Summary of the case

Matthew[1] had complex health needs, having been diagnosed with Global Developmental Delay and Cerebral Palsy. Neither abuse nor neglect were factors in Matthew's death, which was both sudden and unexpected, aged five years.

Matthew's mother and father separated when he was just a few months old, and he lived between his parents (who resided in different London boroughs). Caring for a child born with such complex medical issues was never going to be easy for Matthew's family. Coupled with periods of decline in mother's mental health, English being her second language, an absent family support system, housing issues and relationship breakdown, the need for support was strikingly clear.

There was evidence that those working with the family did so with professionalism and attention on many occasions, but this was often within the parameters of their own agency. 'Silo working' hindered the opportunity to develop an early and coordinated response from the beginning. There were occasions when professionals involved with the family lacked a clear overview of Matthew's needs or weren't informed about significant events that had taken place. Team around the Child meetings went some way to achieve this coordination, and these helped provide a focus on Matthew's needs. That said, at times, the quality of practice continued to be affected by issues such as poor information sharing and a lack of professional curiosity and challenge.

Finding 1: There was good evidence that some practitioners took the time and effort to hear Matthew's voice.

Finding 2: Matthew's non-attendance at medical appointments was generally responded to appropriately, but children not being brought to appointments remains a key theme for awareness raising across the partnership.

Recommendation 1: To help reinforce to all practitioners the importance of a strong response to children not being brought to medical appointments, Bromley Safeguarding Children Partnership should develop and/or promote available guidance on this issue.

Finding 3: An interpreter was not routinely offered to mother as part of her engagement with professionals, including occasions where complex medical information was being shared and serious / life changing diagnosis being given

[1] This is a pseudonym chosen in line with BSCP policy

Recommendation 2: The BSCP should establish reassurance from all agencies that their recording systems properly capture the need for the use of interpreting services and that such services are provided consistent with the expectations of good practice and sector specific guidance.

Finding 4: The effectiveness of the arrangements for the provision of equipment for children with disabilities and complex health needs can add stress and frustration to families who are already dealing with significant challenges.

Recommendation 3: Bromley Safeguarding Children Partnership should seek reassurance about the sufficiency of processes in place to provide equipment for children with disabilities and complex health needs, with a particular focus on children in shared care arrangements**.**

Finding 5: Cross borough working is a challenge that requires routine and frequent communication by practitioners working in different areas. For Children in Need and children on Child Protection Plans, the London Child Protection Procedures (6th Edition)[2] provide guidance on the roles and responsibilities of practitioners.

Recommendation 4: The BSCP share the findings about the transfer of Child in Need cases with the Editorial Board for the London Safeguarding Children Partnership's Procedures.

Finding 6: Poor information sharing, exacerbated by a lack of coordinated professional curiosity and challenge, resulted in many practitioners having a limited understanding of Matthew's lived experiences and the circumstances of his family.

Recommendation 5: The BSCP should review its multi-agency guidance to ensure that it sufficiently covers the issue of professional curiosity and the need for practitioners to hold 'difficult conversations'

Recommendation 6: The BSCP should seek reassurance that single agency training and the multi-agency training delivered by the BSCP comprehensively covers the knowledge and skills required by practitioners to be professionally curious and challenging.

Recommendation 7: The BSCP should seek reassurance about the quality of practitioner involvement in the development of EHC plans and their participation in EHC Plan Annual Reviews. This reassurance should include addressing aspects such as the naming of a lead professionals, and the sufficiency of information sharing with a particular focus on social care needs.

[2] Children & Families Moving Across LA Boundaries – London CP Procedures