



city & hackney
safeguarding
children board

Multi-Agency Case Review

Chadrack Mbala-Mulo

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1. Background Summary

- 1.1 In 2010, Chadrack's mother, Esther Eketi-Mulo, travelled from the Democratic Republic of Congo (DRC) to live with her family in the UK. Ten years earlier, accompanied by his then wife and four children, the man who was to become Chadrack's father, had also moved from the DRC to the UK. Chadrack's parents began a relationship in 2011 although they separated before his birth.
- 1.2 Chadrack was born on 2 January 2012 following Esther unexpectedly presenting at hospital in Hammersmith. Esther's pregnancy had not been booked at the hospital, she had received no antenatal care and was reported by medical staff as being vague about her family circumstances. The hospital was concerned about Esther's capacity to care for her baby due to her being young, vulnerable and seemingly having little support. The hospital also noted that Esther had epilepsy, that she was not attending medical appointments and that she had not been taking her medication.
- 1.3 Due to these concerns, the hospital made a referral to Hackney Children's Social Care (CSC). The subsequent assessment undertaken by CSC identified that Esther had support from her family and that Chadrack was not at any risk. No further action was considered necessary and although the case was closed, a Congolese worker from a charitable organisation was identified to provide ongoing support to Esther.
- 1.4 In January 2013, CSC received another referral whilst Esther and Chadrack were residing in temporary accommodation. This was unrelated to the 2012 referral and resulted in a further assessment being undertaken. Esther was no longer living with her family and whilst no concerns were identified, it was concluded that Esther would benefit from the ongoing help of the Congolese support worker. The case was closed to CSC.
- 1.5 In March 2013, Esther and Chadrack moved into permanent accommodation provided by Hackney Council. In May 2013, Esther registered both herself and her son at a new GP practice.
- 1.6 From a young age, Chadrack was known to have suffered from a number of health issues and in September 2014, he was seen for an assessment at the Complex Communication Clinic in Hackney. At this point it was believed that he probably had autism. He demonstrated severe difficulties with communication, social interaction and play. He was essentially non-verbal.

- 1.7 Also in September 2014, Esther attended hospital having suffered a seizure. She advised health staff that she was epileptic and that she had not been on any medication for three years. The hospital advised Esther to visit her GP and request a referral to neurology.
- 1.8 Esther saw her GP to progress this referral via the NHS '*choose and book*' system¹. This process requires patients to book an appointment by calling a central number and using a password, which is issued at the time of the referral. However, Esther returned to the practice as she was having difficulty doing this. She was seen by a locum GP who advised her to re-book a further GP appointment with an interpreter so that the system could be explained to her.
- 1.9 Esther did not make another appointment with her GP and never attended neurology.
- 1.10 In November 2014, Chadrack started at his first nursery. Esther had also registered at a local college to undertake an English language course.
- 1.11 In June 2015, Chadrack was formally diagnosed with autism by Community Paediatrics. He was subsequently referred for speech and language therapy and work began to develop an education, health and care (EHC) plan².
- 1.12 In September 2015, Chadrack moved to a nursery setting attached to a local primary school, initially attending for morning sessions. This was slowly increased until Chadrack was attending full time from the start of the 2016 spring term. Chadrack's EHC plan was issued in December 2015, with funding allocated to support its implementation.
- 1.13 Esther was very proactive and highly engaged in her son's education. She always attended parents' evenings, workshops and other school events. Chadrack, despite the challenges he faced, was making good progress. He had good attendance and was always clean and tidy.
- 1.14 In September 2016, Chadrack moved into the reception class at school. Shortly afterwards, he was introduced to another school that specialised teaching pupils with complex needs. Esther agreed that this setting was more suited to her son's needs. A review was arranged for 26 September 2016 to facilitate Chadrack's transfer to this

¹ Now referred to as the NHS e-Referral Service.

² An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

school, although this was subsequently rescheduled for 3 October 2016 at Esther's request.

2. Synopsis of Events in 2016

- 2.1 Chadrack had learning difficulties and when his mother died unexpectedly at home in early October 2016, he did not know how to call for help or feed himself properly. He died a fortnight later of dehydration and starvation.
- 2.2 Chadrack was not seen in school after Friday 30 September 2016. On this day, Chadrack did not eat and it was thought that he might have a slight cold.
- 2.3 On Monday 3 October 2016 (Chadrack's first day of absence), the school initiated its procedure for pupil absence. The school attempted to call Esther on the first and second day of absence but received no reply. Esther was the only person listed on the school's emergency contact sheet.
- 2.4 On Wednesday 5 October 2016, the school attempted a home visit, although the member of staff did not gain access to the block of flats due to the security entry system at the main doors.
- 2.5 On 12 October, 2016, the school attempted a further home visit, but again did not get beyond the main entrance. This was Chadrack's eighth consecutive day of missing school and the twelfth since he was last seen.
- 2.6 At the time of Chadrack's absence, the school was engaged as part of the '*Social Work in Schools*' project (SWIS). This initiative, which has since ended, involved a number of schools in Hackney being linked with a senior social worker from CSC. The SWIS social worker would, amongst a range of other responsibilities, act as a single point of contact for advice and guidance. Weekly meetings were held with SWIS social workers to discuss any children about whom there were concerns.
- 2.7 The school and their SWIS social worker met on 12 October 2016. Consistent with the standard operating procedures at the time, the SWIS social worker subsequently provided the school with a summary of the cases that were discussed during this meeting. This included a written narrative about three open cases to CSC and two cases that weren't.

- 2.8 The school's account for this review is that the SWIS social worker was also spoken to about Chadrack's absence. The school report that they were advised the family was not known to CSC and that the threshold for CSC involvement was not met. No further advice was reportedly given by the SWIS social worker on what to do next, other than to make contact again if the school believed that Esther was a danger to her child.
- 2.9 Whilst noting the above, there is no record held by either the school or CSC that confirms this account.
- 2.10 On 12 October 2016, the school also met with Hackney Learning Trust (HLT) as part of a regular cycle of meetings set up to consider children with attendance issues. Chadrack's absence was discussed, with a number of possibilities being considered to account for him missing school (including the family moving or being on holiday).
- 2.11 HLT records of this meeting note that the school was advised to make a referral to CSC and that the school had said this was being completed by the Deputy Head. The school's account is different in that they state no formal referral was being progressed as there had already been a conversation with the SWIS social worker.
- 2.12 Following the meeting, a School Attendance Officer (SAO) from HLT agreed they would also attempt to visit the family home that day. This visit took place, but the SAO did not get beyond the main doors of the tower block where the family lived.
- 2.13 On Monday 17 October 2016, Child C's whereabouts remained unknown and the school again contacted CSC. The SWIS social worker was on leave and another social worker provided the following advice:
- Contact anyone on the emergency contact list provided by parent.
 - Follow up with Hackney Ark³ to see if they have had any contact from Esther about her plans, or have alternative contact numbers.
 - Hand deliver a letter to Esther letting her know that Chadrack is at risk of losing his school place.
 - Check if there are any signs of the family being out of the home for some time (i.e. post collecting in the entrance etc.).
 - If no response by Thursday 20 October 2017, to re-contact SWIS.

³ Hackney Ark is a centre for children and young people with disabilities and additional needs. It brings together services from across the fields of health, education and social care to provide an integrated response to the needs of disabled children and their families.

- 2.14 Later the same day, at 22:53hrs, a cousin of Esther contacted the police to report he had not seen Chadrack and Esther for 3 weeks. He advised that Esther was epileptic and Chadrack was non-verbal. He also advised that the family had never gone missing before, that Chadrack had not been at school and that the school had contacted him. The cousin said he had been to the home, but there had been no reply.
- 2.15 The police responded and at 01:00hrs a decision was made to force entry into the family home. At 01:30hrs police gained access to the flat with assistance from the London Fire Brigade. The bodies of Chadrack and Esther were found in a bedroom.
- 2.16 An inquest into the deaths of Esther and Chadrack was held in April 2017 and concluded that Chadrack lived alone in the family home for over a fortnight after his mother's death. He was found a couple of days after his own death, with his arms around his mother's body.

3. The City & Hackney Safeguarding Children Board

- 3.1 Following notification of Chadrack's death, a Rapid Response meeting was convened in line with the City and Hackney Safeguarding Children Board's (CHSCB's) process for managing unexpected child deaths⁴, with the case subsequently being escalated for formal consideration at the CHSCB's Serious Case Review (SCR) Sub Group.
- 3.2 On 16 February 2017, the Independent Chair of the CHSCB communicated his decision not to initiate a SCR to the National Panel of Independent Experts⁵. The National Panel concurred with his view that the case did not meet the criteria as defined in 5(2)(a) and (b)(i) and (b)(ii) of the Local Safeguarding Children Board Regulations 2006. There was no evidence noted that abuse or neglect were either known or suspected factors in Chadrack's death.
- 3.3 However, the Independent Chair did agree that a multi-agency case review should be undertaken to analyse what happened, why, and to identify any practice improvements that should be made by organisations to safeguard and promote the welfare of children and young people.

⁴ [The Child Death Overview Panel](#)

⁵ [The Serious Case Review Panel](#)

3.4 The review focussed on two key lines of enquiry, alongside providing commentary on the specific recommendations made by the Coroner⁶.

- **Key Line of Enquiry 1** - Professional knowledge of the family's history, specifically Esther's epilepsy, missed health appointments, non-compliance with medication and the previous involvement by CSC.
- **Key Line of Enquiry 2** - The response to Chadrack's absence from school.

4. Findings & Recommendations

4.1 At the outset, it is important to emphasise that the circumstances in which Chadrack and his mother died were not predictable. Whilst a range of practice improvements have been identified as part of this review, it would be wrong to suggest that anyone could have foreseen the tragic way in which Esther and Chadrack eventually died.

Key Line of Enquiry 1

4.2 With regards to professional knowledge about Esther's epilepsy, missed health appointments and non-compliance with medication, these factors were appropriately shared by the hospital in their original referral to CSC in 2012. At this time, the situation was assessed as being safe and the case was closed.

4.3 Multi-agency practice during this episode was child focussed and effective, as it was during the response to the 2013 referral.

4.4 However, the review did identify that a number of professionals who were working with Esther and Chadrack, had not known about the original concerns or the previous involvement of CSC. The review considered whether these professionals should have been aware of this information, why they weren't and whether this would have made a difference to their practice at the time.

⁶ [Regulation 28 – Prevention of Future Deaths report](#)

The GP Practice

- 4.5 In respect of the family's GP, on registering with the new practice in May 2013, Esther did not disclose that she suffered from epilepsy. The new GP practice had no information about the health concerns in respect of Esther and was unaware of the previous interventions by CSC.
- 4.6 Whilst acknowledging hindsight bias, the new GP practice felt strongly that had they known these details (particularly those relating to Esther's prior non-engagement with health services), they would have followed up the referral to neurology more closely following Esther's seizure in September 2014.
- 4.7 Without doubt, the GP should have been aware of this information, although it would be wrong to conclude that its availability would have prevented the deaths of Chadrack and his mother. Its absence does, however, raise questions about the effectiveness of the transfer of patient records between GP practices.
- 4.8 When someone changes GP, it is usual for any patient records to be sent to the new practice. When paper notes arrive, they should be reviewed and summarised, with any pertinent information transferred onto an electronic record. This record is used by GPs to facilitate easy reference to important information.
- 4.9 With regards to the records of Esther and Chadrack, these were never received by the new GP practice and their absence was neither identified nor pursued. The review has been unable to establish why, but the failure in this process meant that the GP was unsighted on important aspects of the family's health and social history.

Recommendation 1

The City & Hackney Clinical Commissioning Group (CCG) explore and seek assurance from NHS England that the process for transferring patient records is safe and effective.

- 4.10 Another associated issue identified as part of the GP's engagement related to Esther being referred to neurology via the '*choose and book*' system. When Esther was having difficulty booking her appointment, she came back to the practice and was seen by a locum GP. The locum advised Esther to re-book an appointment with an interpreter so that the system could be explained to her.

- 4.11 When this episode was discussed with the permanent GPs at the practice, they stated that they would have booked the appointment for Esther at this point (or instructed the GP administrators to do this). This would have been a much more pragmatic way of dealing with this situation, rather than requesting Esther return at a future date.

Recommendation 2

The City & Hackney CCG to disseminate the following guidance to all local GP practices and escalate this particular learning point to NHS England.

‘When patients with language, sensory impairments and/or other vulnerabilities are referred via the ‘choose and book’ system, the GP should make an assessment as to whether it is feasible for them to book the appointment. If there are expected difficulties due to any communication issues, the appointment should be booked directly or by the administrative team.’

The School

- 4.12 The school staff responsible for managing Chadrack’s absence reported that they didn’t know about Esther’s health condition or the previous intervention by CSC.
- 4.13 At the inquest, the school stated that knowledge of Esther’s epilepsy might have prompted a more urgent response from them. With the benefit of hindsight this is an understandable conclusion, however, it is unlikely the school would have been aware of this information unless certain conditions had been met.
- 4.14 With strict laws and regulations governing the sharing of medical records, the school is only likely to have known about Esther’s condition had she told them herself or if there had been a further period of statutory intervention by CSC (and a subsequent decision made that there was a justified ‘*public interest*’ in the sharing of such confidential information).
- 4.15 With regards to the latter issue of ‘*public interest*’, during Chadrack’s time at school, there wasn’t one that would have enabled staff to have either sought or been given the information about Esther’s epilepsy. Ordinarily, for information to be shared in this respect, one of the following criteria would need to be met:
- *Evidence that the child has suffered, or is likely to suffer, significant harm;*

- *Reasonable cause to believe that a child has suffered, or is likely to suffer, significant harm;*
- *To prevent significant harm arising to children or serious harm to adults, including through the prevention, detection and prosecution of serious crime (serious crime means any crime which causes or is likely to cause significant harm to a child or serious harm to an adult)⁷.*

4.16 With regards to why this information wasn't shared with consent, put simply, Esther was never asked. There was no defined process in place that would have prompted the school to request this detail from either Esther or any other parent / carer.

4.17 Knowing about Esther's condition could have been significant and could have prompted the school to think much earlier about Chadrack's absence in terms of his immediate welfare. Whilst it is impossible to conclude this would have happened or that it would have prevented Chadrack's death, providing parents / carers with a routine opportunity to share such information seems a sensible approach going forward.

Recommendation 3

Parents / carers are given the opportunity to disclose any information about themselves (health or otherwise) that might be relevant to the care of their child and/or relevant when responding to an emergency. This should take place when a child is registered in any education setting and as part of annual updates to records. The arrangements for the safe storage of such information should be robust and clearly explained to parents / carers.

4.18 The review recognises, however, that not every parent / carer is going to feel comfortable in disclosing such sensitive details and nor should they be forced to. In this sense, any judgement of potential vulnerability to children, whether related to an episode of absence or any other matter, clearly needs to extend beyond a sole focus on parental need.

4.19 All professionals working with children should consider any concerns, whatever their context, alongside the wider factors impacting upon the family and importantly, the individual needs of children themselves. The review recommends that more detailed advice on vulnerability is made available in the guidance concerning school attendance consistent with **Recommendation 6**.

⁷ London Child protection Procedures 5th Edition 2017, Part B – Practice Guidance – Para 4.3.8

- 4.20 As with the GP, the school was similarly unaware of the previous involvement by CSC, although for entirely different reasons. CSC intervened with the family and closed the case prior to Chadrack ever starting school and hence there were no records to be transferred from another education setting.
- 4.21 Had the school known about the history with CSC, given the time when this intervention occurred (in 2012 and 2013), it is unlikely that this would have changed their response. However, the school's lack of knowledge in this regard does illustrate the challenge that professionals can often face when trying to ascertain who else is (or has been) involved with a child. This can be important in helping promote professional curiosity and facilitate discussions between professionals that can influence the response to children who might be in need of help or protection.
- 4.22 Whilst *ContactPoint*⁸, an initiative scrapped by the coalition government in 2010, was intended to help in such situations, there is no existing technical solution that allows professionals to easily establish who else might be relevant to talk to.
- 4.23 In the absence of this, leaders in all organisations have a critical role to play in driving a culture where multi-agency conversations about children's needs and potential risks are the norm. Importantly, leaders need to ensure that their staff put the protection of children before the protection of information and that there is a robust understanding about when and how to seek information from other disciplines and what can and can't be shared.

Recommendation 4

That the CHSCB seek reassurance from all partner agencies that information sharing across the professional network is sufficiently well understood (at both a strategic and operational level) to ensure children are being effectively safeguarded in all contexts.

⁸ [ContactPoint](#)

Key Line of Enquiry 2

The response to Chadrack's absence from school.

- 4.24 School staff experienced good engagement from Esther and identified a clear commitment from her towards to her son. There was no pattern of Chadrack missing education and no visible issues of concern beyond the very real challenges that he was facing in respect of his known vulnerabilities.
- 4.25 Chadrack was not of statutory school age and the school demonstrated good practice by invoking their absence procedure on 3 October 2016 and then engaging other agencies on 12 October 2016. Their numerous attempts to contact Esther and visit the family home reflect a response that was proactive and aimed at establishing Chadrack's whereabouts at the earliest opportunity.
- 4.26 However, it is not unreasonable to conclude that throughout the period that Chadrack was missing, no professional fully considered his absence in the context of him being in potential danger. Had they done so, it is likely that they would have contacted the police prior to 17 October 2016, as opposed to this being done by a family member.
- 4.27 Two key factors are likely to have influenced the professional response at this time.
- 4.28 Firstly, whilst the school responded to Chadrack's absence in line with the non-statutory guidance⁹ on school attendance, the primary focus of this guidance is predicated on getting children back into education. This is clearly illustrated in the opening pages of this document:
- “Central to raising standards in education and ensuring all pupils can fulfil their potential is an assumption so widely understood that it is insufficiently stated – pupils need to attend school regularly to benefit from their education. Missing out on lessons leaves children vulnerable to falling behind. Children with poor attendance tend to achieve less in both primary and secondary school.” School Attendance, DfE 2016 (p4)*
- 4.29 In the opinion of the review, the guidance is weak insofar as it lacks sufficient emphasis on protection, simply referencing on page 8 that schools should follow up absences to

⁹ [School Attendance](#) – Guidance for maintained schools, academies, independent schools and local authorities, DfE, 2016

“ensure the proper safeguarding action is taken”. In this sense, the whole culture that underpins this process is not one that prioritises the active consideration of safeguarding in the wider context of a child’s life. This lack of focus is likely to have been reflected in the actions of staff.

- 4.30 Secondly, the significant majority of attendance issues do not involve any safeguarding risks and are resolved without any harm to children. Absences are followed up by schools, calls and home visits are made, children are located and explanations provided.
- 4.31 This experience is also likely to have influenced the actions of staff. An underlying assumption that risk was not an issue meant that the response to Chadrack was no different to that of any other child. Professionals failed to fully appreciate the context of the family and importantly, rule out the hypothesis that Chadrack might be in danger.
- 4.32 Having reviewed available local guidance, the non-statutory guidance on school attendance and the statutory guidance ‘Keeping Children Safe in Education’¹⁰, the review considers that these could all be strengthened.
- 4.33 In order to help drive a culture whereby professionals are thinking about a child’s absence in the context of their potential vulnerability, the narrative on attendance needs to include more than just ‘good grades and penalties for parents’. It must reinforce safeguarding as the first priority.

Recommendation 5

The Independent Chair of the CHSCB to write to the Department for Education (DfE) recommending that a stronger focus on safeguarding is reflected in both the statutory and non-statutory guidance that relates to school attendance.

Recommendation 6

Both Hackney Council and the City of London Corporation to review and strengthen the local guidance available to schools on managing attendance. This guidance should emphasise the need to consider ‘safeguarding first’ and the necessary pathways to follow.

¹⁰ [Keeping Children Safe in Education](#) - September 2016

Recommendation 7

Given the relevance to children who are not of statutory school age, both Hackney Council and The City of London review and strengthen the guidance available to pre-school settings on responding to attendance issues.

Recommendation 8

Given the clear national implications arising from this review, the Independent Chair of the CHSCB to write to both Ofsted and The Independent Schools Inspectorate, requesting their assistance in communicating the review's key messages to all education settings.

- 4.34 Guidance should also indicate that relevant information can be requested from the Local Authority (LA) CSC Department and/or Multi-Agency Safeguarding Hub (MASH) to help schools better judge levels of risk. This contact would not necessarily be a referral to CSC, but a request that CSC share any relevant historical information that may add to the assessment of vulnerability for the child.

Recommendation 9

That the CHSCB amend the respective threshold tools in use in Hackney and The City of London to ensure that children missing education through unexplained absences are appropriately risk assessed in terms of their safety and that advice on information sharing is explicit.

- 4.35 In respect of the Coroner's comments about obtaining family/ friends telephone numbers, in the context of strengthening both national guidance and local protocols, the review fully supports this position. It further recommends the following:

Recommendation 10

That the DfE and Hackney Council / The City of London Corporation reinforce in guidance the minimum expected information that should be obtained by schools to help them manage episodes of absence effectively. Guidance should state that this information is clearly recorded on a child's school file and be easy to access by relevant staff.

- 4.37 Information should include aspects such as the basic details of who lives in the family and as a minimum, the following:

- **Emergency contact details of three adults (friends/ family / neighbours)** – *the school only held one contact number for Esther.*
- **Known professionals contact details** – *alongside including these details, guidance should emphasise the early engagement of other professionals when trying to locate a child. In responding to Chadrack’s absence, the school was advised by the SWIS social worker to contact Hackney Ark on 17 October 2016. They did this and a professional subsequently contacted Esther’s cousin later the same day. The cousin called the police. The review has been unable to identify who this professional was, but is it clear that other contact details for the family were held within the professional network. It is also known that the school would have been alert to Hackney Ark’s involvement and earlier liaison with this service could have been made.*
- **Known access restrictions to premises** - *None of the three home visits undertaken resulted in a professional reaching the threshold of the family home. This meant that no-one knocked on the front door, looked through the letter box or windows or spoke to any neighbours. Whilst there is no guarantee that these actions would have prevented Chadrack’s death, the security doors to the flats were a clear barrier to the visiting staff. They shouldn’t have been. Indeed, it is likely there would have been a number of options to gain access to the building, including calling another flat number, waiting for someone to exit or visiting at a time when the “trade” button on the security doors could be pressed to grant automatic access (between the hours of 7:00am-7:30am). In light of these issues, the following recommendations are made:*

Recommendation 11

Points of contact should be established within Local Authority Housing Services (and referenced in relevant guidance) to help professionals gain access to flats and/or other premises that have security controlled entrances. As part of this process, Local Authority Housing Services should facilitate contact with other housing providers as appropriate.

Recommendation 12

The CHSCB should seek reassurance that practice by all safeguarding professionals reflects the importance of visiting children at home and that there is confidence staff know how to respond if access is frustrated.

Involving the police

- 4.38 Whilst acknowledging the school's response to the Coroner's inquest that a home visit will be made for each child for whom telephone contact cannot be made, it is unlikely that all schools or Local Authority Attendance Services will have sufficient resources to respond in this way on the first day of absence for every child.
- 4.39 Furthermore, in respect of the school advising the Coroner that if there is no answer at the family home, "*they now immediately contact the police, who in most cases are likely to force entry*", it is unlikely that the police will respond to all such scenarios in this way.
- 4.40 To put this into further context, in Hackney the police would be typically called at least 3 or 4 times every day to force entry into homes if this measure was applied. The Metropolitan Police Service has also recently issued guidance confirming it is not part of their core duties to carry out '*general welfare checks*' on behalf of other non-police agencies.

"Police will carry out a 'welfare check' when a request is made to police about an individual, if it is an emergency and there is a real concern that something serious is about to, or has already occurred to the relevant individual on those premises. The police will respond because it enables a professional intervention if an individual is in need of immediate assistance due to a health condition, injury or some other life threatening situation."

- 4.41 In line with this guidance, it is essential that professionals take an early view on whether a child's absence suggests the need for "*immediate assistance due to a health condition, injury or some other life threatening situation.*" Where such criteria are believed to be met, the police should be contacted without delay given both their legal powers and practical ability to force entry with other emergency services.

Recommendation 13

Both national and local guidance on managing attendance should make explicit reference to the criteria for escalation to the police and that this should be the first aspect considered when a child's whereabouts are unknown.

5 Conclusion

- 5.1 Over the last three years, the CHSCB has undertaken a range of reviews into the deaths and serious injuries of a number of children. The evidence we have gathered and the experience we have gained reinforces a simple but critical lesson; irrespective of our primary role or the issue being dealt with, we must all think **safeguarding first** and actively consider the wider context of a child's life. Contextualised professional curiosity can enhance our collective ability to safeguard and protect the young and vulnerable.
- 5.2 This simple yet powerful approach needs to be adopted as best practice across all professional groups and volunteers. It must be prioritised in the local policies and procedures that guide all of our work with children and young people, including those relating to attendance at school and pre-school settings.
- 5.3 National guidance also needs to reflect and encourage these principles, putting safeguarding first at its heart. Given the present guidance on school attendance, it is perhaps unsurprising that practice is more focused on children not falling behind in their education as opposed to them falling through the net because of risk. This needs to change.
- 5.4 Circumstances and complex needs will also make some parents, carers and their children more vulnerable, particularly those with special educational needs and disabilities (SEND). It is essential that professionals and volunteers tailor their responses to the increased vulnerabilities that this group of children and their families can face.
- 5.5 Indeed, despite the good practice of the school (and many others) teaching their pupils what to do in the case of an emergency, Chadrack's needs were such that he was never likely to be able to respond to any sort of emergency on his own. Tragically, this proved to be the case.
- 5.6 The circumstances of Chadrack's death and the lessons that come from it must become more than a terrible headline; they must map a route to a greater focus on the needs of the family and a response that is fundamentally driven by a **safeguarding first** approach.