Zac

Local Child Safeguarding Practice Review

July 2024

This Local Child Safeguarding Practice Review has taken steps to preserve the anonymity of the subject child and of other family members. The subject child is represented by a name chosen at random.

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1. Introduction and Background

The background of the Local Child Safeguarding Practice Review

1.1 This Local Child Safeguarding Practice Review (LCSPR)[1] was commissioned by Derby and Derbyshire Safeguarding Children Partnership (DDSCP)[2] following agreement at the DDSCP Child Practice Review Panel on 11 August 2022.

1.2 The catalyst for this LCSPR was that an eleven-year-old child died following a fatal injury (severe liver trauma) which was initially thought to be as a result of an unwitnessed accidental fall from a tree. The fatal injury was later found to be the result of a physical attack by the child's father which took place at the family home.

Methodology

1.3 The review has been conducted in line with Working Together to Safeguarding Children (2018)[3] statutory guidance using a systems approach to learning with a focus on how all professionals work together to safeguard and promote the health and wellbeing of children and their family.

1.4 An Independent Reviewer with relevant expertise and experience was commissioned to conduct the review. The Terms of Reference sets out all partners involved with the family and provides the key lines of enquiry for the review.

1.5 The scope of this LCSPR covers relevant historical information and examines a period of twenty-one months, starting from September 2020 when the parents decided to electively home educate the child up until father's arrest for the child's murder in June 2022.

1.6 The LCSPR was supported and quality assured by a panel of managers and safeguarding leads from the partnership organisations involved, who have actively engaged throughout the process.

1.7 Front line practitioners, managers and safeguarding leads from partner agencies involved with the family were invited to attend a number of individual learning events to consider their safeguarding role and identify areas of learning and improvement.

1.8 Parental involvement in the reviewing process was seen as being important to gain an insight into the family's observations and experiences of working with professionals in the services identified. An invitation to take part in the process was

[1] **Local Child Safeguarding Practice Reviews (LCSPR)** - are systemic reviews of serious child safeguarding cases to promote learning and improve practice to reduce the likelihood of a similar situation happening again.

[2] **Derby and Derbyshire Safeguarding Children Partnership (DDSCP)** – safeguarding partnerships support and enable local agencies and organisations to work together in a system where there is a clear shared vision for how to protect and improve outcomes for children.

[3] **Working Together to Safeguard Children (2018)** – is statutory guidance produced by the government which outlines how practitioners working with children and families should work together to safeguard children and promote their welfare.

declined by both parents and their right to do so has been respected. Following the completion of the review, both parents took the opportunity to read the report and make comments about the recommendations.

1.9 The subject child will be referred to as "Zac" throughout this report in order to maintain his anonymity. Identifiable personal details surrounding the mother and Zac's sibling have not been shared as part of this review for legal reasons.

Terms of Reference

1.10 The areas for specific address within the Terms of Reference as identified by the Rapid Review process and approved by the Panel include:

- How to strengthen awareness of the inter-related factors that together indicate the vulnerability of a child.
- Exploration and development of measures that can be taken so that relevant agencies are aware of vulnerable children who are electively home educated.
- Seeking to strengthen local arrangements to ensure that agencies can identify the potential vulnerability of children who move between services and geographical areas.
- Considering the effectiveness of the Joint Agency Response (JAR)[4] as part of the Child Death Review[5] process following the death of the child.

2. Family Context

Family structure at the time of the child's death

2.1 **"Zac"**: Subject child (age 11) – White British male. Recorded as being electively home educated. During his school journey there was no identified unmet needs in relation to race or ethnicity. Additional needs considered by practitioners working with the family were in relation to the child's medical needs and the family response to those needs which are further discussed in this report.

2.2 **"Younger Sibling"**: Attends school. No further information provided to protect the child's identity.

2.3 **"Mother"**: Birth mother. White British, single, unemployed and cared for the children full-time.

[4] **Joint Agency Response (JAR)** - is a process for reviewing child deaths whereby a team of key professionals come together for the purpose of enquiring into and evaluating each unexpected death of a child.

[5] **Child Death Review** – is a process to understand why children die and puts in place interventions to protect other children and prevent future deaths

2.4 **“Father”**: Birth father. White British male. Indicated that he owned a business. Spent time at the family home to visit the children. The abusive nature of the parent’s relationship involved serious coercive controlling behaviours by father which was unknown to professionals during the time period of this review.

Home environment

2.5 Mother was on state benefits and received some financial support from father which allowed her to own a car for transporting the children to school. At the time of Zac’s death, the family had lived at a privately rented property for eight months which was paid for by father on a cash payment basis.

2.6 Prior to this, there had been several address changes (three during the time period) which were not reported to agencies involved as would have been expected. The home environment was said to be very clean and tidy when seen on one occasion for an Early Help Assessment[6] which was being carried out on behalf of school. Father’s home address was given as his mother’s property in Nottingham, but it was later found that he did not really spend any time there. The police investigation found that prior to Zac’s death, father visited the family home morning and evening and was sleeping in the back of his van away from the family address.

Context of family background

2.7 Mother’s information relating to her historical family background was not included in this report for legal reasons.

2.8 The history of the parent’s relationship was that mother had been in full-time employment prior to meeting Zac’s father at an event. Their relationship quickly developed, resulting in her leaving her job and she soon became estranged from her own family and friends.

2.9 Zac was born in 2010 after which the couple separated, but despite this separation the couple had a second child a few years later with an agreement that they would continue to parent their children together.

2.10 Father’s historical family background is unclear, but it is known from his medical record that his parents had separated when he was quite young and had seemingly been estranged. When father was aged eight, he was the subject of an Initial Child Protection Conference[7] followed by him being assaulted by his mother’s partner, the outcome of which is not known. He appears to have spent some time with the parents of his father’s girlfriend and later returned home to his mother’s address after periods of going missing.

2.11 As a young man, father was known to the police for burglary, robbery, possession of offensive weapon, possession of cannabis and offences against the

[6] **Early Help Assessment (EHA)** – is an initial assessment and planning tool which looks at the needs of children and their family to establish ways in which they can be supported.

[7] **Initial Child Protection Case Conference -** is a multiagency meeting held when there are concerns that a child may be at risk of significant harm. The aim is to keep the child safe and ensure their needs are met by supporting family strengths and addressing risk.

court with nineteen convictions in total. In 2007 he (aged 26) was stabbed and seriously assaulted by a number of assailants thought to be members of an organised criminal gang resulting in him sustaining life threatening injuries from which he fully recovered.

2.12 A number of months following this incident (in 2008) he reported to his GP that he was feeling stressed, less confident and had given up smoking cannabis due to him having difficulty breathing following injuries he received during the assault. Then in 2013 he approached his GP with anxiety linked to the assault and was referred to Mental Health Services for Talking Therapy, but he seemingly did not attend the appointment. Also, in 2013 father was arrested by police for fraud which was dealt with at the time with no further police involvement until the incident involving Zac.

3. Significant information and events

Relevant information prior to the timeline

3.1 Zac and his sibling had been born healthy and apart from Zac having some early speech delay there were no child developmental issues identified. There was a number of address changes resulting in some missed health appointments which were appropriately resolved at the time.

3.2 Zac started school in 2016 aged five years and was found to be a happy child of average ability who was able to make friends easily. A short time after starting school there was an incident during a weekend contact with father where Zac was taken to the local Emergency Department with a deep laceration to the top of his forehead requiring suturing. There had been a conflicting story between father and Zac about the way the injury occurred which led to an appropriate safeguarding referral[8] and Child Protection Medical[9] examination concluding that the injury was accidental and consistent with father's story.

3.3 A follow up social worker visit to speak with the child took place at the child's school resulting in no further intervention from Derbyshire Children's Services.

3.4 When Zac moved from Infant to Junior School in 2018 there was a headteacher to headteacher communication about concerns regarding Zac and his mother who was seen to be a "very private person". It was noted that she did not interact with other mothers at school and avoided conversations with teachers. The headteacher shared concerns that Zac had a number of restrictions on his activities in school which had been put in place by mother such as no school trips, not having his surname on schoolbooks and no photographs. There had been some school absences with difficulty in contacting mother and changes in address which were not reported to school. School shared how they had been proactive in working with

[8] **Safeguarding referral** – is a contact to children services because of a concern about a child's safety and well-being.

[9] **Child Protection Medical** – is a full medical examination undertaken by a Paediatrician to look for signs of harm which may have happened to a child.

mother to minimise the restrictions imposed on Zac to lessen the impact on his school life.

3.5 In 2019 it was noted that Zac had a skin condition (psoriasis) which required light treatment at the hospital three times per week which continued for three months. Staff at the hospital became concerned about Zac's sad demeanour and father's harsh responses towards him resulting in liaison with school who shared concerns about Zac stealing food such as chocolate from other children. Until this point school staff had been unaware of father's contact with Zac and had no record of him on their school file.

3.6 The hospital information gathering exercise resulted in a referral to Starting Point (contact and referral service for children's services) who recommended that school should conduct an Early Help Assessment which took place by school through a commissioned organisation who carried out the assessment on the school's behalf.

3.7 The parents had initially been cooperative with the Early Help Assessment process but refused further early help support at the point that they were asked for permission to contact the hospital to gain more insight into the child's health needs. The Early Help Assessment process succeeded in bringing about some temporary positive changes for Zac in terms of him being able to go on a school trip and starting school dinners with his friends. His attendance at school increased to 97% and he was making good progress during this period.

3.8 After a few months (2020) Zac's school attendance dropped to 84%, he was no longer having school dinners (stopped by his parents) and he had again started to steal food from other children. School discussed the issue of Zac stealing food with the parents who reassured the school that they would seek advice about his behaviour from the GP.

3.9 Ten days following this conversation the first Covid 19[10] national lockdown occurred resulting in Zac and his sibling being educated at home like thousands of other children in the UK.

Summary of events within the timeline of the review (September 2020 – June 2022)

3.10 At the end of Covid 19's first lockdown (September 2020), which lasted six months, Zac's sibling returned to school whilst Zac continued to be educated at home. His parents reported that Zac had engaged well with home schooling and they wanted to continue with this.

3.11 The parents wrote to school confirming their intention to home school Zac and following a discussion between the parents and school, Zac was removed from the school roll and a referral to Derbyshire's Elective Home Education Service[11] was

[10] **Covid 19** - stands for coronavirus disease (upper-respiratory tract disease) which became a world-wide epidemic in 2019 resulting in a number of lockdowns and contact restrictions set out by the UK Government to contain the disease.

[11] **Elective Home Education** – is a term used to describe a choice by parents to provide education for their children at home or in some other way they desire, instead of sending them to school full time.

made. Once information had been shared, officers from the Elective Home Education team made efforts to contact the parents by phone. Zac's mother made a return call and a voicemail was left. Subsequent calls made by the business officer went unanswered. Then, owing to an administration error Zac's referral failed to be processed as expected practice resulting in no further action being taken by the Elective Home Education service.

3.12 In November 2020 Zac attended a dermatology appointment at the hospital, where it was found that his skin was in good condition following commencement of new treatment and he was discharged from the hospital. This was the last time that Zac was seen by any professional.

3.13 Seven months passed (June 2021) and on receipt of the annual "school placement list" from the Local Authority Derbyshire Services for Schools to Public Health 0-19 Service it was noted that Zac had moved to Nottingham resulting in his public health record being transferred from Derbyshire 0-19 Children's Service to Nottingham 0-19 Children's Service[12].

3.14 The following month (July 2021) a notification of the parent's intention to electively home educate Zac's sibling was received by the Elective Home Education team which indicated that Zac too was being home educated. Several attempts were made to secure a conversation with parents, but calls went unanswered and a face to face appointment was not kept. Further follow up calls were not answered which was followed up by an email request for mother to contact the service with available dates for consultation, a response from which was never received resulting in no further action.

3.15 Three months later Zac's sibling took up a placement at a different Derbyshire school with an explanation that he was not coping with Elective Home Education as well as Zac. The sibling settled well in the new school and apart from father's unrealistic request which was rejected for the child to be released from school early to attend swimming lessons there were no issues and Zac's sibling appeared well cared for and he spoke positively about homelife and Zac.

3.16 Zac's 0-19 Children's Service public health record which had been transferred was reviewed in Nottingham in September 2021. The Specialist Public Health Nurse (formally School Nurse) found that Zac had previously lived in Nottingham between 2011-2014 with no health needs identified. An introductory letter was sent to the parents for contact with the service and a call was made to find out which school Zac was attending without success.

3.17 In March 2022 the local authority service responsible for children being home educated in Nottingham contacted their team for children missing education to clarify if there was any school involvement with Zac, noting that the sibling had a different address. It was found that Zac was not known by the service and no further follow up was made. During this period, the family continued to evade support from the relevant Elective Home Education services offered by both Derbyshire and

[12] **0-19 Children Service** – formally known as Health Visiting and School Nursing Service, responsible for promoting the health needs of children.

Nottingham allowing Zac to be in effect lost to the system. By this stage Zac had been off school roll for eighteen months.

3.18 At the time of the incident where Zac was fatally injured, he had been out of school for twenty-one months and was last seen by a professional (health professional at the hospital) nineteen months prior to his death.

The incident

3.19 In June 2022 father called 999 with a fabricated report that his son had an unwitnessed fall from a tree and was struggling to breathe. The location given was a public area in the community. Father claimed that he had put the child in his van to attend hospital but had pulled over because the child looked unwell. A first responder attended the scene within seven minutes. Father reported they had been playing hide and seek and Zac had been found at the bottom of a tree following an unwitnessed fall from approximately four meters high. Following initial emergency treatment Zac was transferred to the nearest Emergency Department where he died of his injuries.

Child death investigation

3.20 The Joint Agency Response (JAR) Team investigating the child's death was undertaken by the Nottingham JAR Team because Zac had initially been viewed as a "Nottingham Child" due to father providing a Nottingham address and Nottingham GP on Zac's admission to the Emergency Department.

3.21 Derbyshire Constabulary appointed a Senior Investigating Officer (SIO) and commenced a child death investigation because the incident had occurred in Derbyshire. A Home Office post-mortem was held following the medical view that the cause of death could not be confirmed. The police investigation was initially based on the hypothesis that Zac had died following a tragic unexpected accident as reported by father.

3.22 Eleven days following the incident a credible witness came forward to make a police statement alleging that father had caused Zac's injuries and subsequent death by assaulting him. Up until this point the police had found difficulty in contacting father with a number of areas for investigation outstanding at that point. A murder investigation was launched and father was arrested and charged with murder. It also transpired at this point that Zac and his family were living at a Derbyshire address and not a Nottingham address as previously indicated.

Police investigation – findings

3.23 The police criminal investigation found that the defining feature within the family was that of father's "horrendous" coercive controlling behaviour which dictated every aspect of the lives of the mother and their children. Father used the fact that he had sustained life-threatening injuries following a criminally motivated serious assault for drug debt in 2007 as a lever to continue controlling his ex-partner following their separation. Father dominated the family by using the rhetoric that they were all in danger from a criminal organised gang when in fact he himself was the danger within.

3.24 The police criminal investigation found that the children had been treated very differently at home with the sibling being the favourite child. For example, the sibling owned a quad bike, given treats and allowed to go to school whereas Zac (age 11) had not been allowed the same privileges and had not been allowed to leave his bedroom or get out of bed until his father arrived at the house in the morning.

3.25 It is now known that the fatal physical assault happened at home when father suddenly lost his temper with Zac. Following the attack father initially left the home and returned later to take Zac out of the house and drove to the location where he eventually called emergency services as Zac's condition deteriorated. It was found that father had fabricated the story of Zac having a fall to deliberately deceive professionals and to cover up what he had done.

Outcome of the criminal trial

3.26 Initially Zac's father pleaded not guilty to murder but he later changed his plea to guilty resulting in a custodial sentence with a minimum term of twenty-one and a half years before being considered for parole. The presiding judge said that "whatever happened was a result of you going crazy" and that Zac "may have survived with prompt and appropriate treatment" and then "you tried to cover your tracks". The court heard that the father "had tried to cover up what happened at the family home by stripping almost every item one would expect to find in a home, even the meter was missing and there was no power to the premises".

3.27 At the end of the criminal case the court heard that Zac had "loved singing and lining up his teddies in his bedroom" and he was "special and beautiful and creative".

4. Analysis and Key Learning Themes

4.1 Analysis and learning have been drawn from the Rapid Review process, LCSPR panel members, practitioners attending the learning events and Independent Reviewer.

Key learning themes include:

- Coercive control.
- Recognising and safeguarding vulnerable children.
- Impact of Covid 19.
- Elective Home Education.
- Transient families and cross border issues.
- Child Death Review processes.

5. Coercive Control

Introduction

5.1 *"Coercive controlling behaviour by a perpetrator is an act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm,*

punish, or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour". (Women's Aid).

5.2 Coercive control is not only an act of domestic abuse towards another it is also a form of child abuse (emotional abuse) which can have a profound negative impact on child victims who are exposed to the perpetrator's toxic and dangerous behaviours.

Hidden men and coercive controlling behaviour

5.3 Firstly, it should be made clear that at no time did any professional working with Zac and his family suspect that coercive control was a feature within the family. It is only with the benefit of hindsight using information found during the police investigation into Zac's death that coercive control has been found to be a significant feature in this LCSPR.

5.4 "Hidden men" is a descriptive term used in safeguarding to describe men who may either a) avoid attention and may pose a risk to a child or b) are ignored and could have helped to nurture a child. NSPCC (2015) found that professionals tend to focus on the quality of the mother's caregiving and can often overlook the role and impact of fathers and father figures in the child's life.

5.5 The police investigation has found that the impact of father's coercive and controlling behaviour and narrative of fear resulted in the family shrouding themselves in secrecy and spending no more than two years at one address with several moves around the area between Derbyshire and Nottinghamshire. Mother appeared to keep herself and her children steadfastly private by her not engaging with other mothers, not allowing school trips, not allowing surnames on books and no photographs of the children. Whilst these behaviours raised concerns in school, who had felt "something was not quite right", there had been no evidence of physical abuse or domestic abuse which would have prompted an opportunity to alert Children's Social Care for intervention.

5.6 Father had initially been a "hidden man" to school over a number of years. School had no record of his existence until the hospital staff at the dermatology department contacted them to enquire about Zac's wellbeing. Once teachers in school became more interested in the family, father seemingly took over the situation and was found to be confrontational, challenging and used verbal threats about knowing his rights and knowing people in high places to manipulate the teachers into backing away from the situation.

Learning: There is a lesson here for professionals to be alert to the significance of "hidden men" who manage to stay out of sight until something happens to threaten the status quo resulting in them taking steps to prevent professionals from finding out what is happening at home which seemingly occurred in this case. **(Area for training and awareness raising).**

Learning: With the benefit of hindsight, this case illustrates the dangerousness of coercive and controlling individuals and the damaging impact they can have on their partner/ex-partner and on their children. Professionals need to remain alert to the personality traits of coercive and controlling individuals, the secretive behaviours of their victims and the possibility of domestic abuse at home. Additionally, this learning should be brought to the attention of the Derbyshire Safer Communities Board. **(Area for training and awareness raising and relevant to Recommendation 1)**

6. Recognising and Safeguarding Vulnerable Children

6.1 Recognising and safeguarding vulnerable children is a key role of all agencies working with children and families under the statutory guidance of Working Together to Safeguard Children (2018) which was in place at the time. In this case there had been two historical safeguarding referrals and an Early Help Assessment which are relevant to this LCSPR. An additional area of learning was found in how schools can recognise and respond to vulnerability in children with health needs.

Safeguarding Referral – 1

6.2 The first historical safeguarding referral took place in 2016 following Zac (age 5) being presented by father to the Emergency Department with a laceration to his forehead. When asked how it had happened Zac said “he (father) did it”. Father gave an alternative story of it being an accident whilst Zac had been playing tug of war with his younger sibling who was aged two.

6.3 Staff were appropriately concerned about the inconsistent story surrounding the injury and made a safeguarding referral resulting in a Children's Social Care assessment and a Child Protection Medical examination which took place the following afternoon. The findings of the medical examination were that the mechanism of Zac’s injury had been in line with father’s explanation. However, it was of note that father was present at the medical which may have compromised the procedure given that best safeguarding practice suggests that children should not be questioned about any allegation in the presence of their suspected perpetrator.

6.4 The case was closed after a children’s social worker spoke with Zac at school in the presence of his teacher. Whilst Zac confirmed his father’s story there was no way of knowing if Zac had been “groomed” to provide his father’s version of events or if Zac’s original allegation had been intended to mean something else.

Learning: In response to this historical incident the DDSCP are committed to reinforcing the need to effectively listen to children when making a possible allegation of abuse and to expedite action in response to safeguarding concern. The aim is to protect the child who would otherwise be left to the devices of the perpetrator who may then threaten and cajole the child to prevent them from speaking out again. **(Area for training and awareness raising)**.

Safeguarding Referral - 2

6.5 The second safeguarding referral occurred three years later in early 2019 when Zac was with his father for a hospital appointment (father was present for all

hospital appointments) at the Dermatology Out-Patient Department where he was attending three times per week for treatment of a skin condition. Staff at the hospital were concerned about Zac's sad demeanour and father was observed to be unreasonably angry and speaking harshly to him. Father had then appeared to have "gone over the top" when staff made a reasonable enquiry about the situation.

6.6 There was good practice by the way hospital staff considered emotional abuse and worked to safeguard Zac and to defuse the situation. They demonstrated a good level of professional curiosity and good record keeping about what had been discussed and actions taken. Safeguarding advice via the hospital safeguarding lead had been sought at the time which resulted in a short period of monitoring and information gathering which included a discussion with the 0-19 Children's Service (school nurse) and the child's school who had been completely unaware of father until their conversation.

6.7 School revealed that Zac had appeared more withdrawn and he had been stealing sweets and chocolate bars from other children in school. The hospital safeguarding information gathering exercise led to them making a safeguarding referral to Starting Point (contact and referral service for children's services) which met the threshold for an Early Help Assessment to be undertaken. Father's reaction to hospital staff's concerns was to make threats regarding making a complaint at the hospital about their actions.

Learning: There was good practice by the way that staff managed to maintain ongoing treatment for Zac following making a safeguarding referral against father's wishes without the relationship between father and staff breaking down. This situation highlights the importance of honest and open dialogue with parents when there are safeguarding concerns and demonstrates how staff can continue to work effectively with parents when relationships become strained. **(Good practice)**

Early Help Assessment

6.8 The full detail of what happened during the Early Help Assessment process has not been fully explored with the practitioners involved because they have moved on from the service and were not available to contribute.

6.9 Following the hospital referral into Children's Social Care, the Local Authority advised school to conduct an Early Help Assessment following appropriate triage and application of procedure at the time. A specialist organisation commissioned by the school conducted the Early Help Assessment on the school's behalf and were aware of the concerns raised by the hospital and school.

6.10 The completed Early Help Assessment analysis was that the parenting style was a "little too restrictive" presumed to be borne out of worry and concern for Zac's skin condition. There was identified concern that Zac displayed negative behaviours in school due to the limitations at home and recognised that the strict routines may be manageable whilst the children are young but would need to be adapted as the children became older. The parents were happy for their home to be viewed, which was found to be very clean and tidy. The Early Help Assessment concluded that the children were not at any significant risk.

6.11 As part of this review a separate written “Contact Log” from the Early Help Assessment home visit has been seen which outlined the detail of the home visit and reveals a number of issues omitted from the Early Help Assessment form which was submitted back to school. For example, it showed that the children had very little extended family life, with no extracurricular activities or social interactions outside the family home. The children were made to keep to a very strict rigid seven day per week routine which included being in bed by 6:30pm. Also, the children were not allowed to run around at home and dietary restrictions were placed on Zac blaming this on his skin condition.

6.12 These restrictive routines and boundaries were beyond expected norms and there was an opportunity to explore and consider the nature and impact of these restrictions on the wellbeing of the children with other agencies and professionals beyond school which did not take place.

6.13 The contact log reflected that the home visit took three times longer than had been planned for and the parents watched over the Early Help Assessment reviewer whilst they typed up the relevant form, with the parents insisting that only their exact words were used.

6.14 On reflection and with the benefit of hindsight the Independent Reviewer considers that the behaviour of the parents demonstrated a level of intimidation and manipulation which is clearly not in the spirit of partnership working. With hindsight it is probable that this was a ploy by the parents (or father) to ensure that the Early Help Assessment was seen in a positive light so as to complete the process as soon as possible in order to close down involvement with the “authorities”.

Learning: There is learning here for those who conduct Early Help Assessments where parents try to intimidate and control proceedings because it is likely that the parents may be trying to hide the truth. Practitioners should be mindful that they are at liberty to adjourn meetings with parents when they are over running their time or feel they are not able to work in the spirit of partnership. It is often helpful to revisit the issues at a later date and to keep dialogue open for a longer period. Time out away from the situation for safeguarding supervision is also a useful tool for reflection and to consider the need to escalate concerns. **(Relates to Recommendation 2).**

6.15 It was recorded on the Early Help Assessment form that there was no history of domestic abuse which was based on what is now known to be the false narrative provided by the parents. The couple’s relationship was not fully explored beyond that they had separated and agreed to co-parent their children.

Learning: Strategic leaders and professionals working with children should be aware of the DDSCP Guidance for Completing a Family Early Help Assessment (2020) which requires the consideration of the presence of all forms of abuse (including domestic abuse) neglect and violence as part of the assessment process. This should include seeing parents separately so that routine questioning in line with Safe Lives principles can take place in order to fully support and protect parents and their children. **(Relates to Recommendation 2)**

6.16 On a further note the voice of the child was not represented within the Early Help Assessment. Zac was eight years old at the time (sibling aged 5) and able to communicate effectively. However, it does not appear that any professional spoke to Zac directly on his own about what life was like at home or to check that he knew how to ask for help if he required any support.

Learning: This is a reminder to all professionals working with children, that when there are concerns about a child's welfare, children should be spoken to alone to reassure them to speak out at times when they need support. **(Relates to Recommendation 2)**

6.17 The areas of learning identified within the Early Help Assessment process highlights the importance of management oversight to ensure that any gaps or barriers experienced during the assessment process can be fully reflected and addressed through supervision and support.

Learning: It is the responsibility of strategic leaders in all agencies to effectively enable practitioners undertaking Early Help Assessments to have access to good quality management oversight and supervision. This is to ensure there is an opportunity for practitioners to reflect on concerns and address any gaps in the assessment. **(Relates to Recommendation 3).**

Child health and vulnerability

6.18 All children with health needs have increased vulnerability owing to the nature of their circumstances and some children may need to rely on school staff to support them throughout the school day. (Gov 2015)

6.19 0-19 Children's Service (previously known as health visiting and school nursing services) are available to all schools to promote the child's health needs and to assist schools in the health care management of children as required.

6.20 As previously mentioned, Zac attended hospital for the treatment of a skin condition which involved being taken out of school two or three times per week over a period of three months. In addition to the treatment, his parents gave him several restrictions over a number of years which included no chocolate or sweets, no school trips, no physical activities including physical education and no playing in the playground to prevent him running around. These restrictions were applied by school (with some reservation) on the insistence of parents.

6.21 Healthcare advice was considered by the Early Help Assessment lead following their home visit, who requested consent from the parents to speak with the hospital staff to obtain first-hand advice on Zac's condition to better understand what was best for Zac. This request was firmly denied, with the parents withdrawing their cooperation and requested they had no further contact with the Early Help Assessment service, resulting in the case being closed.

6.22 There was a handover discussion between school and the Early Help Assessment lead professional in conclusion to the assessment resulting in a meeting between parents and school, where a closer working relationship was agreed and

with parent's reassurance that they would provide relevant hospital information which never materialised. Father was found to be overly challenging to the teachers at the meeting and negative towards Zac, saying to him in front of the teachers that he was a “dirty little thief”. This lack of empathy and emotional warmth towards Zac by his father should have prompted consideration around emotional abuse given that the original rationale for the Early Help Assessment followed emotional abuse concerns raised by the hospital.

6.23 Despite the challenges during the Early Help Assessment and school meeting this did result in some temporary reduction in restrictions in school resulting in Zac’s improved behaviour and progress. Research is clear that behaviour problems in children (such as stealing food from other children) can be an expression of distress caused by being maltreated (Department for Education 2022). There was a possible reachable moment at this stage to escalate concerns that had begun to emerge at school. However, based on what was known at the time school felt that the grounds for making a safeguarding referral were not sufficiently clear and the school took the decision to continue to monitor the situation.

6.24 When the restrictions on Zac were recommenced by the parents, Zac’s attendance and behaviour in school declined and he started stealing food again from other children. Professional curiosity, involving discussion between the school and other statutory partners, in the best interest of the child, may have provided the opportunity for wider reflection. There was an opportunity to consider if Zac’s behaviours were indicative of Zac being hungry due to lack of food or exhibiting behaviour linked to distress in response to the restrictions placed upon him.

6.25 Reflection may have led to a view that Zac’s behaviours could be indicative of more serious concerns such as emotional abuse or neglect and that the cumulative picture of behaviours being exhibited by parents and especially that of father may have highlighted concern about Zac’s lived experience at home.

6.26 Schools and other professionals will find themselves presented with behaviours by children and young people which are difficult and where the causes are unclear. School staff need to remain professionally curious about children with health conditions when restrictions on a child’s daily activities in school are insisted upon by parents.

6.27 A partnership approach between child, parents, school and healthcare professionals should be encouraged in these situations to ensure that school can best promote the health and wellbeing of the child. In cases where parents are uncooperative and it is unclear if parents are placing realistic restrictions on a child in school for medical reasons, it is reasonable for practitioners to seek advice without the parents’ permission in the best interest of the child.

Learning: Professionals should make use of their internal safeguarding arrangements and the available multiagency advice lines to reflect on and strengthen their thinking regarding vulnerable children in their care and to escalate safeguarding concerns as factors emerge. **(Relevant to Recommendation 3)**

Learning: All should be mindful that information sharing and gathering (with or without parental permission) in the best interest of the child is permitted and is an expected part of effective safeguarding practice. (**Area identified for training and awareness raising)**

Progress: As outlined in a letter following Derbyshire's Inspecting Local Authority Children Services (ILACS) in 2023 which quotes that: "Threshold of risk, need and harm to children are understood and applied by experienced and knowledgeable workers from across the partnership".

7. Impact of Covid 19

Introduction

7.1 Covid 19 was a world–wide pandemic causing severe respiratory problems which first became known in 2019. The highly contagious nature of the disease led to a number of nationwide lockdowns and government rules to limit personal contact to reduce the spread of the disease. This led to school closures with the exception of a few children who were considered "at risk" or had parents working in public services on the front line. Hundreds of thousands of children were kept at home during this period and much has been written in the public domain about the negative consequence of Covid 19 lockdowns on the futures of children.

7.2 A report by the NSPCC: "social isolation and the risk of child maltreatment" (June 2020), raises issues of the negative impact of Covid 19 national lockdowns, suggesting that stressors and vulnerability within families would increase as the connection with support services reduced. The key concern was that for children who were already experiencing abuse or neglect by household members, confinement at home meant prolonged exposure to potential harm.

Consequence of Covid 19

7.3 When Zac's behaviour and attendance started to decline (March 2020) and he was stealing food again, school contacted the parents who said they would take Zac to the GP to check why he was hungry in school following which parents claimed that Zac was going for a blood test. Covid 19 lockdown occurred prior to the alleged blood test taking place with no feedback from parents as had been previously agreed.

7.4 Despite school trying to contact the family on several occasions (as they did with all families) the family were found to be uncontactable. This raised further concern with the teaching staff who on one occasion insisted on seeing the children when mother attended school to return the children's completed work books and to collect new work. Both children were seen in the back of mother's car with no new concerns being raised.

7.5 Covid 19 lockdown ended for schools after six months with Zac's expected return to school however, his parents took the option to continue educating Zac at home stating that he had settled well with home education and they wished this to

continue. School contacted the family to discuss school options but parents were adamant that Zac was to be home educated in future. This in effect ended the relationship with the school and Zac became hidden from view.

Learning: Professional curiosity is essential when working with uncertainty as is following up on any issues which may result in a safeguarding concern. Previous learning has already been identified in a number of Child Safeguarding Practice Reviews in that vulnerable children are at greater risk when they can no longer be seen and heard by professionals on a regular basis. The Covid 19 lockdown was highly significant in this case which is a further example of how parents who want to escape the scrutiny of professionals could use Covid 19 as an opportunity to hide child maltreatment. **(Area identified for training and awareness raising)**

8. Elective Home Education

Introduction

8.1 National guidance makes 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). 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 provide elective home education for their children are expected to provide an educational package which is relevant to the child's age, aptitude and academic ability.

8.2 Local authorities have no duty in relation to monitoring 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 which is the task undertaken by the Local Authority Elective Home Education Service.

Local Elective Home Education processes

8.3 In this case, like hundreds of other children Zac began home education in September 2020 at the end of the Covid 19 first lockdown. The parents provided a letter to school outlining that the move was in line with Zac's wishes and that relevant education websites were being used to educate him at home. At this point, Zac was at the educational stage where if he had remained at school, he would have commenced preparation for his year six Standard Assessment Tests and be considering transition into secondary education. Instead of this, Zac became inadvertently lost within the Elective Home Education system.

8.4 Seven months following Zac leaving school the Elective Home Education Service became aware of Zac for a second time, when they were notified that Zac's sibling was to be home educated also. Officers made several attempts to make contact with the family without success. With the benefit of hindsight, it is probable that the parents were evading contact with the service to keep Zac isolated.

8.5 Following Zac's death, the Local Authority was concerned that mistakes had been made within the Elective Home Education service and other services, which led to an Internal Individual Management Review being conducted to review its processes leading to service improvement. The review acknowledged that following Covid 19 there had been higher than usual demand on the Elective Home Education service who were managing on limited resources at the time. The sharp increase in numbers of parents opting to home educate their children following Covid 19 has been recognised as a national trend. Key findings of the review were that there had been some administration discrepancies resulting in an Elective Home Education Officer not being informed of Zac's elective home education status with no further action taking place.

Progress (1): The review of the elective home education processes at Derbyshire County Council led to implementation and successful roll out of an online reporting tool for school notifications of deregistration; a named officer allocated to a cluster of cases; initial contact with families undertaken within the first 6 weeks following deregistration notification; all families contacted within the timescales; new staff induction including robust safeguarding training; improved arrangements for communication between the service and families; increased resource; improved processes for information sharing between Elective Home Education, Children Missing from Education, Early Help and Safeguarding and Starting Point services. **(Relates to Recommendation 4).**

Progress (2): As outlined in a letter following Derbyshire's Inspecting Local Authority Children Services (ILACS) in 2023 which found all areas to be good and reported that: *"The number of children who are electively home educated is steadily rising. The local authority has strengthened its oversight of this group of children, particularly those who are vulnerable. Any children who are not in receipt of a suitable educational provision are referred promptly to the Children Missing Education team to respond".*

Safeguarding and transfer from school to Elective Home Education

8.6 The LCSPR found that when Zac first commenced Elective Home Education the headteacher of the school contacted the Elective Home Education service to inform them of their safeguarding concerns and were told to keep their concerns on file with no further action taking place which was below accepted standards of safeguarding practice and should have been addressed at the time.

8.7 The specifics for addressing the increased vulnerability experienced by children who are being electively home educated are not covered by the Working Together to Safeguard Children (2018) statutory guidance and 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. The Independent Reviewer has found that there is seemingly a tension between the legislation enabling the rights of parents to home educate versus the rights of children to be effectively safeguarded. Schools have a duty of care to work effectively with the Elective Home Education service to be assured that all issues relating to a child's

vulnerability and any safeguarding concerns are fully understood and records shared as part of routine handover.

Progress: From April 2024, an improved computerised system has been in use which does not allow a child to be de-registered from a school roll until safeguarding information has been uploaded and shared with the Elective Home Education service. **(Relates to Recommendation 4).**

Progress: The Child Safeguarding Practice Review Panel has published a briefing (May 2024) on elective home education in England. The briefing “Safeguarding children in Elective Home Education” highlights the learning themes from local Rapid Reviews and Child Safeguarding Practice Reviews. The need for a National Register has been emphasised and the Panel welcomes the suggestion that a meeting between parents, School and the Elective Home Education service should be held at the point that a child is removed from school roll to enable greater understanding of the needs and vulnerabilities of the child to ensure that safeguarding arrangements are considered as relevant**. (Relates to recommendation 4).**

Elective Home Education and links to public health services

8.8 The LCSPR found that Derbyshire County Council has an information sharing protocol in place between the Elective Home Education service and health professionals which is fully compliant with general data protection regulation (GDPR).

8.9 At the time of this review, there was a “school placement list” sent annually to the Derbyshire 0-19 Children's Service to share relevant information. There was no “real-time” information sharing process available to alert the 0-19 Children Service when children came off school roll to be electively home educated and no "real time" system to indicate when a child moved to a new address in a different area.

8.10 The annual nature of the system in place resulted in a significant delay of several months before Derbyshire 0-19 Children's Service were aware that Zac had moved to a Nottingham address which provided the trigger for his health records to be transferred to Nottingham 0-19 Children's Service to alert them that the child was now in their area.

8.11 It is the case that both Nottingham and Derbyshire 0-19 Children's Service provide a targeted health service to children being electively home educated (and all other children) which involves health monitoring and support in relevant cases which can only be offered once they are aware of the child’s Elective Home Education status in their area which in this case was delayed for several months. This is an area for consideration by Derbyshire Local Authority in terms of ensuring all school age children have their health and wellbeing adequately promoted.

Progress (1): In Nottingham the Local Authority Education Welfare and Education other than at school (EOTAS) Service are responsible for Elective Home Education. The service has an information sharing agreement with the 0-19 Children's Service in their area, to regularly share information, with parental consent, in relation to those children who are electively home educated.

Progress (2): In Derbyshire, school placement lists for children who are known to the local authority to be electively home educated as advised by their parents or carers, is shared with the 0-19 Children's Service (Derbyshire Community Health Services) three times per year. The review understands that this reflects progress and will support the effective sharing of children's health records across geographical borders where it is known that a child has a home address outside of Derbyshire.

Learning: There is a reminder here about the importance of having robust Elective Home Education arrangements and robust pathways supporting routine communication between schools, Elective Home Education services and 0-19 Children's Services to prevent silo working and promote the health and wellbeing of children. **(Relates to Recommendation 4).**

National register for Elective Home Educated children

8.12 There were discussions at both practitioner learning sessions and the LCSPR Panel meetings about the need for a National Register for children who are electively home educated. This issue has been further verified by the House of Commons Education Committee on “Strengthening Home Education” Third Report Session 2021-22.

8.13 The spring 2023 census identified that the number of electively home educated families known to local authorities had risen to 86,200 and estimated that 116,300 children were electively home educated during the academic year 2021/2022. However, these figures cannot be confirmed due to a lack of compulsory registration to Local Authority registers. This means it is easy for families to go ‘undetected’ by Elective Home Education services and for children to miss out on a suitable education.

8.14 The LCSPR considered that the presence of a UK Government National Register for Elective Home Educated Children, which is currently going through parliament, may have in this case prompted the Elective Home Education service to make effective contact with the family and would have provided the means for relevant professionals (including the 0-19 Children's Service) to make checks on an individual child’s whereabouts and educational progress.

8.15 DDSCP remain committed to highlighting the need for a National Register at the Association of Elective Home Education Professionals meetings where the need for a register has been escalated. The Local Authority has taken part in Elective Home Education – Department of Education - guidance consultation (January 2024) which includes references to the implementation of a national register for children receiving Elective Home Education. **(Good practice)**

9. Transient Families and Cross Border Issues

Introduction

9.1 Children and families who move more frequently between local authority areas include homeless families, asylum seekers and refugees, traveller and Roma families and families experiencing domestic abuse. Also, it is the case that some

families in which children are harmed move home frequently to avoid contact with concerned agencies, so that no single agency has a complete picture of the family requiring vigilance and professional curiosity. (NSPCC).

9.2 Working Together to Safeguard Children (2018) statutory guidance is clear that cross border cooperation between statutory agencies is key in tracking, managing and promoting the welfare of children during transitions as they move from one area to another. The expectation is that services professionals will promptly notify and discuss issues (as relevant) with their cross-border counterparts, and that written or electronic information should follow at the earliest opportunity.

9.3 Safeguarding transient children is a challenge because often families will move without telling the agencies involved which can leave children increasingly more vulnerable as the services they may have relied on (such as a nurturing school) are removed from their network of safety.

Local cross border transfer arrangements

9.4 In this case, agencies working with the family were unaware that they were regularly moving addresses between Derbyshire and Nottinghamshire. The review found that the majority of systems and processes for transferring information between the two counties were effective. However, as previously identified, there was a procedural time delay (in Derbyshire) by the way that "school placements' lists" were issued to the 0-19 Children's Service on an annual basis only. This often results in children living in a new area for several months before the child's health record is transferred to the new area where they may have already moved on. This area of practice has since been resolved as reported in paragraph 8.11.

9.5 A further matter in this case was that it was only Zac and not his brother who was found to have changed address. The systems in place did not adequately account for two siblings living at different addresses and with no built-in process to alert professional curiosity to find out the reason for the change in circumstance.

Learning: Children's vulnerability can increase as they are moved from area to area and as their family structure and situation changes. Effective cross border arrangements which are timely and professionally curious are key to safeguarding transient children and promoting their welfare. **(Relates to Recommendation 4)**

10. Child Death Review Processes

Introduction

10.1 Child Death Review and Statutory Operational Guidance (England) (Gov 2018) and Sudden Unexpected Death in Infancy and Childhood - multiagency guidance (RCPCH 2016) sets out a number of key processes which need to take place following the death of a child.

10.2 All relevant processes have been fully scrutinised as part of this LCSPR in response to Zac's death, where it was initially found that his death was the result of a tragic accident when in fact Zac had been physically assaulted and murdered by his father.

Emergency response

10.3 A 999 call was made by father in respect of Zac's deteriorating condition with a story that he had fallen. The call handler gave appropriate advice and a paramedic arrived at the scene within seven minutes in line with service standards.

10.4 On assessment Zac was found to have multiple injuries and approaching cardiac arrest. Resuscitation immediately commenced and HeliMed (helicopter ambulance) was requested and attended the scene where advanced life support commenced (good practice). Police attended the scene to support proceedings and relevant child safeguarding referrals to Derbyshire Children's Services were made as expected practice.

10.5 Zac was taken to the Emergency Department in Nottingham where he was appropriately treated at the major trauma centre by a specialist trauma consultant and Paediatric Trauma Team who are skilled in the management of serious injuries in children. Despite all their best efforts, Zac sadly died of his injuries.

10.6 The story provided by father in the Emergency Department was felt to be consistent with the presenting injuries. Father gave a history of himself and Zac playing hide and seek when father heard Zac fall approximately four metres. In the absence of any witnesses in the public area, father reported that he had carried the child to his van to take him to hospital but stopped at the roadside because he felt Zac was deteriorating. This story became the initial working hypothesis for the child's death.

Initial child death investigation

10.7 Immediately following Zac's death, a Joint Agency Response (JAR) was initiated in line with Nottingham Child Death Review processes as Zac was believed to have a Nottingham address. Derbyshire Constabulary retained primacy for the child death investigation because the incident had occurred in Derbyshire.

10.8 The initial impression had been that Zac had died following a tragic accident however, the joint external examination of the body by the trauma consultant and police could not confirm the cause of death. Following a medical peer review the next working day, concerns were raised about the mechanism of injuries and the case was referred to the Home Office for post-mortem examination in line with expected practice.

10.9 The initial post-mortem findings were that the mechanism of injury was consistent with the history given. However, as further information came forward including medical photography and police information it was concluded that Zac's injuries could not be explained by a simple fall (from a tree) as there had "been multiple impacts to multiple planes of the body" (as reported in October 2022).

10.10 Derbyshire Constabulary established an investigative approach to determine the circumstances of the alleged accident. The aim of the police was to make arrangements with father to conduct a first account interview and visit the scene which remained unresolved until his arrest. Police progress was hindered by father's avoidance of any contact with them.

10.11 Nottingham JAR Team conducted their review as expected practice, seeing both parents at separate addresses as determined by the parents. The JAR Team had been unaware at the time that false addresses had been given and no concerns had been raised at either visit.

10.12 Later when the Nottingham JAR professionals (who were highly skilled and astute) discovered that father had been totally disingenuous in everything he had told them, they were astonished at the level of manipulation and control he was able to exert over them. On reflection they could find nothing during the visit that alerted them that anything was wrong. This demonstrates how parents can manipulate professionals into believing false stories about children who have been abused in their care.

Learning: As part of the reviewing process there was an acknowledgement by Derbyshire Constabulary and Nottingham JAR Team that Child Death Review protocols are interpreted slightly differently by each area which was highlighted during cross border working. **(Relevant to Recommendation 5).**

The disclosure

10.13 A reliable witness disclosure was made to the police that Zac was physically assaulted by father at home which was in Derbyshire and not at a Nottingham address as previously indicated. This resulted in all relevant Nottingham JAR information being forwarded to Derbyshire for their attention in line with expected practice and the case was closed to Nottingham.

10.14 Following this disclosure, Zac's father was arrested and subsequently convicted of murder. Derbyshire Children's Services appropriately held a strategy meeting under Section 47 of the Children Act 1989 on behalf of the sibling and a home visit to check the welfare of the child took place to find that the home had been stripped of all possessions and items that one would expect to find in a standard family home. Safeguarding arrangements were immediately commenced in the best interest of the sibling.

11. Conclusion

11.1 The death of any child is a tragedy and for a child to die in such a violent way by the person who professed to be protecting them is abhorrent. The nature of the abuse of the child in this review demonstrates that parents can disguise what is happening to a child at home and demonstrates how Covid 19 and Elective Home Education could be used as a tool by parents to deliberately evade statutory

agencies to keep children hidden from interested professionals and allow child abuse to continue uninterrupted.

11.2 This review highlights a number of areas of learning for consideration by Derby and Derbyshire Safeguarding Children Partnership to strengthen their local area safeguarding systems and practice, to seek greater assurance of the safety and wellbeing of children who are less visible to services.

Areas identified for training and awareness raising:

- The dangers and abusive nature of coercive control including how to recognise the signs in parents and their children.
- Safe Lives principles on domestic abuse as part of the wider safeguarding arena.
- How to listen to children and effectively respond when they allege possible abuse.
- Where, how and when to request safeguarding advice and supervision.
- Have an understanding of the relevance of hidden men.
- School's role in managing vulnerability in children with health issues in school.
- Understand the role and when to refer to the of 0-19 Children's Service.
- Information sharing without parental consent in the child's best interest.
- Understanding that parents who harm their children can be untrustworthy and manipulative.
- The safeguarding needs of children less visible to services – lessons from Covid 19.

12. Recommendations

Recommendation 1

DDCSP should share the learning of this review with its multiagency partners, Derbyshire Safer Communities Board and with Nottingham City and Nottinghamshire Safeguarding Children Partnerships.

A focus on briefing agency partners in Derbyshire, particularly schools in relation to promoting awareness as to the importance of management oversight and quality assurance of commissioned early help services would be advisable.

Recommendation 2

DDSCP should audit Early Help arrangements in 2024 with a focus on the quality and content of assessment and analysis including;

- Whether the purpose of the Early Help Assessment is clear and in line with threshold and Early Help procedures.
- Evidence of multi-agency information gathering and liaison including seeking advice from the 0-19 Children's Service where there are identified health needs.

- Evidence of a “think family” approach including consideration and understanding of all family members voices (especially children) and their lived experience.
- Whether there is thorough analysis of risk, need, protective factors and strengths.
- Evidence of the consistent use of appropriate assessment tools and guidance

Recommendation 3

DDSCP should seek evidence from partner agencies about the measures they have in place for safeguarding cases to assure themselves of the quality of management oversight and supervision including;

- Evidence that practitioners are supported to stay alert to and explore gut feeling regarding domestic abuse, coercive control and neglect issues.
- Evidence that training on domestic abuse and coercive control is promoted and monitored.
- Evidence that practitioners are being supported through their internal safeguarding arrangements and available multiagency advice lines. The aim is to ensure that practitioners have sufficient opportunity to reflect on parental barriers to engagement, decision making, next steps and escalation especially where parents have been uncooperative with the Early Help Assessment process.

Recommendation 4

Derbyshire Local Authority to provide a scrutiny report to DDSCP by October 2024 which focuses on the impact and effectiveness of communication and information sharing arrangements between schools, the Elective Home Education Service, 0-19 Children's Service, Children Missing from Education Service (including cross border arrangements) with reference to:

a) Handover between school and Elective Home Education service to include;

- The consistency and quality of pre-elective home education meetings and evidence that there is a focus on safeguarding and vulnerability concerns.
- The inclusion of quality safeguarding information in school's de-registration processes.
- The consistent use of the vulnerability register.

b) Contact between Elective Home Education service and families including:

- Assurance that defined frequency of contact is met.
- The quality and frequency of the liaison between the Elective Home Education Service and the Early Help Service.
- Assurance that domestic abuse alerts are recorded where appropriate.

c) School placement lists including:

- Assurance that data about children who are electively home educated is being effectively shared with the 0-19 Children's Service within agreed timescales.

d) IT sharing platforms including:

- Evidence that enhancements to the IT system has improved data sharing.

Recommendation 5

Derbyshire, Nottingham and Nottinghamshire child death leads should facilitate a specific meeting to include, Integrated Care Boards, Local Authority and Police members, to consider how the Joint Agency Response guidance can be strengthened to promote cross border working in relevant situations when a child dies suddenly and unexpectedly. Also, to include the specifics of when children die following unwitnessed injury.

13. References

Working Together to Safeguard Children (2018) HM Gov.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

Coercive Control – Women's Aid
https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

Supporting children at school with medical conditions (Gov.UK, 2015)
https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

Controlling or Coercive Behaviour in an Intimate or Family Relationship (2015) Home Office
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

Recognising and responding to abuse (2023). NSPCC
https://learning.nspcc.org.uk/child-abuse-and-neglect/recognising-and-responding-to-abuse

Effects of child abuse (2023) NSPCC
https://www.nspcc.org.uk/what-is-child-abuse/effects-of-child-abuse/

Social isolation and the risk of child abuse during and after the Coronavirus pandemic (2020) NSPCC.
https://learning.nspcc.org.uk/research-resources/2020/social-isolation-risk-child-abuse-during-and-after-coronavirus-pandemic

Strengthening Home Education (2021) House of commons Education Committee
https://committees.parliament.uk/publications/6974/documents/72808/default/

Child Death Review: statutory and operational guidance (2018). HM Gov.
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

Serious Case Reviews 1998 – 2019, continuities, changes and challenges (2022). Department of Education
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1123293/Serious_case_reviews_1998_to_2019_-_continuities__changes_and_challenges.pdf

Safeguarding children in Elective Home Education (May 2024). The Child Safeguarding Practice Review Panel. Panel Briefing 3.
https://assets.publishing.service.gov.uk/media/664341d1bd01f5ed32793a9c/Safeguarding_Children_Elective_Home_Education_PB3_May_2024.pdf