

IN THE FIRST-TIER TRIBUNAL
SPECIAL EDUCATION NEEDS AND DISABILITIES
APPEAL NUMBER

Between (parent name) the Appellant

-and-

(Local Authority Name) the Respondent

I (parent name) of (address) parent/guardian of (Name and date of birth of young person/ subject of the appeal), do hereby make this witness statement in support of my appeal against the contents of my child's Education and Health Care Plan (EHCP)

I make this statement in support of my appeal concerning sections, B, E, F and I of current EHCP. The appeal concerns my child's safety, access to education and the provision necessary to meet the needs arising from Pica, and his other associated SEN needs.

My position is that the current EHCP does not adequately describe my child's needs and does not quantify or specify provision sufficiently. Without the provision requested within this appeal, my child is unable to access education safely.

My child has Pica and other conditions (state what are those conditions are)

Pica is a compulsive disorder that is characterised by the eating of non-food items and may result in injury or death. The behaviour presents an ongoing risk of choking, airway obstruction, physical injury, dental injury, oesophageal and intestinal tears, parasitic and other infections, emergency medical intervention, or death. The risks do not disappear during educational activities. The risks extended to classrooms corridors, playground, transport, changing areas, toilets, and common environments.

My child needs constant and active supervision throughout the entire school day. Unstructured environments increase risk, unplanned activities increased risk. Anything that may cause Anxiety increases risk. My child has limited awareness of danger and is at risk of ingestion of dangerous substances within the school premises.

My child cannot independently manage these risks without adult supervision. Adult intervention is needed every waking moment whilst on school premises.

The impact of Pica extends beyond healthcare and affects every aspect of how safely my child can access education. My child requires monitoring during every transition. My child needs support during every waking moment, so this must cover breaks and lunch periods and playtime.

Risks arise rapidly and often without warning. The environment must continually be assessed for hazards, and an environmental sweep is needed as soon as there is an inedible item on the floor or within his reach.

Ordinary school stuff and arrangements cannot adequately manage the risk. My child's ability to access education is linked to the availability of appropriate supervision. Without supervision, participation in education becomes unsafe. Supervision is an essential safeguarding part of the educational provision.

The evidence before the tribunal includes material about Owen Garnett. Owen Garnett was a 19-year-old autistic man who died because of Pica at his education provision in Warwickshire at the end of 2023. The health and safety executive find the education provision £300,000 and the coroner into the inquest of his death. Also published a prevention of future deaths and incident report.

The evidence from the prevention of future deaths and incident report and the health and safety prosecution report shows that Owen had Pica and requires constant supervision. My child has Pica and requires constant supervision. The evidence records that Owen Garnet needed to constant vigilance by staff with Pica training and information sharing that would have meant transparency and monitoring between the school and his carers.

The evidence further records ineffective communication of risk, between staff and carers after a near miss incident that happened a week before the fatal, choking incident. No review of risk realisation had been undertaken in the previous week's incident; no

management of risk assessment took place when the near incident happened the week before his death.

The implementation of risk assessment and review did not happen, and no lessons were learned from the near miss incident. So, a week later Owen was not supervised when he accessed blue paper towels again and choke to death because he was ingesting the blue paper towels. This happened because Owen was not appropriately supervised.

Incidents of (give dates) where my child ingested, sand, soil, crayon, chalk, paper stones, staple of paint glue, items that have been passed in my child's waste material. There have been instances when there has been crayon colours inside of the mouth, and all of these illustrate near miss events that have not been communicated. When asked if a review of my child's risk assessment has taken place. I am told that the information has been added. I do not know what the information has been added to what records what the situation is, or what the circumstances were.

I do not believe that this goes far enough and the requirements of the health and safety executive guidelines are that clear transparency between parent carers and loco parentis professionals is essential for safeguarding children like mine. The National Pica Advisory Service has in its resources a Picaof monitoring form and they also have the Pica risk assessment format. I have shared that information with staff and have been met with nonchalant attitude or an attitude. I have been made to feel like I am asking for too much when I ask for incidents of ingestion be recorded on the monitoring sheets and shared with me.

It is important for my child that these incidents are recorded, and if possible, what staff think triggered the behaviour. This is so a behavioural specialist can analyse the information and look for peak behaviours and advise accordingly. If we can identify trigger patterns, then we are able hopefully to reduce the exposure to triggers which works towards keeping the young person safer in all settings.

My child is non-verbal, struggles with communication so I need the communication channels to be clear and transparent with the workers around my child so that I can then invoke the medical care plan, that's been put in place for my child, if my child has ingested something dangerous.

I do not believe that staff at school are taking this matter seriously as they should, this is a matter of his safety and the quality of life. This concerns me because it suggests a

reckless attitude and unfortunately that means implementing the care plan that has been put together by medical professionals is not as effective.

One of the reasons the Health and Safety Executive recommends monitoring of items ingested be recorded is if my child attends accident and emergency on an occasion where they have ingested something dangerous, the medical team treating my child will have the widest base of information to treat appropriately. I am having difficulty getting that message across to school staff and to their management. There is no transparency around what items my child ingests in school, that leaves my child in some considerable danger.

Whilst I am not here to apportion blame, I am here to illustrate the seriousness and the foreseeability of risk of serious harm to this child if my child is left at this placement or without the proper supervision.

I submit that the evidence shows that supervision is not adequate, parent concerns are not being taken seriously and ineffective risk management.

The health and safety executive brought proceedings concerning management failures identified after the death of Owen Garnett, against the Warwickshire provision he attended when his death occurred. They published reports recorded their findings in a report in 2025. Owen Garnet died in 2023.

In their findings, the HSE stated that staff around Owen did not have specific Pica training and I have asked for staff to approach the National Pica Advisory Service to obtain specific training and they have refused. This training program has been vetted by Dr Elizabeth Shea, who is the coroner's adviser and the National autistic Society 's adviser on all matters relating to Pica, ARFID, and rumination disorder. Dr Shea considers the training program by The National Pica Advisory Service to be "crucial training" for all organisations. If they have had the training, staff are not implementing the strategies shared in the training.

I submit the current wording in the EHCP is not specific enough and allows for too much discretion, which does not guarantee the implementation of safeguarding guidelines contained in the findings of either the HSE or the "Prevention of Future Deaths and Incidents Report Owen Garnet, as published in 2023, by the coroner who sat at his inquest.

The wording of the EHCP is not specific enough to provide sufficient accountability, is not enforceable, and the vagueness and uncertainty leaves my child at further risk.

I further submit that the current provision is not suitable for my child as the EHCP does not adequately, describe the seriousness of my child's needs, there no measures to

stave off the risks that have been realised already, and does not adequately quantify supervision necessary to safeguard my child.

LEGAL FRAMEWORK

Section 42 Children and Families Act 2014

Section 42 of the Children and Families Act 2014 imposes a duty on the local authority to secure a provision that specified within section F. The local authority is not allowed to simply use “best endeavours” to negate the needs of the child and is not allowed to use budget restrictions to justify not providing specific safeguarding.

This duty is incumbent on the local authority, and staffing pressures or budgetary constraints are not to be used to abdicate responsibility and do not diminish the legal duty on the local authority.

Equality Act 2010

My child is classed as disabled under the Equality Act. Pica, is a compulsive psycho behavioural disorder, and my child has had this condition for a few years now. The schooling provision and the local authority are duty-bound to negate the substantial disadvantage. This condition means that with the current position, there is significant risk. Current provisions are not meeting their duty by not being specific enough and not quantifying proper levels of support, not taking recommended evidence into consideration, and not providing a safe environment, not paying sufficient attention to my Concerns as a parent carer.

Current provision does not adhere to recommended safeguarding practice. School are not adhering to sharing risk management information. They are not recording critical incidents appropriately. Incidents that have occurred. They are refusing to amend risk assessments when the risk has been realised.

Reasonable modifications are needed to keep my child safe at all times. You can see from the log of incidents that I have provided within this statement, that risk has k several times and proper measures have not by the current provision. They have also refused to adhere to guidance set by the health and safety executive and by the coroner in the prevention of future death report.

Reasonable adjustments include trained support specifically for my son and proactive risk management.

Safeguarding is central to this appeal. I know risk of choking, blockages and other injuries as well as poisoning and death constitute a safeguarding concern. Prevention of physical harm falls within the safeguarding responsibilities of educational institutions. My child's welfare cannot be separated from his need to access education safely. Without adequate supervision, his well-being and education are compromised.

Case Law

N v North Tyneside BC [2010] EWCA CIV 135

The court of appeal held that specified educational provision must be delivered and cannot be varied informally. This principle should be applied here and delivered following the recommendations of the coroner's report and the health and safety executive recommendations in the prosecution in the matter of Owen Garnet.

I further submit the provision that I have requested, will meet specificity required by law. Where a child has Pica and there is evidence of serious self harm, there is also risk of injury. Duty of care failures in the provision should be recorded appropriately. Supervision requirements cannot be left to staff discretion, near misses must get immediate reviews because Owen, on its case, illustrates the potential cause, catastrophic consequences when identified risks are not acted upon.

L V CLARKE AND SOMERSET [1998] ELR 129

The court held that provision should be specific and clear. The provision of support should be clear for all and staffing issues do not negate the need or the specificity of the provision dedicated trained one-to-one supervision should therefore be expressly quantified within the EHCP. In the ruling, the judges found that the provisions should be so specific, so clear that there no room for doubt, it's particularly useful when seeking quantified, one-to-one, supervision, staff, training requirements named first aider and the named risk management officer/s.

BM-BM V Oxfordshire County Council[2018]

The upper tribunal held that the provision in the EHCP must be sufficiently specific and rejected provision that lacked detail regarding the level of support for the detail that they felt weren't sufficiently specific where the level of support that was been given, who will give that support and how much of that support will be to provide.

The tribunal held that the provisions must be specific and quantifiable, clear and enforceable. I find that the current provisions in the EHCP do not meet those standards.

My child needs support you in every waking moment, so this means breaks and lunch period risks arise rapidly and without warning. The environment must be continually cleared of hazards. Normal staffing measures cannot adequately manage risk. My child's ability to access education is directly linked to the availability of proper supervision. Without supervision participation in education becomes unsafe.

Supervision is a necessary part of my child's education provision. The evidence for the tribunal includes the prevention of future death and incident report in Owen Garnet. Evidence records Owen needed supervision by staff with Pica training, the information sharing, especially when risk of being realised was not sufficient as the near miss the week before his death had not been shared with his carers. I have attached, as you will see, a log of incidents where risk has been realised, and this is information I have collected from talking to my child.

The evidence shows ineffective, communication of risk of a near miss incident. There is no review of the risk assessment. There are no updates, no proposed plan of action, nothing. The health and safety, executive findings reported that management failures, failure to provide specific Pica training. Risk might have been avoided if training was in place. The health and safety executive also said that there was a failure to respond adequately to earlier incidents, and that the concerns of the family members were not given sufficient attention and the failure to ensure appropriate supervision led to the death of Owen Garnett.

I propose that in section B needs are identified. Needs are to include constant risk of ingesting non-food items, impaired danger awareness, need for close supervision in all environments, risk of choking, airway obstruction, oesophageal, and abdominal tears, injury, infection, emergency, hospitalisation, anxiety and that disregulation is associated with risks.

I propose that section E in outcomes, it is important to record that it is necessary that the child remains safe throughout the schooling day, that there are no ingestion incidents, to access education, safely, to develop communication, and self-regulation skills, and to ensure all staff consistently implement risk controls.

In section F provision needs to be specific and quantified one-to-one, named adult supervision at all times during the schooling day, including transition and all indoor and outdoor area access toileting access, transport, handovers, lunch, and unstructured periods. Written risk assessment reviewed at least once a term and after every incident or near miss. They should also include all staff, having Pica training, choking, response, training, safeguarding training, and a planned emergency, procedure knowledge, environmental sweeps, and removal of all known ingestion hazards will take place every hour, immediate recording of ingestion incidents and parent notification of every incident or near miss. Multidisciplinary review where incidents have occurred. Access to 1st aid trained staff always.

To be clear proposed section **B** should include the following:

Manifestation of dangerous Pica behaviours

Compulsive ingestion risk of non-food items.

Choking risk.

Impaired danger awareness.

Need for continuous and constant supervision.

Need for environmental risk management.

Need for trained Pica staff.

Anxiety associated with Safety management

For the clarity on the proposed section **E** wording should include:

Safe access to education across all settings.

Reduction of ingestion incidence.

Consistent implementation of risk control.

Participation in all education activities.

Improved self regulation skills

I propose that section **F** is worded with clarity in the following manner:

My child shall receive dedicated one-to-one supervision by a trained member of staff who has a CPD accredited Pica training throughout the school day.

The supervising adult shall remain within sight and immediate intervention distance.

Provisions shall apply during lessons, break times, lunch, toileting, educational visits, arrival, and departure, transitions. Also, all staff shall receive documented Pica training. All staff shall receive choking response training. All staff shall be aware of the contents of the risk assessment which will be reviewed every term and following all incidents and near misses. Pica monitoring form to be used to communicate with parent carers and other professionals in the network around the young person.

Pica monitoring form shall also be used to help identify patterns and triggers for behaviours. Parent carer concerns to be reported to staff daily using monitoring form. Environmental safety checks shall occur as often as needed. Evidence shows a foreseeable risk of serious harm. Serious risk having realised please look at log of incidents.

In conclusion, the evidence proves the foreseeable risk arising from unstructured activity and ineffective communication and supervision. My child cannot access education safely without appropriate support that is specified and quantified and enforceable. I request an educational setting that enables my child access learning, where they provide specific quantifiable support that is enforceable. The local authority has a duty to provide whatever provision the tribunal has found necessary. The tribunal is respectfully requested to order amendments to sections B, E, F and I.

I believe that the facts stated in this witness statement are true

Name

Signature.

Date

Schedule of evidence

Children and families act 2014 section 42

Equality act 2010.

Send code of practice.

Keeping children safe in education.

Working together to safeguard children.

North Tyneside, BC v N 2010 EWCACiv 135

L v Clark and Somerset County Council 1998 English law report, 129

Prevention of future deaths and incident report, Owen Garnett 2023

Health and safety executive prosecution report after the death of Owen Garnett, 2025

