex and fragmented.

4. Family Involvement

4.1 Family members were informed that the review was taking place. Due to ongoing criminal proceedings, family interviews did not take place as part of the review process. This limited opportunities to fully understand family experiences, beliefs and decision-making.

5. Recommendations

5.1 A set of recommendations have been identified for the Safeguarding Partnership to improve outcomes for children who may be less visible to services and who have complex health, developmental or educational needs.

5.2 Raising awareness of evidence-based interventions for children with autism and additional needs

The Partnership to consider how to develop approaches to working with local statutory and voluntary organisations that support parents, to raise awareness of the importance of the evidence base of interventions accessed for children who experience autism and related conditions.

5.3 Developing a multi-agency pathway for information sharing and safeguarding oversight of electively home educated children

The Partnership to consider the development of a multi-agency pathway for information sharing and oversight to ensure electively home educated children are known, their needs are understood and safeguarding oversight is promoted.

5.4 Strengthening assurance regarding safeguarding arrangements for elective home educated children

The Partnership to assure itself of the effectiveness of local safeguarding systems relating to children electively home educated. This should include consideration of whether children are clearly identified, their voices and needs are understood, agencies understand their respective roles and responsibilities, health professionals contribute effectively to safeguarding arrangements, vulnerabilities are recognised, multi-agency plans are developed where required and children with previous safeguarding concerns remain visible to safeguarding agencies.

5.5 In conclusion, the review found that Child M became increasingly invisible within a fragmented system where no single professional had a complete understanding of needs, risks and lived experience. Stronger information sharing, improved oversight and more coordinated multi-agency responses are required where children have complex needs, receive support from multiple providers or electively home educated. The Partnership should assure itself that learning from this review results in sustained improvements that increase the visibility, safety and wellbeing of vulnerable children.