SERIOUS CASE REVIEW
OF THE CIRCUMSTANCES CONCERNING

CHILD G

Author: KAREN REES
February 2018

Foreword by Local Safeguarding Board Chair

This serious case review (SCR) was commissioned in February 2017 following information presented to me that Child G had died and had been known to a significant number of services.

All SCRs identify findings that individual agencies and multi-agency systems need to learn from so that the future recurrence of similar circumstances can be reduced. This case is no different and as an LSCB, covering all services involved in this SCR, we have accepted the multi-agency recommendations made by Karen Rees. In addition to these recommendations, the agencies directly involved with Child G and his family have also identified a significant number of learning points (single-agency learning in Appendix 5) so their practitioners improve their practice and the agencies improve their safeguarding processes. All of these actions are being monitored by the LSCB – for some agencies their implementation has been completed and for others it is anticipated their actions will be fully implemented over the coming months. The schools sector in particular has embarked on awareness raising and training on children's emotional health and wellbeing, led by two of the schools Child G attended.

In addition to the recommendations from this SCR and the work the schools sector are undertaking, the LSCB has prioritised improvement actions in its 2017-18 Business Plan aimed at continuing to develop the skills and competencies of practitioners that work with our children and families so that indicators of abuse or neglect are responded to and children and families receive the services that are available locally.

In January 2018, I chaired the Quality Assurance Committee of the LSCB and I was provided with an update on the work completed with implementing the recommendations from this SCR, both multi-agency and single-agency. I will continue to monitor how work is being completed and challenge agencies where progress has not been made.

Our collective aim remains to maintain a local safeguarding system that helps in preventing abuse and neglect, and where abuse and neglect does take place that children are effectively safeguarded.

Finally, I would like to offer my heartfelt condolences, on behalf of all the agencies involved in this SCR, to the family of Child G for their tragic loss. I would also like to thank the family members that contributed very bravely to this SCR, especially mother for her insights into how services can be improved in the future.

Nancy Palmer
Independent Chair, Blackburn with Darwen LSCB
February 2018

Contents

1. Introduction 4
2. Significant Incident Learning Process and Scope of Review 4
3. Parallel Proceedings 5
4. Family Involvement 5
5. Structure of the Report 6
6. Key Episodes 7
7. Analysis by theme 14
8. Good Practice 33
9. Conclusions and Lessons Learned 34
10. Recommendations 36

Appendices

Appendix 1: Terms of Reference (Redacted) 37

Appendix 2: Services involved with Child G (Anonymised) 41

Appendix 3: Pathways to Harm, Pathways to Protection 46

Appendix 4: Tables of Key Episodes: Pathways to Harm, Pathways to Protection 47

Appendix 5: Single Agency Recommendations 55

1. INTRODUCTION

1.1. At the time of his death, Child G had been known to numerous agencies in the locality. He had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)[1] and Dyspraxia[2] . He had struggled with feeling different to his peers and developed chaotic substance misuse and associated criminal incidences resulted. Child G also later developed depression and anxiety. His circumstances led to concern that he was at high risk of and possibly a victim of Child Sexual Exploitation; any disclosures he made were later retracted. His family struggled to manage him at home and as a result he became subject to S20[3] care in a local authority children's home. In early October 2016, after spending the day with family, his mother drove him back to Children's Home 1 (see appendix 2). On return it was apparent that he had been drinking but was in good spirits. He spent the evening chatting to staff, had food and drink and played on his computer. That night staff went into Child G's room at 1am, turned his TV and light off. At 11am the following morning Child G was found deceased with a large bottle of vodka under his body. Initial cause of death was not suspicious and is recorded as central nervous system and cardio pulmonary depression and morphine use.

2. THE SIGNIFICANT INCIDENT LEARNING PROCESS (SILP) AND SCOPE OF REVIEW

2.1. This Serious Case Review (SCR) is undertaken following a notification of the childcare incident to Ofsted in October 2016 and subsequent discussions within the Blackburn with Darwen Local Safeguarding Children Board (BwD LSCB) that the criteria for a SCR was met with a notification to Ofsted & National SCR Panel of a SCR being commissioned in February 2017.

2.2. The BwD LSCB agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time.

2.3. The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners involved at the time
- Engaging with families
- Systems methodology
- Avoidance of hindsight bias

---

[1] **Attention deficit hyperactivity disorder (ADHD**) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. http://www.nhs.uk/conditions/Attention-deficit-hyperactivity-disorder/Pages/Introduction.aspx

[2] **Developmental co-ordination disorder (DCD), also known as dyspraxia**, is a condition affecting physical co-ordination that causes a child to perform less well than expected in daily activities for his or her age, and appear to move clumsily. http://www.nhs.uk/Conditions/Dyspraxia-(childhood)/Pages/Introduction.aspx

[3] **(S20) Section 20 of the Children Act 1989** makes provision for the Local Authority's duty to provide a child with somewhere to live because the child doesn't currently have a home, or a safe home:

1. There isn't anyone who has parental responsibility for him
2. The child has been lost or abandoned;
3. The person who has been caring for the child can't provide him with a suitable home, whatever the reason for this and regardless of whether this is short term or long term problem.

Parental agreement is required negating the need for the Local Authority to go to court to make a care order. The Local Authority do NOT share parental responsibility for the child. Under section 20(8) any person who has parental responsibility can remove the child from Local Authority accommodation at any time.

This SCR has been undertaken in a way that adheres to these principles.

2.4. The Terms of reference agreed that the period under review would be from November 2014 until Child G's death. Further details of the methodology, process and reviewers can be found in Appendix 1.

2.5. The final report was presented to BwD LSCB on 10th October 2017.

2.6. For the purposes of this review agencies will be known by the service they offered to Child G and his family; details of these and the services that they provided are included in Appendix 2.

3. PARALLEL PROCEEDINGS

3.1. There were no suspicious circumstances related to the death of Child G therefore there were no ongoing police investigations.

3.2. There was an Inquest in June 2017. The coroner concluded that this was a drug related death. The coroner recorded that the issues related to the events on the night that Child G died had been addressed in an action plan by Children's Home 1 and that no further action was required.

3.3. Children's Social Care single agency report for this Serious Case Review identified the significant work and action plan for the residential care network that had already been put in place to address the issues related to the circumstances surrounding the death of Child G. The action plan is subject to monthly review. It is largely completed with outstanding actions well under way.

4. FAMILY INVOLVEMENT

4.1. For the purposes of this review the family will be known in the following way:

Family member:	To be called:
Subject Child	Child G
Mother of Child G	Mother
Father of Child G	Father
Step Father of Child G	Step Father
Child G's sibling	Child G's sibling or sibling

4.2. The Chair and the author met separately with Child G's Mother and Step Father on the afternoon preceding the Learning Event. This was to ascertain their views on the services received by Child G and the family and to find out more about Child G. Due to his needs at the time, Father was not in a position to be able to be involved in the review; the reviewers

respected this request from the family.

4.3. The family views have been incorporated into this report at appropriate points.

4.4. Following the completion of the serious case review process, the author and BwD LSCB manager met with Mother to feedback the findings, conclusions and recommendations. Some of Mothers comments and additions have been added as a result. Mother's comments on substance misuse training were felt to be of additional help to the review. They have been included in the report, and lead to a further recommendation. Mother indicated that she was accepting of the report's findings and hoped that the recommendations would lead to improved experiences for children and young people like Child G.

4.5. Father and Step Father declined to receive any feedback following the completion of the serious case review process.

5. STRUCTURE OF REPORT

5.1. Working Together to Safeguard Children 2015[4] does not prescribe a fixed methodology for Serious Case Reviews, but states that the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined and should be conducted in a way in which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

5.2. The author has considered the issues and learning in each key episode using the model presented in the Triennial Analysis: Pathways to Harm, Pathways to Protection Model[5] (Appendix 3). This is used to identify context, vulnerabilities and risks against the key areas for prevention and protection, with an analysis that identifies barriers that then lead to learning and recommendations.

5.3. The text in section six is supported by tables in Appendix 4 to represent the use of the pathways model in each of the five key episodes. Appendix 4 provides more in depth detail of referrals and work undertaken and depicts the escalation of events (showing number of incidents where significantly relevant) and actions throughout the key episodes in a graphic format. This aids understanding and supports analysis.

5.4. As the chronology of involvement is extensive, the episodes within the scoping period are summarised in order that analysis and learning can be addressed and understood. Individual

[4] HM Government (2015) **Working Together to Safeguard Children**
[5] Peter Sidebotham et al. (2016) **Pathways to harm, pathways to protection: a triennial analysis of serious case reviews** 2011 to 2014 London, Department for Education https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014

agency reports analyse single agency involvement in detail and many organisations have produced action plans to address their own learning (Appendix 5).

6. KEY EPISODES

A 'key episode' is an episode from which it is possible to gain an understanding about the way the case developed and was handled.

Key Episode One: Background prior to scoping period; setting the context

6.1. The following provides a summary of information gathered from agencies that falls outside of the scoping period set in the Terms of Reference for this review (Appendix One). It sets the context with which the later scoping period begins, it identifies early risks and vulnerabilities and the early intervention by Universal Services in school and health to prevent and protect from harm (See Appendix 4).

6.2. Child G was the first born to Mother and Father. Histories taken by the Hospital Trust indicate that the parental relationship was that of an 'on/off' nature and would suggest that parents did not live together. Some agencies in the early stages were aware of parental histories. It is not clear if these issues impacted on Child G as Adverse Childhood Experiences[6] and this will be addressed within the analysis. Child G was nine years old when it is recorded that Mother had a new partner; Child G's sibling was born four days before his 12th Birthday. Mother told the reviewers that she was first concerned that Child G may have some difficulties when he was seven. She noticed he was struggling to concentrate and was not progressing socially as she thought he should. As early as when he was eight years old she sought help from her GP which resulted in a referral to a paediatrician. He was referred to occupational therapy, speech therapy and for a parenting course. A diagnosis of Dyspraxia was made when Child G was nine but no other diagnosis was made at this time.

6.3. Appendix 4 indicates the outcome of the assessment by the occupational therapist; a Common Assessment Framework[7] or Statutory Special Educational Needs Assessment[8] were not started nor is there evidence that a discussion was held with Child and Adolescent Mental Health Services regarding a possible referral at this time which was a suggested action from the outcome of the assessment.

6.4. At a home visit made by the Educational Psychologist, Mother concurred that she felt that Child G had dyspraxia tendencies, difficulty with organisation and was, at times, obsessive. It was also reported that Child G had night terrors and had a poor sleep pattern. Mother

[6] **Adverse childhood experiences (ACEs)** are stressful or traumatic events, including abuse and neglect. They may also include parental separation, parental mental ill health, household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

[7] **The Common Assessment Framework** is a shared assessment and planning framework for use across all children's services and all local areas in England. It aims to help the early identification of children and young people's additional needs and promote coordinated service provision to meet them.

[8] **A Statutory Assessment of Special Educational Needs** is undertaken to identify what extra help a child needs in school and leads to a statement of special educational needs that describes a child's needs and all the extra help they should get. The system is now superseded by Assessment for an Education, Health and Care Plan.

disclosed that Child G had threatened her with a knife and had hit her. This disclosure did not result in any referral to other agencies at this point.

6.5. Child G's ongoing needs were managed within school and he was subject to School Action Plus[9]. There was a period of improvement where strategies and input appeared to be helping. School also reported that Step Father appeared to be a male role model that had a positive impact at this time.

6.6. On leaving primary school, Child G was achieving well socially and academically and had developed strategies to cope with stress but it was felt that he would be vulnerable at transition.

6.7. Child G transferred to High School as planned and was placed on the school's Special Educational Needs Register remaining at a level of School Action Plus. Transition to high school proved difficult for Child G and previous progress soon deteriorated. His behaviour was volatile and additional concerns were raised about Child G leading to a further referral to Educational Psychology. During the second year, the school funded anger management sessions. Child G engaged well and showed good reflection on his actions.

6.8. Lack of academic progress and increasing frustration with himself manifested in self-harm and led to further referrals as can be seen in the Key Episode table (Appendix 4).

6.9. Some positive one to one work was undertaken by the Family Support Service (following a referral from school) with Child G clearly indicating what changes he wanted to make (see the Key Episode table). When he was 13, Child G first disclosed to Family Support Service worker about his drug and alcohol use. Mother disclosed that Child G had returned home drunk on several occasions when he was just turned 14. School attendance remained good in this period.

6.10. Initial work by Family Support had a child focus but moved to an adult focus when there was a change of allocated worker i.e. there was a lot of emotional support to Mother. This is not surprising as Child G's behaviour was escalating and his sibling was only 19 months old at the time. Mother told the reviewers that she started to be concerned about the safety of her younger child.

6.11. The Social Communication Panel concluded that Child G was not autistic when he was 14 years old.

6.12. Despite the considerable support that was offered to Child G, the number of severe behaviour incidents escalated and at the point of permanent exclusion he was referred to the Pupil Referral Unit and commenced on roll in year nine, just before his 14th Birthday. Once on roll at the Pupil Referral Unit, school attendance dropped significantly.

[9] School Action Plus **("SA+")** is used where SA (School Action) has not been able to help the child make adequate progress. At SA+ the school will seek external advice from the local Education Authority support services, the local Health Authority or from Social Services. For example, this may be advice from a Speech and Language Therapist (SaLT), an Occupational Therapist (OT) or Specialist Advisory Services dealing with Autism, Behavioural Needs etc. SA+ may also include one-to-one support and the involvement of an Educational Psychologist. As well as the use of external services, SA+ requires more detailed planning of interventions for children whose progress has been limited. A child's progress at SA+ stage should also be reviewed regularly (i.e. at least twice a year) and an Individual Education Plan (IEP) should also be written to assist the child. http://www.specialeducationalneeds.co.uk/school-action-and-school-action-plus.html

Key Episode 2: Child in Need to Child Protection, November 2014 to May 2015

6.13. The first referral to Children's Social Care was made after Child G became intoxicated and required hospital treatment. Ambulance services attended and police assistance was requested due to aggression. Child G's behaviour deteriorated and he was taken into police custody but later returned to Accident & Emergency following a decision by the custody nurse that his medical needs must be a priority. He was sedated in A& E and became calmer and was then admitted.

6.14. The police had risk assessed the incident using their Protecting Vulnerable People system as medium risk and submitted that on their vulnerable child referral into the Multi Agency Safeguarding Hub (MASH). This was responded to by Children's Social Care and was categorised as Child in Need[10] with high risk indicators and progressed to a Child and Family Assessment. Whether this system should have been accessed earlier will be analysed further.

6.15. The following day there was a professionals' meeting attended by schools and the Family Support Service to review educational plans. The minutes of this were shared with Children's Social Care. The increasing number of systems that were applied will be referred to further in the analysis.

6.16. Considerations of possible diagnoses were ongoing. A referral was made by the community paediatrician to Child and Adolescent Mental Health Services to assess for ADHD. The GP contacted Child and Adolescent Mental Health Services to expedite the referral. A diagnosis of ADHD was made at the Child and Adolescent Mental Health Services appointment in March 2015; Child G was 14.

6.17. Young People's Substance Misuse and Recovery Services 1 began to try to engage Child G. Child G did not engage in any ongoing support work but did agree to some work regarding harm reduction but he refused any further engagement and avoided contact. Mother engaged and was involved in trying to set up suitable and appropriate appointments. It is recorded that Child G was now using drugs daily.

6.18. The Police Early Help Service (see Appendix 2) became involved with Child G and his Mother. Child G was seen in school by the allocated worker but further attempts to engage with Child G were unsuccessful. The allocated worker continued to be a point of contact and attend meetings.

6.19. As other services were becoming involved the Family Support Service agreed to close the case, making an onward referral to Troubled Families intervention services. In fact, the Family Support Worker remained involved and, following agreements by the specialist early help panel, Family Support Services continued involvement as they had positive relationships with Child G.

6.20. There had been a delay in the social worker contacting the family due to high workloads but the social worker did see Child G alone at a home visit in December 2014. The first Child in Need meeting took place in mid-January 2015 and although there was attendance from Education, Police, Social Worker and Young People's Substance Misuse and Recovery Services 1, there was no health representation despite several health services being involved. This gap was rectified by the second meeting with invitations to health staff, although the GP was not

[10] Section 17 Children Act (1989) Provision of services to **children in need** and their families

invited and no other health representation attended. Child in Need meetings continued every 6- 8 weeks in this period.

6.21. The social worker completed the assessment by early March and plans were to include involvement of the Adolescent Support Unit (See Appendix 2).

6.22. Issues for Child G began to escalate and the table in Appendix 4 summarises the ongoing and escalating concerns within this period that several agencies and processes were seeking to support and address. It is of note that the majority of the services and processes (listed in the last column in Key Episode 2 Table, Appendix 4) would have individual assessments, plans, and interventions.

6.23. At the Learning Event, it became apparent that there was significant history within the parents' lives that were either not known, or not considered or explored further as part of assessment processes. This is discussed further in the analysis in terms of the impact it may have had on the life of Child G.

6.24. The escalation in incidents and behaviour led to a Child Protection Conference in May 2015; Child G became subject to a child protection plan.

Key Episode 3: Section 20 Accommodation to Movement out of Area, June to December 2015

6.25. For the first few weeks of June 2015, there was a period of improvement and engagement from Child G.

6.26. He appeared to have responded well to the boundaries and possible consequences of not adhering to what was required of him by the Youth Justice Team. A specialist school placement was sourced and outreach was offered from the Adolescent Support Unit. Child G remained mainly drug free for a period of three weeks.

6.27. Child G's behaviour escalation had led to him being cared for by various other family members for short periods. This realisation of the consequences of his behaviour leading to difficulties in Child G living with his Mother and sibling, may have been another contributing factor to some period of improved engagement.

6.28. This improvement was not sustained and in late June 2015 there was a serious incident during which Child G assaulted his Mother. He was arrested and remained in custody overnight and was placed at the Adolescent Support Unit and then into emergency foster care until further decisions could be made.

6.29. Child G went missing from home on several occasions and these were reported by the Foster Carer to the Police with return home interviews undertaken, carried out by the Child Sexual Exploitation Team as per protocol.

6.30. Child G remained in Foster care for a month when he moved to Children's Home 1 as a suitable longer term foster placement could not be found. This was undertaken via a S20 agreement with parents as they were not able to care for him due to the risk he posed to Mother and younger sibling.

6.31. Reparation continued as per the youth caution requirements and the Youth Justice Team engaged Child G in domestic abuse perpetrator work following the assault on Mother.

6.32. Missing from Home episodes became a greater feature in this Key Episode with an associated increase in risk. Child G was not willing to state where he had been and who he had been with when he was missing.

6.33. Child G began at Special School at the beginning of Year 9, just after his 15th Birthday. Due to various events, he did not attend well at first. There were two periods in October 2015 and November 2015 that year where attendance was better and represented the most consistent attendance in some time.

6.34. In this episode, Child G disclosed that he had been subject to a sexual assault that could have been indicative of Child Sexual Exploitation. A police investigation commenced but Child G later stated this was consensual activity. The Child Sexual Exploitation Team worked to support Child G and to protect and prevent harm. Child G also disclosed a further sexual assault that had happened prior to him being accommodated. Neither investigation led to any prosecution as details of potential offenders could not be obtained. This resulted in increased activity by Police and the Child Sexual Exploitation Team. It was also at this time that Child G was informed that an out of borough placement had been authorised. It is possible that this information contributed to a period of improvement.

6.35. Child G did not want his parents to be informed about the disclosures and following legal advice, it was agreed that information could be given about physical harm but not sexual harm. There was a Section 47 enquiry that documented escalating risks and that despite the numerous agencies and systems in place to support and protect (Appendix 4), there continued to be very significant concerns. An out of area placement was sought and agreed for a period of three months to break the local links, reduce access to drugs and allow time for reflection and change.

Key Episode Four: Out of Area Placement, December 2015 to March 2016

6.36. An out of area placement was found and Child G moved in December 2015. He was informed about the three-month placement by the social worker and the Child Sexual Exploitation Team worker.

6.37. The plan of care given to Children's Home 2 was based around provision of parenting to reduce missing episodes, provide education, provide opportunities to develop social skills with peers and to engage Child G in substance misuse work (see Appendix 4).

6.38. There were almost immediate improvements in that Child G initially had no access to drugs and began to show an interest in the gym and other leisure activities. Contacts with family were largely positive.

6.39. It is of note that Child G refused to engage in education and substance misuse work. At first, he spent a lot of time in his room but began to interact more at the home as he settled.

6.40. On one occasion an empty bottle of whisky was found in his room which he stated be brought with him. On another occasion in January 2016 it was believed that he stole a bottle of whisky from a supermarket and became intoxicated, was sick and caused damage to his room. He ran away and police were called, he was later found by staff and his behaviour led to arrest with

Community Resolution. He had admitted to taking ketamine. Child G was remorseful for his behaviour.

6.41. Following this Child G continued to follow boundaries set, interact positively with staff, accessed the gym but still did not engage with education or substance misuse services. Child G was also stating that he no longer wanted not take anti-depressant medication and did not take his medication consistently.

6.42. At the beginning of February 2016, he warned staff at the home that he would jump on a train back home if he was not out of there within two weeks, but continued positive engagement otherwise. In February, a bong was removed from his room and he was warned about smoking cannabis in there.

6.43. Child G continued to engage positively and was looking forward to returning to home area in March 2016.

6.44. Looked After Child Reviews continued in this period. Education services were also reviewing progress and education plans in readiness for Child G's return.

6.45. This plan was then changed as it was felt returning to the home area on a Friday would carry risks. He was informed of this by staff at the home and he stated that he was not happy but remained positive with staff. He told staff that he may be getting the train home the next day.

Key Episode Five: Return to Home Area to Date of Death, March to October 2016

6.46. This episode started with Child G absconding from Children's' Home 2 in March 2016 after hearing of the change of plans detailed above; he was missing for six days.

6.47. He returned to Children's Home 1 but throughout this period there were increasing concerns about his chaotic substance misuse. Missing from Home episodes increased and he refused to say where he had been because of the problems police searches caused with his friends.

6.48. There was apparent confusion about his education provision in this episode as the special school stated that they did not know of Child G's return and the special needs team believed that the Special School had refused to accept Child G back. This led to Child G not being back in education until May 2016.

6.49. With the increasing issues for Child G, he became more aggressive at times and engaged in violence against others and self-harm. His risk of Child Sexual Exploitation was significant and he was friends with other young people who were known to the Child Sexual Exploitation Team (albeit due to criminal histories not as identified victims of Child Sexual Exploitation).

6.50. Child G refused to engage with services and his level of substance misuse and missing from home episodes was such that very little appropriate work could be undertaken by Child G and Adolescent Mental Health Services or the Child Sexual Exploitation Team. Child G often refused to get out of bed for appointments or to see visiting professionals. He also had occasions where he attended the Urgent Care Centre with overdoses of drugs, deemed to be accidental.

6.51. The continuance of S20 accommodation created tensions as some professionals challenged if parents could keep him safe and make appropriate decisions given the level of his challenging

behaviour.

6.52. There were also several professionals who challenged if Children's Home 1 remained a safe and appropriate placement but these challenges did not lead to significant change in the placement at that time and is discussed within the analysis.

6.53. Following consent from Mother, Child G spent some time with a cousin. The rationale for this was that it was a little further away and he might be safer. He spent overnight stays with the cousin which raised concerns for the children's home staff as they had a regime of observing him overnight if he was intoxicated or under the influence of drugs. The decision at this stage to continue S20 and its appropriateness is discussed in the analysis.

6.54. Child G attended Accident & Emergency in June 2016 following a further disclosure to the Child Sexual Exploitation Team worker of consensual sexual activity that he thought had caused internal damage. This added to his anxiety and troubles; Child G had ongoing concerns of physical health issues such as abdominal pain and chest pain that are evidenced in Appendix 4; no physical cause could be found for these and they were largely attributed to anxiety.

6.55. There is evidence offered in the agency reports that lead to suggestions that in fact this was a violent sexual assault and that Child G later changed the explanation to consensual activity.

6.56. It was during this phase that the long-term plan for reunification with family changed. Child G voiced that he knew he could not achieve what he wanted to and that he was further away from getting home than he had ever been.

6.57. The table in Appendix 4 for this episode is characterised by an increased number of meetings under different headings. All those meetings were trying to establish protection for Child G that eventually culminated in, after being originally refused by senior managers in Children's Social Care, an agreement for a further out of borough placement.

6.58. Child G was then involved in a serious assault on another child leading to Magistrates requiring an out of borough placement as part of bail conditions. Finding a suitable placement proved difficult and was then deemed not to be in in Child G's best interests; the court approved amendment to conditions to agree that Child G should remain at Children's Home 1 under intensive bail arrangements. Following Child G's arrest in September 2016 for this offence, he stated that he would do anything not to get a custodial sentence and this appeared to be a trigger for a period of improved engagement to comply with the requirements of the bail package that was put in place.

6.59. The Young People's Substance Misuse and Recovery Services 2 offered a change to a male worker and this appeared to have significant positive impact with Child G's engagement.

6.60. In early October 2016, following a significant disclosure to his Mother at the end of a day spent with family, Child G returned to the Children's Home and had been drinking, he was in apparently good spirits. The events that unfolded are described in section 1.

7. ANALYSIS BY THEME

7.1. By analysing the agency reports and using the information gathered at the Learning Events it is possible to identify areas where there is learning that can lead to improvement.

Understanding Child G and his voice

7.2. Child G developed complex risky behaviours leading to intense assessments and plans to try and meet his needs and improve his outcomes. In order to provide possible explanations for his presentation it is important to consider any learning related to who Child G was and what his voice may have been telling those that were involved in his life.

7.3. Child G lived at home with his Mother and then with his Step Father and new sibling. He was a child whose parents had voiced concerns about from the age of 7 and this ultimately led to a diagnosis of Dyspraxia and ADHD. These conditions have many similar features such as:

- Literal use of language
- Difficulty in organisation
- Poor short term memory
- Difficulty adapting to new situations
- Anxiety
- Sleeping difficulties
- Social difficulties
- Easily distressed
- Impulsivity
- Difficulty in attention
- Difficulty in staying still.

7.4. These issues meant that Child G was likely to struggle in the complex world around him and indeed from being a young child he was acutely aware of these difficulties telling his Mother that he felt different, that there was something wrong with him and that he was not normal. On feedback of findings of the review to Mother, she added that Child G would show signs of depression, anxiety and distress from an early age.

7.5. Child G was also approaching his adolescent years as these diagnoses were becoming evident. It is well researched and studied further by Romer (2010)[11], that adolescent risk taking behaviour is part of normal development and is in some part explained by the maturation processes within the brain. Strategies to manage adolescent risk taking behaviour are multifaceted and depend on early childhood experiences and interventions to manage and control using campaigns to highlight risks (e.g. media and educational programmes) as well as motivation to achieve certain life goals.

7.6. It was also known that Child G was exposed to some Adverse Childhood Experiences. The impact of these was not wholly understood or assessed in the work of some agencies, although the School Action Plus intervention was to manage social, emotional and behavioural issues.

[11] Romer, D. (2010). **Adolescent Risk Taking, Impulsivity, and Brain Development: Implications for Prevention** Dev Psychobiol 52(3): 263–276. http://onlinelibrary.wiley.com/doi/10.1002/dev.20442/epdf

7.7. For Child G, the diagnoses and difficulties he was facing could have meant an inability to think through the wider and long term implications of his behaviour. This required professionals to understand the difference between normal risk taking of adolescence, Child G's behaviour related to his learning difficulty and later on his mental health issues as well as any impact of Adverse Childhood Experiences. There is some evidence in recent research that there are links with early Adverse Childhood Experiences and a later diagnosis of ADHD[12&13]. This needed to be considered in the work that professionals were undertaking with Child G in order that his voice could be truly understood.

7.8. Professionals then needed to apply strategies that recognised the difference at an early point. It does appear that this was the understanding of professionals in Key Episode 1 but did not appear to influence practice of all professionals in later key episodes.

7.9. The Equality Act (2010)[14] places a duty on all services to make reasonable adjustments in order that a person with a Learning Difficulty is not disadvantaged when compared with a person without that characteristic. This is the basis under which services operate best practice.

7.10. In the early Key Episodes, we can see that the educational response was to manage these difficulties using the services that were available to them. It was hoped that obtaining a diagnosis which would explain the emerging behaviours and difficulties would enable an appropriate Individual Educational Plan (IEP).

7.11. This essentially worked well initially and Child G responded to the support; by the time he left primary school he was achieving well academically and socially. Primary school was a place that could manage the issues detailed above in a small contained environment that he was used to.

7.12. The transition to senior school, although it falls out of the scope of the initial review scoping period, is an important time in understanding how Child G may have seen the world and his place within it. It could be argued that the transition was not well managed given the difficulties that Child G was displaying. It is acknowledged that diagnoses of the above conditions were made later but the list of difficulties that Child G had were well known. The transition focussed on what was required to support Child G to enable academic achievement with support to manage behaviour. The transfer to a large very busy environment that was unknown to him at a time where there were other changes in his life i.e. a new sibling, required a different approach.

7.13. On feedback of the report to Mother, she expressed some concerns that she experienced in trying to support Child G at this time and felt that the school were not making appropriate allowances in managing and supporting Child G's difficulties.

---

[12] Manuel E. Jimenez, et al (2017) **Adverse Childhood Experiences and ADHD Diagnosis at Age 9 Years in a National Urban Sample.** Acad Pediatr 17(4): 356–361 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5555409/pdf/nihms881325.pdf

[13] Brown NM et al (2017) **Associations Between Adverse Childhood Experiences and ADHD Diagnosis and Severity. Acad Pediatr** May - Jun;17(4):349-355 https://www.ncbi.nlm.nih.gov/pubmed/28477799

[14] **The Equality Act** came into force on 1 October 2010 and brought together over 116 separate pieces of legislation into one single Act. Combined, the Act provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act simplifies, strengthens and harmonises legislation to provide a discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society. https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

7.14. Understanding these difficulties that Child G faced, other ways to have supported him in this move may have included a phased transition that allowed for him to spend short periods of time in the new environment and carefully managed strategies to support his learning needs with all the staff clear about best ways to approach and work with Child G.

7.15. Child G remained subject to School Action Plus plans, but within the senior school these were not reviewed regularly nor did they involve parents.

7.16. An earlier instigation of a statutory assessment of educational needs may have afforded a systemic approach that would have had a multi-agency element to support the specific needs of Child G and would have involved parents. The Individual Education Plan (IEP) and the School Action Plus approach was not applied robustly but even if it was, it may not have been enough to manage and contain the needs of Child G from a long-term perspective.

7.17. As the Key Episodes progress, there are many other examples of where a helicopter view of the long-term issues required different approaches. Child G was subject to many processes and systems all that had his protection at their heart and the effectiveness of these is discussed further below. What was clear from the agency reports in response to the question about addressing and responding to Child G's diversity issues, is that some agencies did not know about these issues, and they did not feature in all referrals that were made to services. There is little evidence that services responded to him in a way that would be meaningful and appropriate for a child with those needs e.g.

- Breaking tasks down into steps
- Setting clear boundaries
- Focusing on positive behaviour
- Giving very specific instructions
- Using incentive schemes
- Intervening early when frustration is likely
- Encouraging exercise
- Managing sleep.

7.18. As well as his Learning Difficulty diagnosis, Child G also developed anxiety and depression. These mental health conditions alongside any impact of possible Adverse Childhood Experiences would have compounded the difficulties he faced in dealing with issues that were affecting him. The mental health issues also required professionals to consider how best to adjust services to meet his needs.

7.19. That is not to say that some services did not undertake to meet his needs and some good examples were noted with practitioners adjusting appointments to see Child G at home or in an environment that suited him better; e.g. Child and Adolescent Mental Health Services offered appointments in his own environment to reduce anxiety about attending an outpatient clinic, the special school and the Pupil Referral Unit offered a personalised timetable and hours that would suit him better.

7.20. Staff at Children's Home 1 informed Child G of his appointments and took him to many appointments. They also reminded him of when professionals were due to come and see him.

7.21. An example of where less attention was paid to Child G and his needs was identified by the Family Support Service. They initially focussed on Child G and the support he needed to manage the feelings and anxieties that were causing his behaviour. Later this focus switched

to family mediation and the support mother required in managing Child G. In trying to establish a reason for this it is clear that there was very little discussion or information sharing early on regarding the emerging mental health and learning needs that Child G was experiencing. This left the Family Support Service not being able to consider this within their decision making and care planning.

7.22. Agreements had been made in a multi-agency meeting that school would work with Child G on his behaviour and the Family Support Service would work on home life home life with the adults. Whilst this may well have been considered the best way forward, it could be argued, and indeed the agency report for the Family Support Service identifies, that the lack of information sharing meant that the voice of Child G became largely lost from this point in the Family Support Service recordings.

7.23. It is of interest that the times within Child G's life when he showed compliance with what was required and an improvement in his positivity about life, were as a direct result of the strategies outlined in 7.17 being used either coincidently or deliberately.

7.24. Examples from the Key Episodes include as mentioned above in primary school but also other examples when clear boundaries and incentives had a positive impact e.g. when Child G moved to the out of area placement he was aware that good behaviour and compliance meant that he would return to the home area and he stated that he knew this. He was encouraged to take care of himself physically and he found exercise helped him. Staff in Children's Home 2 have recognised the need for training regarding ADHD and Dyspraxia, but were not able to access this during the time that Child G was placed with them.

7.25. Child G also responded well when subject to the Intensive Supervision & Bail Support package and largely complied well with this, again there were strict boundaries and an incentive to avoid custody.

7.26. The change to a male substance misuse worker who was assertive with Child G and waited and insisted that Child G came out of his room to see him was responded to positively by Child G and a trusting relationship began to form.

7.27. None of the agencies could identify how they made reasonable adjustments to ensure that Child G could fully engage in meetings that were about him; given his age it would be expected that he was fully engaged. He did take part in his Looked After Child Reviews but there is nothing specifically recorded as to how this was managed in respect of his learning needs.

7.28. There were several reasons why some professionals did not employ strategies and reasonable adjustments when working with Child G. There were misunderstandings regarding the impact of the diagnoses and some professionals assumed health professionals would inform them of such impacts. Health professionals argued that as Learning Difficulty is wide spread, they would have expected non-health professionals to seek advice from them if this was the case.

7.29. Professionals also articulated that Child G was able to reflect on his actions and clearly understood the impact that his actions had on himself and those around him. This contrasts with what one may have expected given his Learning Difficulty. It was clear though that at times he was unable to think at the time and stop himself from undertaking harmful actions. It is acknowledged that many adolescents behave in a similar manner.

7.30. This then, reminds us of the research referenced in 7.5 (Romer [ibid]) into adolescent behaviour and the importance of considering whether it is the learning difficulty, mental health issues, normal adolescent behaviour or other influences (e.g. Adverse Childhood Experiences, substance misuse) that are underlying explanations for chaotic and risky behaviours.

7.31. It could be argued in Child G's case it was probably a combination of all of these reasons. It can be seen, therefore, why professionals did not consider making plans that focussed on learning difficulty and mental health above other issues.

7.32. It is of note that multi-agency meetings did not generally make mention of Child G's Learning Difficulty. This meant that the duties required of professionals under the Equality Act were not considered.

7.33. What is clear is that as more services, assessments and interventions were added in an attempt to manage and contain Child G's escalating risky behaviours, the more he appeared to increase those behaviours. His learning and mental health needs and the responses to those may go some way to explain why that might be. Child G might well have been voicing his frustration and anxiety to the complexity that was materialising around him.

Learning Point 1:
Differentiating between learning difficulty, common adolescent behaviour and understanding any impact of Adverse Childhood Experiences is vital to inform strategies for assessment, support and intervention. (**Recommendation 1a)**

Learning Point 2:
Adjustments required by the Equality Act (2010) to service provision and plans may increase engagement and reduce anxiety. (**Recommendation 1b)**

Learning Point 3:
Seek advice across the multi-agency network to understand the impact of conditions such as learning difficulty. (**Para 10.1)**

Complexity in Child Protection

7.34. Child G was a child with complex needs as identified above. The services that were becoming increasingly involved to meet these needs added to the complexity of working effectively in a multi-agency environment. As well as Child G's emerging learning and mental health needs was the addition of substance misuse. This risky adolescent behaviour added into his other issues created additional risk and complexity.

7.35. It is useful to draw on the work of Stevens and Cox (2008)[15] as a theoretical framework for understanding complexity in Child Protection and why the assessments and interventions did not achieve their goals. Stevens and Cox gathered information from several sources and identified that the systems that children and families live in are complicated 'open' systems. They contend that families and services are complex and can be unstable systems and

[15] Stevens, I. & Cox, P. (2008) **Complexity Theory: Developing New Understandings of Child Protection in Field Settings and in Residential Child Care**. British Journal of Social Work 38, 1320–1336

therefore are prone to the impact of abrupt changes.

7.36. They further argue that a small change in one part of the system may lead to unpredictable change or even no change at all. This is unlike a closed system where a change in one part will always create a predictable change in another part. This means that in an open system an event may well happen but when and how the event will occur is not as predictable; even when a situation is predictable there are other factors that may steer the event one way or another at a point where there are options and choices.

7.37. Stevens and Cox further found that policies and procedures do not allow for a range of predictable options.

7.38. In this case practitioners were following many processes that were linear in type and were more akin to a closed system i.e. the policies and processes are expected to create a change that is predicted and beneficial. In themselves there was nothing wrong with each individual process, they are tried and tested. However, when there are so many processes being undertaken in so many services, each with individual risk assessments and interventions a change, positive or negative, in one part of the system is likely to lead changes that are unpredictable or even have no affect at all in another part in the system.

7.39. There are many of the issues identified above and in later sections in the analysis that impacted upon single agency involvement that added to complexity (e.g. management oversight, limited supervision, recording issues, newly qualified practitioners as well as, not following guidance and procedures). If single agency involvement does not achieve the right goals using set out processes, then it will not lead to effective multi agency working, especially within a complex case such as this.

7.40. The following are examples of the processes and how they affected other parts of the system.

7.41. The processes of early individual agency assessments and focus on diagnosis possibly contributed to a failure to make early referrals into Children's Social Care via the Multi Agency Safeguarding Hub. There was evidence of clear risk and unmet needs that were being presented to various agencies e.g. primary school, GP, Paediatrician, occupational therapy, speech and language therapy, secondary school, Pupil Referral Unit and Family Support Service. None of these services effected change in another part of the system by objectively using the system of the BwD LSCB Continuum of Need[16] to identify level of response required.

7.42. Assessments across all Key Episodes did not appear to consider any impact or risk from parental history on Child G. It is not apparent within assessments that the possibility of any Adverse Childhood Experiences were considered or assessed so it is not known if there were any specific experiences that had any impact.

7.43. The Police Protecting Vulnerable People system of assessing risk and sharing that risk with social care and health is at work and evident throughout the key episodes. This is not, however, in line with the BwD LSCB Continuum of Need [iibid] and is based on the policing system and what is known to the police at the time of the incident. Therefore, if a medium risk

[16] BwD LSCB: Children's Continuum of Need and Response Framework
http://www.lscb.org.uk/wp-content/uploads/Childrens-Continuum-of-Need-and-Response-Framework-April-2016.pdf
accessed 29th May 2017

Protecting Vulnerable People alert is received, that does not necessarily translate automatically to a medium risk along the continuum of need but may persuade practitioners to believe that.

7.44. The decision in November 2014, on receipt of the first Protecting Vulnerable People alert into the Multi-Agency Safeguarding Hub, that the level was Child in Need and medium risk, at that point may well have been the right one. Accepting however, what is understood about complex open systems, there needed to have been a full consultation with all the agencies that were involved.

7.45. The Child in Need meeting in January 2015 did not have all the agencies together that were offering services and support to Child G and his family at that point. There were several health services that had seen and assessed Child G during Key Episode 1 and further referrals had been made but none of these were represented at the meeting. Therefore, even at this first stage in the Child in Need process, the complexity was not fully understood or addressed; decisions were made on what was known and not what was knowable had there been information from other sources. Key agencies held historic information that would have better informed the assessment at that time. There was information from the first key episode (i.e. from the Educational Psychologist) of considerable concern (see 6.4) that does not appear to have been judged as high enough risk to escalate to child protection. This therefore impacted on the quality of the assessment and the outcome of the process.

7.46. A high risk Protecting Vulnerable People alert was submitted later in January 2015 and contained some significant evidence of escalating concerns but this did not translate into a review of the level of need and it remained at Child in Need level when it should have been at Level 4 (Child Protection) according to the BwD LSCB model [ibid]. There was still no representation from any of the health services that were involved even though there were some meeting invitations. These issues were not escalated (see 7.79).

7.47. This therefore provides evidence that abrupt changes in the circumstances did not result in a responsive change in the system that it should have.

7.48. Other examples of this are seen throughout the Key Episodes; When Child G first became subject of youth justice services in April 2015 a lack of understanding of the history and all the information by that service led to a risk score of below that which would have resulted in a Multi-Agency Risk Management Meeting as per protocol[17]. At the Learning Event, professionals from that service identified that had they had all the information that was knowable at the time, the risk score would have been higher and triggered a Multi-Agency Risk Management Meeting. Again, this would have been a further opportunity to understand risk and complexity by all.

7.49. The system used by the Police to record Child Sexual Exploitation risks and actions, discussed later in the analysis, also highlights where systems and processes can add to complexity if they are not coordinated and managed appropriately. It provides a further example of where changes in the system did not have the desired impact to another part of the system.

7.50. The length of out of borough placement was not sufficient to allow time for relationships and trust to build and effect change in Child G as was initially intended and the purpose of the

[17] Operational Protocol Between Children's Services (Social Care, Leaving Care) and the Youth Justice Service http://blackburndarwenchildcare.proceduresonline.com/chapters/p_operational_proto.html#marm

placement, therefore no change occurred. There was too much required of a short-term placement for a child with very complex needs.

7.51. Communication difficulties within education when Child G returned to the local area, resulted in Child G not being offered a place back in Education for two months following his return; communication issues within the system did not lead to the required change.

7.52. It was noted that many professionals asked Child G about his substance misuse. Throughout the timescale covered by this review, Child G disclosed many and varying drugs that he was using and that he also used alcohol which would increase risk. It became apparent during the learning events, that many professionals did not necessarily recognise the implications that this would have on the intervention and/or risk management that the substance misuse workers would employ when working with Child G; substance misuse workers were not aware that he was using opiates.

7.53. It was also noted that periods of sudden abstention from drugs was seen as a positive step, however, this would need to have been managed well due to risks of changes in tolerance levels and risks of overdose.

7.54. Again, these changes in Child G himself, were not recognised as significant and information was not shared with substance misuse workers who would have been able to try and effect change in another part of the system. This leads to learning for non-substance misuse workers about the importance of communicating types of substances involved and any change to the nature of substances.

7.55. On feedback of the report's findings to Mother, she indicated that she felt that substance misuse training should include supporting practitioners to recognise the difference between a person who is 'gouching'[18], from someone who is merely sleepy and in those cases the importance of seeking urgent medical assistance.

7.56. At the Learning Event, various services identified the elements of their risk assessment processes which were helpful in adding to the understanding of complexity. It is clear that each service is required to risk assess independently as their services are responding to slightly different needs.

7.57. In this complex case, it could be argued that practitioners were not able to offer and think about more dynamic approaches as their focus was on their own element and largely were not able to understand the wider picture; many services were not aware of others involved.

7.58. What would have been of benefit is the summary of all those risk assessments being used in a plan that was understood by all and that was worked to by all. This would have meant that the factors in play and the abrupt changes to the open system could have been managed more dynamically.

7.59. Bringing all the assessments, plans and interventions that were being undertaken together in one place, that clearly identified the ongoing risks from each service's perspective and included information on history and diagnoses that was known to all may have given a wider picture of the complexity and risk. That is not to say that professionals did not understand that

[18] **Gouching** is a term sometimes used to describe a period of sedation and tranquility also known as being "on the nod" following ingestion of some substances such as opiates.

this was a complex case, but they did not appear to be able to identify exactly what needed to be undertaken differently and by who. A pooling of ideas and resources with a solution focus regarding the various issues of risk that were being presented may have been helpful.

7.60. There were existing multiagency assessment and planning processes that were in use during most of the scope of this review (e.g. Child in Need, Child Protection and later Looked After Child reviews) and others that should have been e.g. Common Assessment Framework). Had there been good use of these processes with good attendance and effective multi agency challenge (see from 7.68 below) this would have been the place to discuss all existing plans. Where practitioners were finding issues difficult to address, there is scope to include more senior managers for support.

7.61. Indeed, Children's Social Care has identified, in their single agency report, that there should be a better use of their strategy meetings process. This multi-agency review supports this but would take this further with a view that all agencies should review their input into strategy meetings in complex cases to ensure that there is a sharing of single agency plans. The support and involvement of senior managers where required would enhance strategy meetings for complex cases. If robust, this should be able to provide every service with an overall plan and view of the goals and required outcomes. Again, that is not to say that each service would not have their own plan, but that each plan would have been cognisant of the other plans and interventions and assurance that there was no overlap or gap in provision.

7.62. Professionals at the learning events felt that a system that brought together senior managers from various key agencies, where cases are significantly complex would be very supportive of professionals who were feeling that their actions were not making a difference and is discussed in section 7.87 (multi agency supervision).

7.63. Multi agency contingency planning as part of a strategy meeting in complex cases would have been a useful feature to aid planning for sudden changes that was understood by all e.g. there was a 'Missing from home' trigger plan that was identified as a Police response to missing episodes due to the level of Child Sexual Exploitation risk and this was shared with Children's Social Care. Others at the Learning Event accepted that this may be a Police trigger plan but, that if shared with other professionals, it may help in early location and identification of further risks e.g. a notification to health services may identify a missing person if they attend a health service whilst missing.

7.64. Some services represented at the Learning Event stated that they had no idea at the number of services that were involved but what was also apparent was that each service was absolutely trying everything that they could to make a difference to Child G and sought to find the intervention that would help him address his issues.

7.65. One of the health organisations identified that they had several nurses, all with slightly different roles who were involved with Child G. There was a nurse for children Looked After, a Child Sexual Exploitation nurse as well as a school nurse/youth nurse. Single agency learning for that organisation has identified the importance of clarifying and recording who will be the lead/key worker to avoid duplication or gaps in provision and to provide clarity of role to other professionals and the child/young person and their family.

7.66. From Child G's perspective, the services and plans around him must have seemed overwhelming. Given the learning identified above (7.2 to 7.33), he must have struggled to understand who was doing what and how he could engage with all the services, many of

which were in play at the same time. It is of significant note that Child G's comment to the Child Sexual Exploitation nurse regarding a dental appointment that he'd 'had enough of speaking to professionals and would attend the dentist on another occasion' gave a clear voice of how he felt about this.

7.67. It could be argued, that it would have been in Child G's best interests to rationalise the services that were actively involved in offering direct interventions and recording the rationale for those decisions. Management oversight and scrutiny in strategy meetings in this complex case may well have been of benefit here with senior managers agreeing which services were to continue offering support and a rationale recorded within the multi-agency plan/s.

Learning Point 4:
Complex cases require dynamic approaches to child protection and support from senior managers. **(Recommendation 2)**

Learning Point 5:
Shared contingency planning in complex cases provides clarity of required response for all predictable outcomes. **(Recommendation 2)**

Learning Point 6:
It is important that professionals are aware of:

- the need to share information about specific substances being used with substance misuse workers in order that risk management can be substance specific.
- Identification of indicators drug induced symptoms that may require medical assistance. **(Recommendation 4)**

The role of challenge, supervision and reflection

7.68. There are several areas evident from the agency reports and discussed at the Learning Events where there were challenges across services and several others where it was evident that challenge might have been appropriate.

7.69. It was from Child G's Independent Reviewing Officer[19] where most challenge was seen. This included challenges regarding the appropriateness to continue with S20 accommodation and whether the move back to the local area was right for Child G. These challenges where wholly appropriate and happened internally within Children's Social Care.

7.70. The Independent Reviewing Officer raised concerns that a return to the local area may not be in Child G's best interests unless effective work had been undertaken. Indeed, Children's Home 2 identified that there were issues for them regarding the length of the placement. Given Child G's learning and mental health needs, it is not surprising that he would take a while to settle and to trust the staff in Children's Home 2. With that understood, by the time he had settled

[19] **Independent Reviewing Officers (IROs)** are qualified social workers with at least five years' experience, and who have ideally had some management experience. The role of the IRO is to review, monitor and scrutinise the care plan. The review checks that the care plan is the right one; and that what is in it is actually being carried out. If the IRO believes that the practice or policy of the local authority is detrimental to the child's welfare or if the child's human rights are at risk of being breached, they have a duty to challenge the local authority.

he was already planning his move back to the local area. Children's Home 2 commented in their agency report that there was little time to undertake any meaningful work and indeed he was on the waiting list for Child and Adolescent Mental Health Services for most of his placement. Child G did not engage with drug services whilst out of area and this would have been a key component of recovery work. A longer placement may well have given practitioners a chance to build a good enough relationship for Child G to accept services.

7.71. The challenge regarding the continuance of S20 accommodation was also wholly appropriate. On return to the local area, Child G's risky behaviour was escalating. It was known that Mother was now fearful of him and that it was difficult for her to say no to him especially when he was stating where he wanted to stay and areas he wanted to frequent. It also became evident later on that Child G had been drinking and accessing drugs when with wider family members further adding to the indication that parents may have been having difficulty exercising parental responsibility appropriately.

7.72. In May 2016, when the first challenge was made, the Children's Social Care agency report author states that at that time this may have been the right decision and legal advice had been sought. These internal challenges followed the processes required within the single agency.

7.73. By May 2016 there was general agreement that a further out of area placement was necessary and there was consideration of secure accommodation. A challenge to this was that it was felt that Child G was in receipt of a comprehensive package of support and that a movement at that time would impinge on this. The author of the Children's Social Care agency report and indeed the author of this review refutes this as Child G was not actively engaging at that point and there was evidence that he was safer and undertaking less risky behaviour when he was placed out of area.

7.74. Professional challenge can also come from outside of an agency where there is disagreement regarding the right way forward. The earlier reluctance to find a second out of area placement should have prompted challenge. This may have resulted in an earlier decision to move Child G away from local risks and influences.

7.75. There was good external challenge from the Special School who argued alongside the Independent Reviewing Officer and others, that Children's Home 1 or indeed the whole locality was not a safe place for Child G. Whilst there was challenge here, it was not escalated when not heard and no action taken. Some of the reason for this was due to the issue being discussed within several meetings and different emphasis. Also, the strategy meetings where it was discussed were chaired by different managers. The lack of consistency appears to have resulted in detail of all concerns regarding the placement not being heard in one place and therefore the challenge and escalation was not robust or wholly understood in decision making.

7.76. There were other occasions that received no challenge across agencies that may have been missed opportunities:

7.77. An earlier Statutory Assessment of Educational Need would have involved and brought together a multi-agency view of Child G's educational needs and may have resulted in an earlier referral into Children's Social Care for assessment of risk and need.

7.78. The Child in Need plan should have been challenged earlier as there was evidence by the second Child in Need meeting in that Child G's unmet needs were at Level 4 according to the BwD LSCB Continuum of Need Framework [ibid.]

7.79. It is also of note that, when practitioners were not involved in multi-agency meetings as they thought they should have been, this was not challenged formally nor was non-attendance at multi agency meetings following invitation. Multi agency assessment and decision making relies on the involvement of all agencies and therefore, if the system is defective in this area, then it should be challenged and escalated in order that outcomes are effective for children.

7.80. When challenge does not lead to change and practitioners remain concerned that their reasoning is not being heard, it is important that escalation policies are used to lead to appropriate resolution of professional differences of opinion.

7.81. The BwD LSCB has a Protocol 'Resolving Inter-Agency Disagreements'[20], although there is no evidence that it was used when there were concerns. It is not clear why this was but links to currently unpublished serious case reviews in the area identify that the guidance requires refreshing and leads to support for the recommendations of previous serious case reviews.

7.82. There is also an element in this case where there should have been more challenge of Child G. Many of the services identified that he appeared to choose the services he wanted to engage with and when. As identified in Section 7.2- 7.33, Child G had learning needs and other issues that would suggest that clear boundaries, targets with incentives and consequences may have worked well if they were broken down into understandable chunks. It can be seen from the Key Episode tables that those services and professionals that he engaged with the most were ones that had those set elements either as a statutory requirement (e.g. Youth Justice) or because that was the way the professionals worked (e.g. male Young People's Substance Misuse and Recovery Services 2 worker). Had more services challenged Child G in this way, they may have engaged him more effectively.

7.83. This review does acknowledge that some of the possible reason that Child G may have chosen to engage more at times may have also been on the occasions where there were incentives towards being able to live with family. That manifest itself initially when Child G could no longer be cared for within the family and more latterly when there were possibilities for reunification with family. These occasions did see some improved periods of engagement, albeit for a limited amount of time.

7.84. Opportunities to challenge should be highlighted by the opportunity for robust reflective supervision and management oversight of practice. Some of the agency reports did not identify if supervision was taking place, of those that discussed it, all identified areas for improvement, commenting that there was little evidence of reflection and challenge within the recording of supervision. Some agencies reported significant issues with supervision not being recorded appropriately.

7.85. The role of effective and robust supervision has long been argued as an important element in safeguarding children. Learning from Serious Case Reviews nationally, as identified in the Triennial analysis of Serious Case Reviews [ibid] and locally[21] identify effective supervision as

[20] Pan Lancashire Policy and Procedures for Safeguarding Children Manual 8.1 Resolving Professional Disagreements http://panlancashirescb.proceduresonline.com/chapters/p_resolving_prof_disagree.html accessed on 26 May 2017
[21] LSCB – Learning from Serious Case Reviews, BwD LSCB Briefing October 2016 (unpublished)

elements of learning. Bruton (2009)[22], brought together a range of sources in a safeguarding briefing, identifying that not only should supervision have reflection and challenge but also identified the need for professionals to play devil's advocate to aid their own critical thinking when situations are changing rapidly.

7.86. The Triennial Analysis identifies that in circumstances where resources are finite and services undergo restructure, and it could be argued, retendering, the role of supervision becomes even more important for frontline practitioners.

7.87. There could also have been a case for multi-agency supervision with managers and practitioners coming together to share reflections on the case progress. Sharing of thoughts and ideas for solutions and identifying what had made a difference where services had engaged with Child G successfully may have been supportive of the professionals. A finding from a recently published SCR in Hartlepool concurs that:

"*All practitioners need to be supported and challenged in their practice to constantly reassess their views on a case and professional supervision provides the most appropriate forum for this to take place. Where multi agency professionals can come together to be supervised jointly, this will be even more effective*."[23]

7.88. There is also similar learning in a, yet unpublished, SCR that has been undertaken by BwD LSCB. Learning from this and other SCRs locally and nationally was shared at a professionals' briefing in October 2016. This case has led to further learning regarding supervision and professional challenge.

7.89. A culture of challenge (**A**ssertive practice), **R**eflective supervision along with **K**nowledgeable practitioners (ARK) is a contemporary framework that was introduced by a national safeguarding expert at a recent BwD LSCB development day and this is currently being used as a longer-term framework to promote best practice in safeguarding.

Learning Point 7:
An embedded culture of internal and multi-agency professional challenge enhances safeguarding children practice. **(Para 10.1)**

Learning Point 8:
Robust reflective supervision encourages challenge and critical thinking regarding views of current practice challenges. **(Para 10.1)**

Learning Point 9:
In complex cases, multi-agency reflective supervision to identify blocks and barriers to managing risk and complexity may support dynamic approaches. **(Para 10.1)**

[22] Bruton, S. (2009) **The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?** C4EO Safeguarding Briefing 3 National Children's Bureau. http://archive.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_3.pdf accessed on 25th May 2017

[23] Serious Case Reviews – "Olivia" and "Yasmine" Executive Summary and Board Response http://lscbhartlepool.org/ Accessed 13 July 2017.

Identifying Child Sexual Exploitation and its Response

7.90. There has recently been much national press and interest in the progress of systems regarding recognising and responding to Child Sexual Exploitation in the wake of national inquiries into the issue. This review has given an opportunity to analyse the practice in this case against recognised current local and national best practice and guidance.

7.91. From the Key Episode tables, it can be identified that Child Sexual Exploitation was first highlighted formally as a risk for Child G in August 2015 when assessment identified a high-risk score. Child G had been known to the Multi Agency Child Sexual Exploitation Team from June 2015 as it is that team who undertake the Missing from Home Return Interviews due to the associated link between Missing from Home and Child Sexual Exploitation[24].

7.92. It appears that some areas within the Pan Lancashire Child Sexual Exploitation Standard Operating Protocol[25] were not followed resulting in a much later identification of Child Sexual Exploitation risk and identifying Child G as a possible victim of Child Sexual Exploitation.

7.93. It is of note that the first Child in Need meeting identified that Child G had been missing from home on several occasions but that formal return home interviews were not conducted as per the Missing from Home protocol. This was because those missing episodes had not been reported to police or any other agency by parents. The parents were encouraged to report future episodes but a retrospective return interview was not undertaken at this point contrary to advice in the Pan Lancashire Missing from Home Protocol[26].

7.94. At the first Child in Need meeting in January 2015 there were many indicators of Child Sexual Exploitation risk; of the nine indicators from the SAFEGUARD acronym (included in the Pan Lancashire Procedures) to support professionals in identifying Child Sexual Exploitation risk, there was only one not to be a known feature for Child G.

7.95. National[27] and Local Guidance (Pan Lancashire Protocol [ibid]) related to Child Sexual Exploitation also identifies the vulnerabilities sometimes referred to as 'Push-Pull' factors that often lead to increased risk of Child Sexual Exploitation. The Push factors for Child G factors such as family breakdown' low self-esteem, emotional and learning difficulties. Pull factors that were possibly drawing Child G into risky situations were being offered drugs, alcohol and gifts, getting a buzz and the excitement of risk taking/forbidden behaviour and being offered somewhere to stay where there were few rules/boundaries.

7.96. The Children's Social Care assessment at that time did not draw together all the risk indicators to identify that there was a high risk of Child Sexual Exploitation for Child G. The knowledge of these indicators should have led to a risk assessment and referral being completed, and as

[24] Emilie Smeaton, E. (2013**) Running from hate to what you think is love: The relationship between running away and child sexual exploitation**. Ilford Barnardo's https://www.barnardos.org.uk/15505_cse_running_from_hate_2l_web.pdf accessed 29 June 2017

[25] Pan Lancashire Child Sexual Exploitation Standard Operating Protocol http://panlancashirescb.proceduresonline.com/pdfs/lancs_Child Sexual Exploitation_standard_op.pdf

[26] Pan-Lancashire Joint Protocol: "Children and young people who run away or go missing from home or care" http://panlancashirescb.proceduresonline.com/pdfs/joint_proto.pdf

[27] Dept. for Education (2017) **Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf accessed 20 July 2017

already open to children's social care, a strategy meeting involving the Child Sexual Exploitation Team should have been convened.

7.97. Neither the Missing from Home nor the Child Sexual Exploitation Protocols were followed. This was because the allocated social worker was newly qualified and had not recognised these issues as requiring a response under the protocols.

7.98. There were other practitioners involved in the Child in Need process who had responsibility to understand the requirements of protocols and processes and should have been able to advise the social worker. There were also later multi agency processes (Child Protection and Looked After Child) as well as two case decision forms signed off by Children's Services social care heads of service and meetings that did not identify child sexual exploitation concerns and therefore did not consider a referral to the Child Sexual Exploitation Team in line with the protocol.

7.99. A newly qualified social worker, or indeed any newly qualified professional, needs mentorship and careful supervision and support in order that they can develop their skills and understand the processes that are in place to support practice. Therefore, the fact that the social worker was newly qualified should not have made a difference if the support and the multi-agency partners were working effectively. Learning from a very recent, unpublished SCR (Child R) undertaken by BwD LSCB also identified this as a learning point.

7.100. This earlier identification of indicators of concern would have alerted all professionals to the Child Sexual Exploitation risk and preventative work could have started earlier.

7.101. When the Missing from Home interviews were conducted by the Child Sexual Exploitation Team from June 2015 onwards no Child Sexual Exploitation concerns were identified and it was not until a risk assessment carried out by the Children's Social Care Child Sexual Exploitation worker in August 2015 that the score was deemed to indicate high risk of Child Sexual Exploitation. Despite the number of missing from home episodes, this did not result in an earlier 'Missing from Home Trigger plan'; it could be argued that this was a missed opportunity for an earlier identification of risks.

7.102. The police early help worker who had engaged with Child G in early in 2015 also had a role in prevention of Child Sexual Exploitation as part of the Police Universal offer to support early help and intervention. The Police Early Help worker had issued Section 2 notices[28]. Section 2 notices are issued as part of the prevention work in Child Sexual Exploitation in an attempt to stop adults providing inappropriate gathering places for children. It was identified at the Learning Event that the team that the worker worked within did not record information on the same system as the usual police teams and did not record anything until April 2015 and that there are multiple police recording systems. This meant that police information, including information about the serving of Section 2 notices, was stored in several places albeit shared verbally at multi agency meetings. For this reason, there is an impact on the police understanding of the multi-agency perspective at various points as it was this worker that was attending Child in Need, Child Protection and other professionals' meetings to represent the

[28] **Section 2 Child Abduction Act 1984 – (offence)** A person not connected with the child is guilty of an offence if, without lawful authority or reasonable excuse, they take or detain a child under the age of 16 so as to remove the child from the lawful control of any person having lawful control of the child. This offence applies to any child under 16. Once a potential perpetrator has been identified they can be served with notice requirements under S2 and S49 on behalf of the parent, carer or guardian of the child/young person. From the Pan Lancashire Child Sexual Exploitation Standard Operating Protocol.

police. Other officers in other policing teams responding to various risks and crimes were not able to see everything in one place and there is no flagging system for child sexual exploitation visible to all across the system. This has been addressed within the single agency learning by the Police and recommendations have been made to address this.

7.103. The multi-agency meetings regarding Child Sexual Exploitation that are undertaken monthly as part of the wider Child Sexual Exploitation protocol, first included mention of Child G in October 2015. It is the contention within this review that that he could have been included much earlier had the right risk assessment and known information been used and shared. The first disclosure from Child G that could have indicated that he was a victim Of Child Sexual Exploitation came within the same month.

7.104. There were also some accepted difficulties that were discussed at the Learning Event, with the recording and information sharing from these multi agency meetings that were not minuted. The record that was created was stored within police systems and not shared formally so was not incorporated into the Looked After Child review. The record identified disruption actions but did not identify the significant issues that could have been suggestive that Child G was a victim of child sexual exploitation. It was expected that attendees at the meeting would make notes and take these back to their own agency. The system therefore does not support formal information sharing from this multi-agency meeting. This adds further weight to the learning identified above regarding the issues with multiple plans not being shared in a formal process.

7.105. It is not known whether earlier identification and intervention would have had an impact given the level of Child G's engagement, but it would have evidenced staff being knowledgeable and alert to the systems and processes that allow for early identification of risk.

7.106. Despite the above, it is of note that adults who may have been increasing or contributing to risk factors for Child Sexual Exploitation continued to be served Section 2 notices. Disruption of possible perpetrators is also an important part of managing Child Sexual Exploitation and its risks. Whilst this was good practice and part of earlier intervention, it was not part of an overall Child Sexual Exploitation action plan that was incorporated into other plans.

7.107. It is pleasing to note that the system for issue of Section 2 notices by the Police Early Help Worker has been reviewed. Authorisation by a Detective Sergeant or Inspector is now needed to ensure coordination and management oversight.

7.108. It is also of note that the agency reports do not evidence how they formulated plans to engage and hear Child G's voice related to disclosures he made. His learning needs may well have been significant in the type of intervention at this time at the Sexual Assault Referral Centre, by the Child Sexual Exploitation team and within sexual health services. If there had been grooming and coercion of any sort, the needs of a person with Learning Difficulty may have made the ability to see any action as abusive even more difficult than for other young people; this is known to be a significant factor in the disclosure of Child Sexual Exploitation by children.

7.109. Recent work at a Sexual Assault Referral Centre within the same region has identified the issue of working with people with Learning difficulty who have been sexually abused and made a funding application to help improve the accessibility, appropriateness and effectiveness of sexual assault services for clients with learning disabilities and therefore also helpful when working with people with a learning difficulty. These resources will be a useful

for all practitioners working in those areas.

7.110. The disclosures that Child G did make about sexual assault could not be progressed to possible prosecution of perpetrators by Police as Child G later retracted that they were assaults and stated that the activity had been consensual. There is further learning here in the way that professionals see and understand disclosure and retraction of such in cases of possible Child Sexual Exploitation.

7.111. On one occasion related to a disclosure to the Child Sexual Exploitation team, Child G had stated that his memory was hazy as he had taken a cocktail of drugs and alcohol. This sexual activity, therefore, could not have been consensual as, at the time, he did not have the capacity to consent. There were other identified occasions where it was apparent that Child G made disclosures that indicated that he had sex when under the influence of drugs and/or alcohol.

7.112. Secondly, research[29] would suggest that suspected Child Sexual Exploitation victims who have suffered the most severe abuse may be least likely to cooperate with service agencies and that imminent threats from offenders may also lead to suspected victims deceiving law enforcement during initial stages of investigations.

7.113. In light of the current research and 'key messages' from the Centre of Excellence for Child Sexual Abuse[30], a more robust approach to dealing with possible perpetrators was required, rather than sole reliance on prosecution from disclosures. The support to build effective relationships with specifically identified professionals (see below 7.117) should also have included support to understand the possible criminal processes that may have ensued following any disclosure.

7.114. It could be argued, therefore, that if professionals are alert to the above information, then children such as Child G should be seen and treated as victims of Child Sexual Exploitation as opposed to being 'at risk of'. Some professionals at the Learning event indicated that they were treating Child G as a victim, but others were not aware of the 'victim' status until they read the agency reports as part of this SCR. Child G as a victim, did not feature in plans and interventions and was not discussed overtly at meetings.

7.115. Child G's family were not aware of the above professional viewpoint. It could be argued that they could therefore not exercise any protection using that knowledge and parental responsibility that they retained as part of the S20 status. One of the reasons for this was because Child G had requested confidentiality regarding any sexual harm, and following legal advice this had been respected. Professionals faced a dilemma and did respect Child G's confidentiality. With hindsight, however, working with Child G towards disclosure to his Mother may have afforded more protection and open working in the context of Child Sexual Exploitation.

7.116. Seeing Child G as a victim may have led to a further view of the nature and underlying causes on all aspects of his presentation (chaotic substance misuse, depression and anxiety, constant fear of physical damage/symptoms, and increasing violence against others) or at least why he

[29] Srikantiah, (2007) & Moossy, (2009) In Ahern, E. et al (2017) **Wellbeing of Professionals Working with Suspected Victims of Child Sexual Exploitation**. Child Abuse Review Vol. 26: 130–140.

[30] A suite of publications, 'Key Messages' include four tailored for specific professional groups and one for the multi-agency team. Three are paired – with one for frontline practitioners and one for commissioners. https://www.csacentre.org.uk/research-publications/key-messages/ accessed 25 September 2017

did not feel able to address these issues.

7.117. Many of the elements of the 'See me, hear me' Framework identified in the Inquiry into Child Sexual Exploitation in Gangs and Groups[31] is in place in the area. One of the key elements of what young people and evidence informs us works with supporting young people who are at risk of Child Sexual Exploitation, is building positive relationships and trust. This was evident in this case with several workers being allocated to Child G for a considerable length of time (e.g. Social Worker, Child Sexual Exploitation Team worker, a youth nurse). Child G did not always engage with these workers but they remained consistent in their attempts to support him and build trusting relationships with him. Early identification, however, and a review of 'what works' from a solutions perspective to engagement may have been helpful in understanding earlier exposure and risk and to build positive relationships much earlier.

7.118. Very recent guidance related to Child Sexual Exploitation[32] supports much of the learning that this review has found including the important role that parents can play in prevention, recognition and protection from abuse. Current guidance also identifies the work of Shuker (2013)[33] that there are three key elements to safety i.e. relational, physical and psychological. The movement away from the locality may have been positive in terms of *physical safety* but it did not recognise the importance of *relational safety* and the fact that new professional relationships needed to be formed in the new area. Movement out of area also disrupted the *psychological support* Child G required.

7.119. Practitioners in this case were not working within that framework as it is not included within the current guidance. Some of those practitioners were focussed on the presenting escalating behaviours and attempting to deal with those, rather than seeing those escalating behaviours as indicators of possible child sexual exploitation. As noted above some professionals did not understand this element of Child G's life until they read the agency reports during the process of this review.

[31] Berelowitz, S. et al (2013) **If only someone had listened** Inquiry into Child Sexual Exploitation in Gangs and Groups, Final Report. Office of the Children's Commissioner, London

[32] Child sexual exploitation: **How public health can support prevention and intervention** (2017) Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629315/PHE_child_exploitation_report.pdf Accessed 14 August 2017

[33] Shuker, L (2013a) '**Constructs of Safety for Children in Care affected by Sexual Exploitation**' in Melrose, M (Ed) Critical Perspectives on Child Sexual Exploitation and Trafficking. Palgrave Macmillan. Via CSE Research: Short films for practice Research Briefing Note #11 https://www.beds.ac.uk/__data/assets/pdf_file/0007/461437/RBF.11.Shuker-jhLS.pdf accessed 14 August 2017

Learning Point 10:
Local and national guidance to support early identification of Child Sexual Exploitation risk, including response to Missing From home episodes is key to early intervention and possible prevention. **(Recommendation 3)**

Learning Point 11:
Guidance and support for newly qualified workers is required from managers and supervisors as well as from the multi-agency partners involved in a case. **(Para 10.1)**

Learning Point 12:
Risk of Child Sexual Exploitation and possible victim status needs to explicit in all plans and shared with all professionals. Where appropriate, family should also be aware of this to add layers of protection. **(Recommendation 3)**

Learning Point 13:
Children and young people who have specific learning needs require different and specific approaches when attending sexual health services following disclosures of sexual abuse. **(Recommendation 3)**

Learning Point 14:
Local guidance needs to reflect current research. **(Recommendation 3)**

Learning Point 15:
Professionals must consider the nature of capacity to consent in decision making. **(Recommendation 3)**

Learning Point 16:
All professionals working with a child or young person are responsible for following protocols and processes and must support/advise and challenge where this is not happening. **(Recommendation 3)**

Learning Point 17:
Where there are multiple recording systems, information must be cross referenced so that there are no gaps in information. **(Recommendation 3)**

Learning Point 18:
The recognition of early indicators of Child Sexual Exploitation risk are required in order to trigger multi agency responses to prevent and protect from harm. **(Recommendation 3)**

Learning Point 19:
Robust recording of meetings via centrally produced minutes that are distributed to all involved, ensures for accurate responses and information sharing to all partners. **(Recommendation 3)**

Learning Point 20:
Due to the nature of grooming, coercion and abuse, victims of child sexual exploitation are very likely to retract statements and disclosures. This should not preclude formal action against possible perpetrators. **(Recommendation 3)**

8. GOOD PRACTICE

8.1. This case featured a plethora of good practice from knowledgeable and dedicated practitioners who worked tirelessly to encourage Child G to engage in services that would support him to make the required changes to keep him safe. Notwithstanding the learning identified in the previous section, the following represent some examples of that good practice identified by the professionals themselves at the learning event.

8.2. The Child Sexual Exploitation Team demonstrated that they were knowledgeable about the risks and indicators of Child Sexual Exploitation once the risk was identified and worked hard to engage Child G and reduce risk. There is acknowledgment that this serious case review has identified that Child G should have been seen as a victim of Child Sexual Exploitation.

8.3. Despite the lack of involvement of all agencies in some of the meetings and processes, there was evidence of some good multi-agency working with some positive co-location of services within the Child Sexual Exploitation Team.

8.4. Several workers remained constant and this enabled establishment of relationships with professionals and with Child G e.g. the social worker and the child sexual exploitation team worker.

8.5. The Pupil Referral Unit identified that they could contact any agency and ask for help. The Youth Justice Service responded immediately when they were contacted regarding an issue.

8.6. The Missing from Home trigger plan was comprehensive albeit it was not put in place at the time that it might have been.

8.7. At the prospect of custody, Children's Social Care, the Children's Home and Youth Justice Service came up with a good plan which was felt to have good prospects.

8.8. The senior school saw real qualities in Child G and never gave up. Awareness that Child G was easily distracted and influenced led to giving him responsibilities and tasks such as Fire Safety Officer where Child G completed some work with the Fire Service. There was good pastoral care.

8.9. Professionals tried hard and worked closely together and there was a genuine desire to make a difference. Professionals generally kept Child G in the centre of their attention, stuck by him, did not give up and showed care and compassion.

8.10. When Child G went to the Pupil Referral Unit, the senior school completed work around this and maintained contact.

8.11. When Child G was bailed and one of the conditions was three hours' education; the pupil referral unit persisted to ensure that Child G had a chance of education.

8.12. Child and Adolescent Mental Health Services and Children's Home 1 worked well together.

8.13. There were good challenges from the Independent Reviewing Officer in respect of the legal status and appropriateness of the placement which created thinking and stimulated discussion.

8.14. There is evidence of good communication and good information sharing at daily briefings by the Child Sexual Exploitation Team.

8.15. There was good communication and commitment from Child and Adolescent Mental Health Services.

9. CONCLUSIONS AND LESSONS LEARNED

9.1. Using the Triennial Analysis Pathways to Harm and Pathways to Protection model alongside the terms of reference for the review enables a review of the conclusions and overall learning in this case.

9.2. Child G was a young man with a diagnosis of ADHD and Dyspraxia. This review has shown how this was the key vulnerability that was identified very early in his childhood by his parents. There was some family history of family breakdown, a new relationship, new sibling and new home that provided the context within which Child G lived. Professionals had mixed understanding of this in their interventions with Child G and his family and therefore did not robustly apply duties required under the Equality Act (2010).

9.3. Early preventative actions included those in health and education trying to establish a diagnosis and meet his educational needs. Despite these actions, Child G, after initially responding well, did not cope with the transition to senior school. This, along with an indication that Child G felt he was different adding to his anxiety and stress ultimately resulted in aggression and risky behaviours developing. Not all the history known to professionals in Key Episode 1 was shared and incorporated into later assessments leading to a gap in understanding Child G and his needs.

9.4. Initially there was a delay in identifying that assessments should be being undertaken from a multi-agency perspective with statutory assessment of educational need and referral to the Multi Agency Safeguarding Hub not happening as soon as they could. Once the referral to Multi Agency Safeguarding Hub was made, there was a delay in stepping up to Child Protection and identifying risk of Child Sexual Exploitation.

9.5. Child G also developed mental health issues and complex emotional needs. As Child G's risky behaviours further developed and escalated, there was an increase in the number of protective and preventative actions by others in an attempt to prevent the pathway to harm. It could be argued that the more risky and dangerous that Child G's behaviour became, the more complex it became to protect and prevent harm and the more services, assessments, interventions and plans were added. This made it difficult for services to understand what was working and what was not in order that plans could be reviewed for their effectiveness.

9.6. This review has attempted to understand what happens in complex child protection cases and has identified, that whilst each preventative and protective action in itself can be reasoned, that does not necessarily lead to improved outcomes for the reasons that have been identified. This therefore is a hypothesis as to why the systems were not able to protect Child G.

9.7. A more robust approach would be to use the existing available multi agency processes to share all plans and to coordinate and review interventions from a solution focus, identifying what is working and consideration of rationalising the services involved. Those services

prioritised for delivery, may be those that are most likely to be effective in reducing risk and preventing further harm.

9.8. Listening to the child is also important. Child G was showing increasing anger and frustration at how his life was spiralling out of control. At the same time he showed that where there were clear boundaries and consequences to his actions he did in fact respond well to these. There was evidence that he was able to develop trusting relationships with professionals and these were leading to significant disclosures.

9.9. More effective supervision and challenge alongside management oversight may have supported professionals to identify this and may have led to a change of strategy.

9.10. Risk of Child Sexual Exploitation was a key feature in this case that some of the professionals were aware of and working to reduce, however not all professionals working with Child G were aware that the view had moved to the fact that he was possibly a victim.

9.11. Professionals did not consider the number of key indicators alongside the presence of 'push-pull' factors early enough. These factors may have prevented engagement and Child G's ability to address his mental health and substance misuse issues.

9.12. As far back as 2009, Eileen Munro's work to improve child protection systems, identified that it is not possible to remove all risk and that a 'risk sensible' model, where the benefits of protective action must be weighed up against the cost of protective action in disruption to family life and other unintended consequences. Professionals in this case were cognisant of that and were engaged in many meetings, particularly towards the beginning and mid 2016 that were trying to discern the best approaches to keep Child G safe.

9.13. There is no one element of learning in this case that can be identified that would have changed the outcome. Indeed, there were some significant improvements in engagement by Child G that may well have been due to improved relationships that led to him having the confidence to speak to his Mother about concerns he had.

9.14. Child G was using drugs and alcohol and becoming increasingly involved in violence towards others before he died. Professionals discussed the possibility that he may die as a result of his behaviour. Indeed, Child G himself wrote letters to his family acknowledging this risk. He was also concerned about physical symptoms he was experiencing that he felt may lead to his death. It was not possible to predict with certainty that Child G would die, and even more when it would happen. In fact, it did happen at a stage that was possibly the least predicable when there was some considerable improvement in the way Child G was engaging.

10. RECOMMENDATIONS

10.1. This review recognises that many of the identified learning points (3, 7, 8, 9, 11) have been addressed by recommendations in recent reviews, actions against which are already underway and/or completed. Further recommendations are therefore not made within this review.

10.2. The following recommendations are made in respect of the additional learning and assurance required from this Serious Case Review:

1. BwD LSCB should require its partner agencies to provide evidence that:

    a. When working with children and young people, professionals are competent to manage the needs of adolescents with challenging behaviour who also have a learning difficulty and maybe impacted by Adverse Childhood Experiences. Agencies should also evidence ability to signpost professionals for further help and support in managing complex adolescents with learning difficulty, mental health issues and impacts of Adverse Childhood Experiences. (LP 1)

    b. Relevant staff have received training regarding duties under the Equality Act (2010) and can demonstrate, via audit if appropriate, how reasonable adjustments have been made to support adolescents with a learning difficulty to access and engage meaningfully with services. (LP2)

2. BwD LSCB be assured that Children's Social Care along with key identified partners, review the strategy meeting process for complex cases and specifically that the review incorporates the learning from this serious case review (LPs 4 & 5).

3. BwD LSCB should undertake a further case file audit at a relevant future point related to Child Sexual Exploitation to ensure that actions taken and reviewed guidance since this and other recent learning are making a difference to the identification of Child Sexual Exploitation and its response in BwD. (LPs 10 & 12-15).

4. BwD LSCB should require commissioners of substance misuse training to ensure that course content includes the importance of ensuring changes in substance use is alerted to substance misuse workers and indicators of drug intoxication that would require medical assistance. (LP6)

5. BwD LSCB should include ALL the learning points from this review in their next practice briefing and seek assurance from agencies regarding its dissemination to all relevant staff. (Impact assessment via audit of knowledge of the learning may offer some assurance).

Appendix 1: Terms of Reference (Redacted)

1. Introduction:

1.1 This Serious Case Review is commissioned by Blackburn with Darwen Local Safeguarding Children Board following the death of Child G.

1.2 Child G had been in local authority care from June 2015, initially in foster care and then in two residential units. Prior to this the child had been known to a number of agencies for early help services, known to Children's Services at Child in Need and subject to a child protection plan. The parents of Child G requested in June 2015 that he be placed in local authority care as they could not manage his behaviours. He had assaulted his mother on two occasions in 2015.

1.3 Child G was regularly reported missing from foster care and residential care and was assessed at high risk of child sexual exploitation. Due to the assessed risks, Child G was placed in an out of borough residential placement for a period of three months and then returned to the residential unit in Blackburn. In September 2016, Child G was charged with assault, affray and possessing an offensive weapon, and was subject to intensive supervision surveillance (ISS) bail conditions including to reside at a residential unit in Blackburn. Child G was found unresponsive in his bedroom at the residential unit. He died in early October 2016.

2. Legal Framework:

2.1 Serious Case Reviews and other case reviews should be conducted in a way in which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

(Chapter 4 para 11, Working Together, 2015)

3. Methodology:

3.1 This Case Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- Active engagement of practitioners

- Engagement with families
- Systems methodology.

4. Scope of Case Review:

4.1 Subject Child G

4.2 Scoping period: from November 2014 [period when first referred to Multi Agency Safeguarding Hub for concerns about risky behaviours] to October 2016 [date of Child G's death].

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of Child G and his immediate family. This will include any significant events that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

(NB. Please see Appendix 2 for the list of services covered within these agency reports)

5.1 Agency Reports will be requested from:

- Children's Services (Social Care)
- Children's Services (Education and Schools)
- Independent Children's Home
- Police
- Ambulance Service
- Clinical Commissioning Group (CCG) for family GPs
- Health and Care NHS Foundation Trust
- NHS Hospitals Trust
- Family Support Services
- Substance misuse and recovery services 1&2
- Youth Justice Service.

5.2 Agencies were requested to use the report template that was provided BwD LSCB.

6. Areas for consideration:

6.1 Critically evaluate the quality of assessments and decision making. Was the risk to Child G and his unmet needs fully understood? How were developments responded to, including changing levels of risk, eg in the case of allegations of assault? Was appropriate action taken? Also include any risk Child G posed to his mother.

6.2 How well was the history understood for the purposes of assessment? How well were relationships within the sibling group understood? If any preventative work or escalation had taken place or if there were missed opportunities in Child G's case from 2009 to 2014 was this known or shared during the scoping period?

6.3 Analyse the approach taken to Child G's non-engagement. How did this continued lack of engagement impact on service provision as the case progressed? How did it affect agencies' ability to safeguard Child G?

6.4 Multi-agency meetings were taking place in Child G's case. However, could communication and information sharing have been improved between agencies as part of this process? Were the correct agencies in attendance for meetings?

6.5 What role did management oversight play in enhancing the quality of practice?

6.6 Did services fully understand and meet Child G's diversity needs, for example in relation to his learning difficulty? Please comment in the context of duties under the Equalities Act 2010.

6.7 How was Child G's voice incorporated into assessments?

6.8 Did communication within and between services operate effectively, for instance during transitions between parts of a service or between practitioners? What role did record keeping play in this?

6.9 Identify examples of good practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. BwD LSCB will inform the family that this Review is being undertaken. The independent lead reviewers will follow up by making contact with Child G's parents and step-father.

7.2 Their contributions will be woven into the text of the Overview Report and they will be offered feedback at the end of the process.

8. Timetable for Case Review:

Scoping Meeting	February 2017
Letters to Agencies	February 2017
Agency Report Authors' Briefing	February 2017
Engagement with family	Begin March 2017
Agency Reports submitted to BwD LSCB	April 2017
Agency Reports quality assured	April 2017
Agency Reports distributed	May 2017
Learning Event	May 2017
First draft of Overview Report to BwD LSCB	June 2017
Recall Event	July 2017
Second draft of Overview Report to BwD LSCB	July 2017
Presentation to BwD LSCB of Final Overview Report	October 2017

9.0 The Lead Reviewers

9.1 Donna Ohdedar is a solicitor with a public law background as Head of Law for a metropolitan authority. Karen Rees is from a nursing background, having worked for 36 years in the NHS. Latterly Karen worked in safeguarding roles at a strategic level in two NHS organisations. Karen has worked with both Safeguarding Adult and Safeguarding Children Boards over a number of years and specifically on Serious Cases and Case Review sub groups.

10.0 Process

10.1 Following the decision by BwD LSCB to commission a SCR, a scoping meeting and authors' briefing took place in February 2017 to agree the Terms of Reference with representatives for BwD LSCB and to introduce the SILP model process and expectations to authors of agency reports.

10.2 Agency reports identified within the Terms of Reference were completed within the timescale. A Learning Event took place in May 2017 which was well attended by authors, managers, practitioners and safeguarding leads from the organisations involved with Child G and his family.

10.3 A Recall Event took place in July 2017 prior to which the first draft of the report was circulated to attendees. The recall event tested out the learning and gave opportunity for participants to give their feedback and perspectives.

Appendix 2: Services Involved with Child G (Anonymised)

Agency	Service	Provision/Service Type	Remit	Parameters (if Any)
Family Support Services	Family Support Service	Third Sector/Registered Charity (commissioned through individual schools)	Offering school based family support and mediation	Early Help
	Reparation Services	Third Sector /Registered Charity (commissioned service through Youth Justice Service)	Support for Young people who have committed offences to pay back to local community	for Young people who have committed offences
	Appropriate Adult Services	Third Sector/Registered Charity (commissioned service through Youth Justice Service)	Support for Young people in custody	Support where it is not possible for family member to be Appropriate Adult
	Placement Services	Third Sector/Registered Charity (commissioned through Children's Services)	Source suitable fostering placement	
Local Constabulary	The Police	Statutory	Universal	
	Police Early Help	Additional statutory	Targeted to children who display behaviours that may result in future criminal justice service involvement	Early Help before Youth Justice Service involvement
Children's Services (Social Care)	Multi-agency safeguarding hub	Statutory multi-agency team	To screen contacts for s.17 & s.47 referrals; onward referral to early help services for contacts not meeting the statutory threshold	s.17 and s.47 case allocation
	Children's Social Care	Statutory Children's social work	Where Threshold for Children's Social Care Intervention at Child in Need & Child Protection is met.	0-18 on referral and threshold met
	Child Sexual Exploitation Team	Additional Statutory Multi Agency Team	Risk of child sexual exploitation and missing from home services	

Agency	Service	Provision/Service Type	Remit	Parameters (if Any)
	Looked After Children Team	Statutory Children's social work	Looked after children and children leaving local authority care	0-18 on referral and threshold met – up to age 25 for leaving care services for children with learning difficulties
	Children's Home 1	Residential Care and Support	Medium to long term accommodation for Looked after children, support for young people to prepare them for independent living	Ages 11 to 17
	Adolescent Support Unit	Day and overnight respite care for children on the cusp of care or in a range of looked after placements	Short to medium term support for children to rebuild family/carer relationships	Ages 11 to 17
	Review & Protection Team	Statutory for children on child protection plans and Children Looked After	Review, monitor and scrutinise the CP/care planning. Ratify the plan and challenge the Local Authority when there is drift or delay in progressing the plan and improving outcomes	Child Protection and Looked After Child.
Youth Justice Service	Youth Justice Service	Statutory	Provide all services to support a young person through out of court disposals, courts and conviction and to ensure orders/sentences are served and reoffending is minimised; services for young people displaying sexually harmful behaviours	Under 18 on conviction until order ceases
Independent Children's Residential home	Children's Home 2	Private Residential Care	Provide residential care commissioned by Children's Social Care	

Agency	Service	Provision/Service Type	Remit	Parameters (if Any)
BwD Children's Services (Education & Schools)	Educational Psychology	Statutory Educational Psychology	On Referral application of psychological theory, research and techniques to support children, young people, their families and schools to promote the emotional and social wellbeing of young people.	Social, emotional and behavioural difficulties requiring psychology services but below psychiatry thresholds
	Special Education Needs & Disability	Statutory Universal	Assess, support and monitor progress of children who may have SEND	
	Virtual Head	Statutory for children looked after and children leaving care	Provide oversight and referral to additional services to support education attainment, attendance and behaviour for looked after children and leaving care children	LAC & Leaving Care
	The Primary School	Statutory Universal	General Education	Ages 4-11
	The Senior School	Statutory Universal	General Education	Ages 11-16
	The Pupil Referral Unit	Statutory	Education for Excluded/High Risk Children/suspended	11-16 Age Range On Exclusion or threat of exclusion
	The Special School	Independent School	Education for children with Social Emotional Behavioural Difficulties (SEBD)	SEBD
Ambulance Service	Paramedic and Ambulance Service	Statutory Universal	Responding to Emergency calls for medical emergencies	Emergency Service
	111 NHS Call Service	Statutory Universal	24 hour signposting to local health services online and by phone	
GP Practice	GP	Statutory Universal	Providing Primary Health Care	To those registered with the practice

Agency	Service	Provision/Service Type	Remit	Parameters (if Any)
The Health Care Foundation Trust	School Nurse Health Visitor	Statutory Universal (commissioned by LA Public Health)	Public Health Service for children	Ages 0-18
	Child Sexual Exploitation Nurse	Statutory Additional (commissioned by Clinical Commissioning Group)	Work with Young People at risk of Child Sexual Exploitation	On Referral
	LAC & Leaving Care Nurse	Statutory Additional (commissioned by Clinical Commissioning Group)	Provide oversight and referral to additional services to support health needs for looked after children and leaving care children	LAC & Leaving Care
	Criminal Justice Liaison & Diversion	Statutory Additional (commissioned by NHS England)	General health and mental health screening in custody suites	On arrest and subject to police custody
	Occupational Therapy	Statutory Universal (commissioned by Local Authority Public Health)	Enabling participation in daily activities for health and well being	Those with disability, illness or family circumstance mean that they need additional support
	Speech and Language Therapy	Statutory Universal (commissioned by Local Authority Public Health)	To assess and provide therapy for a range of speech and language difficulties	
	Genito-Urinary Medicine	Statutory Universal Sexual Health Services (commissioned by LA Public Health from April 2016)	Sexual Health Service	Children & Young People (up to age 25)
	Sudden Unexpected Death in Children Nurse	Statutory (commissioned by Clinical Commissioning Group)	Responding to sudden and unexpected death in childhood	For all children that die unexpectedly (i.e. the death was not expected the previous 24 hours)
	Adult Mental Health	Statutory (commissioned by Clinical Commissioning Group & NHS England)	Psychology, psychiatry and inpatient adult mental health services commissioned through Clinical Commissioning Group and NHS England. Child and Adolescent Mental Health	Age 16 into adulthood

Agency	Service	Provision/Service Type	Remit	Parameters (if Any)
			Services for 16-17 year olds.	
The Hospitals NHS Trust	Paediatrics	Statutory	Clinical medical paediatric assessment and intervention	
	Emergency Department/ Urgent Care Centre	Statutory	Accident and Emergency Services	
	Hospital inpatient assessment Unit	Statutory	Inpatient paediatric assessment	
	Child & Adolescent Mental Health Services	Statutory	Child and Adolescent Mental Health Services	Ages 5 to 16
	Genito Urinary Medicine	Statutory Universal Sexual Health Services (commissioned by Clinical Commissioning Group prior to April 2016)	Sexual Health Service	Children & Young People (up to age 25)
Teaching Hospitals NHS Trust	Sexual Assault Referral Centre	Additional statutory (commissioned by NHS England)	All age forensic police and medical assessment for victims of sexual assault	All ages
Substance misuse services	Young People's Substance Misuse and Recovery Services 1	Third Sector/Registered Charity (commissioned by Public Health up to March 2015)	Young Peoples Substance misuse recovery services	
	Young People's Substance Misuse and Recovery Services 2	Third Sector/Registered Charity (commissioned by Public Health from April 2015)	Young Peoples Substance misuse recovery services	

Appendix 3: Pathways to Harm, Pathways to Protection from Triennial Analysis of Serious Case Reviews

Appendix 4: Key Episodes; Pathways to harm, pathways to protection

Key Episode 1: Background prior to scoping period; setting the context (significant events and service provision before November 2014)

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
Family and Parental histories • Mother and Father live separately • Step Father part of family • New sibling • Some professionals undertaking assessments become aware of parental histories. **Early parental concerns** • Mother seeking support for diagnosis but does not accept parenting courses due to work commitments.	**Possible emerging Learning Difficulties** • Dyspraxia diagnosed 2010 • Child G feels different and that something is wrong	**Child G's increasing frustration** • With himself that he was not achieving in education **Reports of self-harm** • Hits and bites himself and bangs head on walls **Behaviour is beginning to present challenges** • Behaviour manifests at school and home **Substance misuse** • Child G reports he had tried Cannabis and alcohol as a stress reliever • Mother reports has come home drunk on several occasions **Potential physical abuse** • Experienced by Child G from father observed slapping in school grounds	**Referrals to various health services** (GP, Pediatrician, Speech and Language Therapy, Education Psychology, Occupational Therapy) to identify possible diagnoses and therefore provide protective interventions based on need. **Occupational Therapy** identified need for parenting/Common Assessment Framework/ Mental health assessment/ Special Educational Needs assessment **School Action Plus** and associated assessments Trying to address Child G's education needs and keep him engaged and focused on positive outcomes **Family Support Service** Commenced work with family in April 2014 - Child G wanted a focus on anger management and improving family relationships **Support from Family** Family seeking help and support for Child G.

Key Episode 2: Child in Need to Child Protection, November 2014 to May 2015

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
Family Separation • Mother and Step Father separating, issues lead to Child G being cared for by other family members and some time at adolescent support unit **Parental histories** • Some assessments and services were being offered without a full understanding of the family history and any impact that may have had on the parents or Child G **Multiple referrals for support** • Increasing number of referrals to try and support Child G and his family **Multiple appointments** • Multiple referrals led to an increase in the number of appointments and contacts expected of Child G **Family Stress** • Incidents with Child G impacting on parents mental health and wellbeing and relationship issues due to concern for sibling	**Learning Difficulties** • ADHD • Dyspraxia **Child G feels different and that something is wrong** • Child G telling professionals & family that there is something wrong with him and that he is not 'normal' like others - this increases vulnerability to isolation as he finds it difficult to engage with peers and education **Possible emerging mental health issues** • Early signs of anxiety and stress that require further mental health assessment **Fear from Mother** • Behaviour escalates and violence increases, Mother becomes frightened of him - Child G has always had a strong bond with his mother so his mother becoming a victim of his anger leaves him vulnerable if he loses the support of the person who is his strongest advocate **Not engaging with services** • By not engaging with support, he is vulnerable to services not being able to improve outcomes for him • Child G's engagement with	**Substance misuse** • Substance misuse increases in this period; now daily occurrence; shows insight that it is the drugs that he needs to deal with **Missing from home** • Initially Missing from Home episodes not understood and reported retrospectively by family. Reporting and responding to these becomes part of plans trying to gain an understanding of where he goes (becomes more of a feature in the next episode) • Becomes a victim of crime whilst missing **Violence to others and criminal incidents** • Threats and actual violence towards Mother are increasing and concerns expressed about safety of Child G's younger sibling. Risk for Child G he can no longer live with the family that are his closest bond; this leads to periods in custody and inclusion of Youth Justice Service • Violence in school leads to being educated separately • Total of six incidents where Child G is perpetrator of	**Ambulance Service/ A&E attendances** Conveyed to A & E for safety and treatment total of 11 times sometimes when under influence of drugs and alcohol; requested police support to keep Child G safe. Eight A&E attendances in this episode for a variety of reasons related to mental health and physical symptoms of substance misuse. **Child in Need Plan (Jan-May 2015)** Social Worker leads Multi Agency planning to ensure a robust plan of support from all the agencies involved. Three meetings take place in this period. **Child and Family Assessment** Social work assessment: Identification of Strengths and risk issues on which to build a Child in Need plan. **Family Support Service** Supporting the whole family, but needs outweighed what this service could offer so plans to transfer to Troubled Families programme. **Substance misuse service support and intervention** First engagement by services to directly address substance misuse. **School Action Plus and associated assessments -Commencement of Special Educational Needs Statutory Assessment** Identification of needs requires specialist intervention. Assessment identifies needs and the resources required to meet them. Three reviews take place in this episode. **Police Early Help Officer** Support to engage and discuss risks and issues. Attempting to build a trusting relationship. Also, searching properties Child G attends **Child and Adolescent Mental Health Services Assessment** Attempts to identify any underlying metal health illness and to support with ADHD issues. Commenced treatment but stopped after overdose on medication. Substance misuse prevents accurate diagnosis as causing

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
	services became more difficult **Physical symptoms of stress and substance misuse** • Child G having increasing physical pain symptoms thought to be anxiety related - strengthens his belief that there may be physical health needs adding to anxiety. Has ongoing physical symptoms such as palpitations and chest pains etc. **Missing Education** • As education find it increasingly difficult to manage him and he disengages with education he is more on his own and left to his own devices and begins to go missing **Placement moves (within Family)** • Following increasing issues, Child G goes to live with Father for a period, then returns home, then to Grandparents after assault on Mother • Returns home after accommodation not sanctioned from Children's Social Care	crime **Victim of crime** • On two occasions Child G is identified as a victim of Crime **Self-harm** • Frustration, anxiety and anger result in some episodes of self-harm e.g. punching walls and punching and hitting himself **Risk of Child Sexual Exploitation** • The risk of Child Sexual Exploitation begins to emerge as Child G's behaviour escalates **Paediatric assessment** • Possible neurological or medical causes for Child G's agitation that could not be contributed to his ADHD diagnosis was lost due to multiple appointments (one for LAC medical assessment, one for the agitation and one for overall case management from the GP's referral back in 2014 – all three paediatricians were in separate teams) leading to father cancelling appointments	associated symptoms. **Child Protection Plan (May 2015)** Follows escalating concerns and assault on mother and damage to property. Produced multi agency plan with social worker as Key Worker to support Child G back to School and address substance misuse. Accommodation split around family. One Initial Child Protection conference and one core group meeting take place. **Adolescent Support Unit** Offering interventions and strategies to help address his issues and prevent him becoming Looked After. Overnight accommodation when not able to be at home. **Support from Family** Family remained committed to Child G. This was important to Child G and he identified this as a focus of any work he engaged with. **Youth Justice and Reparation** To work to prevent further reoffending and therefore keep Child G safe. To complete sentence requirements of Youth Caution.

Key Episode 3: Section 20 Accommodation to Movement out of Area, June to December 2015

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
Family Separation • S20 accommodated **Multiple referrals for support** • More services become involved **Multiple appointments** • Continue **Multiple assessments** • Continue **Family Stress** • Adults continue to be impacted with the circumstances affecting mental health wellbeing	**Learning Difficulties** • ADHD • Dyspraxia **Child G feels different and that something is wrong** • Mental health issues • S20 accommodated • Now living away from family and contact with younger sibling denied by Step Father due to risk **Not engaging with services** • Chooses which services to engage with – (often those with specific boundaries and consequences) **Physical symptoms of stress and substance misuse** • Continues to be troubled by physical health symptoms that cause increased anxiety **Missing Education** • Continues to miss education but new placement for specialist education found **Placement moves** • Foster Care, brief period in	**Substance misuse** • Substance misuse slightly reduced in this period but continues alcohol use **Missing from home** • Missing from Home episodes (27 in this Key Episode) start to become a real concern • The Child Sexual Exploitation team now involved with return home interviews • Refuses to say where he is when he is missing **Violence to others** • Assault on Mother results in a second youth caution **Victim of crime** • On one occasion Child G is identified as a victim of Crime **Self-harm** • Continues self-harming behaviour **Risk of Child Sexual Exploitation** • The risk of Child Sexual Exploitation begins to escalate as Child G's missing episodes increase	**Adolescent support unit** Continues to offer support via outreach during the day. **Substance misuse service support and intervention** Contract moved to new provider, remained involved but little engagement from Child G; ended in October 2015. **Youth Justice and Reparation** Continued until November 2015. **Support in custody** Appropriate Adult Services[34] were provided to support Child G in custody. **Looked After Child Review (x2) & Strategy Meetings (x6)** Social work involvement continued following S20 accommodation - became subject to Looked After Child Reviews in order that multi-agency planning continues to identify Child G's needs to support and keep him safe. Challenges to partners by IRO. **Police Actions:** **PVP reports** Information sharing of Incidents: Risks identified to Children's Social Care and Health **Managing criminal behaviour** Community resolution used for offence at local supermarket. **Integrated Proactivity Partnership (Two Meetings)** Proactively manage Child Sexual Exploitation risk - disruption of known adult associates. Allocating professionals, tagging systems, information sharing. Missing from Home Trigger plan. **MARAC[35]** Issues discussed to ensure Mother and Child G are safeguarded and getting support (NB MARAC is Victim focused but due to issues, plan includes support for Perpetrator - Child G)

[34] **Appropriate Adult** Services provide independent support for any vulnerable adult who comes into contact with the Criminal Justice System, whether as an alleged offender, victim or witness of a crime. The Appropriate Adult role was created by the Police and Criminal Evidence Act (PACE) 1984 with the intention of safeguarding the rights and welfare of vulnerable young people and adults in police custody.

[35] **A Multi Agency Risk Assessment Conference (MARAC**) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
	Adolescent Support Unit then Residential Care		**Special Educational Needs Assessment** Specialist provision sourced to try and provide appropriate education. Child G. Commenced Special School in September. Attendance initially more consistent than previous episode. **Child and Adolescent Mental Health Services** CAMHS were continuing with assessments in this period that conclude that Child G does not suffer from psychosis but is depressed; has medication for depression and sleep issues prescribed and is offered individual therapy, family therapy, anxiety therapy and counselling. **Ambulance Service/A&E** Continued as per Episode 2. Two A&E attendances in this episode. **Child Sexual Exploitation Team** Provide support and protection following missing episodes to try and prevent further episodes and to ascertain activity and whereabouts whilst missing. **Missing from Home Plan** This was added now that the Missing from Home episodes were significant (27 recorded by police in this period with 92 in total in Key Episodes 2 to 5). **Sexual Health Services** Nurse offered sexual health advice (part of Child Sexual Exploitation Team) and healthy lifestyles support and arranged for screening. Child G attended for sexual health assessment on one occasion and was seen at the local Sexual Assault Referral Centre for medical. **Support from Family** Remained the same support albeit that they could no longer provide safe accommodation. **Family Support** This service continued even though in September 2015 there was a referral to the Troubled Families Programme.

Key Episode 4: Out of Area Placement, December 2015 to March 2016

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
Family Separation • S20 accommodated; Out of Area Placement **Sporadic engagement** • Periods of improved engagement but not sustained	**Learning Difficulties** • ADHD • Dyspraxia **S20 Accommodated** • Now living away from family and all contacts at the out of area placement/locality **Not engaging with services** • Continues to have sporadic engagement despite less services being involved **Missing Education** • Failed to attend Residential Care Company's school and agreed to be taught at the children's home - did not engage and received no education whilst out of area **Placement moves** • Moves to out of area placement **Child and Adolescent Mental Health Services** • Discharged from service on leaving home area. Out of area Child and Adolescent Mental Health Services had waiting list of three months **Medication not available** • Anti-depressant and sleep medication running low in first few days. Delays in obtaining medication. Refuses on occasion to take the medication	**Substance misuse (mainly alcohol at this time)** •Criminality whilst intoxicated •Risk of being victim whilst intoxicated •Admitted to taking ketamine and alcohol **Missing from Home** •One occasion in this period	**3 Month placement plan** Appeared to have positive impact as knew placement could be extended if did not comply with boundaries. **Children's Home 2 Environment** Encourage healthy lifestyles; access to gym and leisure activities Children's Home 2 staff encourage access to these activities and Child G engaged with these. **Looked After Child Review** LAC Review continues and two meetings held. Plan for transition back to home area and still for reunification to family. **Education Plan Review** To review SEN Plan & plan move back to locality. **Support from Family** Regular phone contact and some visits, with outings and staying at a local hotel with Mother and sibling. Contact over Christmas period an issue; Child G low in mood on Christmas day. **Substance misuse service support and intervention** Child G refused to engage. **GP** Accesses GP for medical concerns when necessary but sometimes refused to go for appointment. Issues related to physical symptoms possible from substance misuse and other concerns. **Sexual Health Services** Child G requests appointment but refuses to attend. **Police & Youth Justice Action** Community Resolution for offence under public order act and being intoxicated. **IPP meetings** Child G continued to be discussed within IPP meetings during this period (two were held)

Key Episode 5: Return to Home Area to Date of Death, March to October 2016

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
Family Separation • Remains S20 accommodated • Returns to Children's Home 1	**Learning Difficulties** • ADHD • Dyspraxia **Child G feels different and that something is wrong** • Depression and Anxiety • Refusing prescribed medication • Delay in Child and Adolescent Mental Health Services referral when back in area **S20 Accommodated** • Living back at Children's home 1 • Spending time from May 2016 at mother's and cousins with the consent of mother **Not engaging with services** • Begins to show some engagement **Physical symptoms of stress and substance misuse and sexual assault** • Continues to be troubled by physical health symptoms that cause increased anxiety **Missing Education** • Continues to miss education although it becomes part of the Bail plan later **Change of workers** • Transferred to Looked After Child social worker as no	**Substance misuse** • Drug use now out of control and impacts on ability to undertake any focused work on Child Sexual Exploitation, substance misuse & mental health **Missing from home** • Absconds from out of area placement and remains missing for six days • Missing episodes escalate (41 in this period) **Violence to others and Criminal incidents** • Violence against others escalates and Child G is arrested for assault in March 2016, bailed and charged • Assaulted staff member at Children's Home 1 • Total of six incidents of Child G being a perpetrator of crime • Arrested for assault in September 2016, bailed and charged **Victim of crime** • On at least four occasions **Self-harm** • Begins to talk about dying due to knowledge of risks of lifestyle **Risk of Child Sexual Exploitation** • Scored very high on new Child Sexual Exploitation assessment	**Education** Further review of SEND plan. **Child Sexual Exploitation Team** Provide support and protection following missing episodes as before. Child G refuses to say where he has been because it had caused problems in the past with his friendships. Also, undertook new Child Sexual Exploitation assessment. **Strategy meetings for Missing From Home** Considers another out of borough placement but concerns that may hinder access to current level of support. A total of nine strategy meetings take place. **Sexual Health Services** Receives assessment on two occasions and self-reported risks identified. **GP** Number of missed appointments for complaints of physical symptoms, but attends an appointment in August where a disclosure of sexual abuse is made leading to a referral to Paediatrics. **Looked After Child Review (x2) & Risk Management Strategy Meetings (x9)** Considers significant escalating risk and seeks legal advice. Challenges if S20 still appropriate. Consideration of further out of area placement. 6th Looked After Child Review August, little progress or change noted. **Child and Adolescent Mental Health Services** Seen again in this period, but for periodic review as refused specific therapy. **Substance misuse service support and intervention** Some sporadic engagement but most importantly a change to a male worker in September who manages to increase engagement. **Ambulance Service & A&E Attendances** Continued to convey as per previous episodes. Attended A&E on 11 occasions in this episode for varying reasons: anxiety and

Context	Vulnerabilities	Risks	Protective/Preventative Actions and Systems
	plans for Child G to go home • Change of Child Sexual Exploitation worker that causes Child G anxiety **Plans start for transition** • In both Child and Adolescent Mental Health Services and Children's Social Care who are now involving relevant professionals e.g. School nurse for care leavers	• Unwell on return from a missing episode, had money from an unknown source, sold belongings and is shoplifting	depression, drug related physical symptoms, injuries from violence and self-harm/ overdoses. **Support from Family** Remained supportive but they were unable to keep Child G safe. **Youth Justice and Reparation** Recommenced reparation in June for offence in March. Two professionals meetings to consider safeguarding risk management Subject intensive supervision following offence in September. **Support in custody** Criminal Justice liaison service visited Child G in custody on two occasions. On the second occasion, denied substance use for over a year and stated drank socially. **Intensive Supervision & Bail Support package** Following Youth Referral Order for assault in September 2016. Largely conformed with the requirements of this package. **Police Actions:** **PVP reports** Information sharing of Incidents: Risks identified to Children's Social Care and Health. **Managing criminal behaviour** Further arrest September 2016. **Multi Agency Child Sexual Exploitation Meetings (replaced IPP)** Created further plans on return as Key Episode3; met six times in this episode under IPP arrangements and twice under MACSE arrangements.

Appendix 5: Single agency recommendations (redacted for publication)

Children's Services - Children's Social Care

Recommendation	Detailed actions
In complex cases, agencies should collaborate at a strategic level to determine which agency takes the lead in overall risk management.	Senior Management to meet and agree: • Key risks and which agency will take overall lead on risk management • Agree to jointly fund specialist resources where appropriate, including placements • Prioritise and sequence risks and services in one overarching multi-agency plan addressing the holistic needs and risks. This may mean making decisions that some services will not be involved until a later stage.
All Children's Social Care case records should be on one system – Protocol.	• Residential Unit records should be written on Protocol. They should retain the written record for the young person, but also keep case records on Protocol under case notes. • Adolescent Support Unit should record their involvement on Protocol under case records. • CSE Team and IRO already record involvement on Protocol, but this should be consistent and include all interventions. • Children's Social Care needs to fund technology in Children's Home 1 and Adolescent Support Unit to ensure that they have good access to Protocol. • Children's Social Care need to update Liquid Logic to be able to include residential and support services. • Events from Residential Units, Adolescent Support Unit, CSE Team and IRO should be part of the chronology. • All staff in Residential Units, CSE Team and Adolescent Support Unit will receive training in use of Protocol and in writing case records and chronologies.
Risk Assessments should be updated every three months and a new Risk Assessment completed and signed by management.	• Risk Assessments will be reviewed every three months. Notes of the review will be made and the Risk Assessment updated, dated and signed off by the manager. • Compliance with Risk Assessments will be the responsibility of the manager and should be reflected, where appropriate, in supervision

Recommendation	Detailed actions
	notes. Put Risk Assessments in Forms on Protocol.
Case Decision Forms should be used consistently across the service.	Head of Service (Assessment Teams) will provide brief guidance for all staff when Case Decision Forms should be used. It will be made clear to staff that a Case Decision Forms will need to be completed when a decision has not been actioned.
Consistent use of Strategy Meetings.	• Ensure staff understand the mandate for meetings, particularly when to use formal Strategy Meetings. • Strategy Meetings must be recorded on the template and put in forms in Protocol. • There should be enough Business Support staff to support this process.

Children's Services – Education and Schools

Recommendation	Detailed actions
Early identification, intervention and prevention.	• Agree a profile for vulnerability in terms of emotional health and well-being. Provide related continuous professional development for school staff and local authority officers. • Audit offer of targeted support for Social Emotional & Mental Health (SEMH). • Improve signposting to support for SEMH.
Improved continuity in case recording, management and escalation in Education Psychology.	• Audit current processes and systems. • Review case management and escalation strategy. • Implement new ways of working.
Improved support on transition between schools in relation to children who have been identified as vulnerable.	• Develop School Transition Policy to improve information sharing between education providers at points of transition. • Identify effective strategies and resource to support vulnerable children on transition.
Develop better communication pathways between Inclusion Services, Education Psychology, Virtual School and Children's Social Care.	• Audit current communication pathways and decision-making processes. • Jointly develop new ways of working e.g. greater schools & education involvement in MASH.

Independent Children's Home

Recommendation	Detailed actions
Develop more efficient process in terms of handover of young persons from one CAMHS to another.	Review of process of referral and handover from local to current CAHMS service.
That team training in the area of Dyspraxia and other learning difficulties is identified as a need in the Impact Assessment process.	A service is identified for carrying out such training to teams once needs are identified via Impact Assessment.
That the placing authority are efficient in processing the referral for an updated CSE assessment based on new placement and location where CSE has been previously identified as a risk for a young person.	Process reviewed in respect of CSE referrals and the allocation of young person to CSE worker. This to be supported by CSE Manager in the Group's Management Team.

Local Constabulary

Recommendation	Detailed actions
To ensure a joined up approach with information sharing within the organisation between specialist teams, from those that identify early signs of CSE to those dedicated to work with CSE.	To ensure the new CONNECT computer system that is being implemented force wide as a full IT infrastructure will adhere to this required outcome by linking information recorded by both Early Action and CSE Teams. This has been raised with the CONNET implementation team and has been added to their work plan. This will further allow sharing of information through all departments as it will be an organisational data capture site incorporating MASH, through the investigation recording of incidents.
To address the retention of information regards vulnerability and how this recorded and actioned with a corporate footprint. Ensuring that multi-agency activity is recorded on corporate systems allowing all staff to identify who is responsible and the current position when working with children.	To ensure the new CONNECT computer systems that is being implemented force wide as a full IT infrastructure will adhere to this required outcome by linking information through the organisation and MASH allowing for a corporate footprint. This has been raised with the CONNET implementation team and has been added to their work plan. The recording of investigations through the data retention arm of CONNECT will allow that multi agency activity can be recorded specific to each child or person with connection to the constabulary and will be retained digitally on the system. Furthermore the recording and retaining of actions for specific children will be recorded on the child's

Recommendation	Detailed actions
	investigation plan and as such will be shared with the allocated action owner in line with regional policies.
To ensure any vulnerability training includes mental health and is inclusive of the Equality Act to ensure learning difficulties and other conditions are considered.	• To ensure vulnerability training which includes all aspects of mental health, learning difficulties is delivered across the constabulary to all employees and support staff. • To ensure the continued use of the Mental Health Triage Team and refresher awareness of its capability to be shared with all employees and support staff. • To contact the College of Policing to gain direction with regards national training available in regard to 'less obvious' hidden conditions (Learning difficulties etc.)

Ambulance Service

Recommendation	Detailed actions
Promote awareness of the safeguarding policy and procedures for all staff groups across the trust.	Communications plan & safeguarding awareness week bulletin to promote updated policy and procedures.
Learning review with staff involved with Child G.	Hold a learning event including all relevant staff to highlight missed opportunities to refer. Share the learning across the trust via the learning lessons forums, bulletin and clear vision articles.
Promote awareness of the vulnerabilities of all young people displaying risk taking behaviours and the impact of the abuse of alcohol and substances in teenagers.	Include children in care and alcohol and substance misuse in the next wave of mandatory and level 3 training.
Discuss with the Frequent Caller Team the thresholds for children.	To discuss if thresholds for child frequent callers are adequate and if there was anything that may have changed our practice with regards to Child G.
To monitor and audit repeat safeguarding concerns submitted by Ambulance Service.	To review on a monthly basis the repeat safeguarding concerns submitted on the ambulance service database and work alongside outside agencies.

Clinical Commissioning Group (CCG) for GPs

Recommendation	Detailed actions
All practitioners within the practice to have an awareness of and the ability to act in identifying and protecting children who are at risk or experiencing abuse including sexual, physical, and emotional.	• Bespoke training in respect of sexual abuse and CSE to be accessed, by the practice. • Review Sample GP policy for safeguarding children to strengthen and include links to LSCB safeguarding procedures and safeguarding advice and support structures that are available for them to access. The safeguarding responsibilities expected from GP's to be outlined within the policy. Strengthen the role of the safeguarding lead within the practice: • CCG setting up GP safeguarding lead/ champion meetings on a quarterly basis, to ensure leads feel supported within their leadership role • Practice meetings to include a specific section for practitioners to discuss any safeguarding concerns • Safeguarding lead role outlined in the GP safeguarding policy.
All practitioners within the practice to feel confident and competent to recognise and respond to disclosures of domestic abuse when the child is identified as the perpetrator.	• GP sample domestic abuse policy to be reviewed and refreshed and be inclusive of the management of domestic abuse when the child is the perpetrator. • All clinical staff within the practice should be trained to the appropriate level as per NICE Guideline 50. https://www.nice.org.uk/guidance/ph50/chapter/7-Glossary#disclosure
Learning review feedback to take place with the practice.	Hold a learning event with the GP practice to highlight the key lessons learned from the review.

Health and Care NHS Foundation Trust

Recommendation	Detailed actions
In the new Trust Supervision Policy launched December 2016, a new process to be embedded in practice – where all CIN/Children on CP Plans/LAC will be brought to supervision on at least a 6 monthly basis.	• New Supervision process is currently being piloted within the Children & Family Health Service. The new supervision process ensures all targeted cases are discussed in a timely manner. • Guidance to be written by the Safeguarding Team advising practitioners to bring appropriate cases to supervision where there are concerns with non-engagement.

Recommendation	Detailed actions
Complex Case Supervision Processes	Complex cases to be discussed at group supervision sessions. Each month supervision session between CSE Nurses/line manager to discuss a number of complex cases; this should be recorded within the ECR record of the child.
Clinical supervision	To be undertaken with line manager on a monthly basis. Individual cases to be discussed. Cases should also be documented within health records when discussed in supervision.
Adherence to the Individual Health Assessment (IHA) Strategic Operating Protocol (SOP).	• For the IHA SOP to be re-launched. • Supervisors/Team Leaders to challenge School Nurses when IHA's are not completed in timely manner.
Review and re-launch Safeguarding Meetings booklet with Children & Family Health Service. Re-launch Safeguarding Template with Children & Family Health Service.	• Booklet to include prioritisation of attendance at Safeguarding meetings by CHFS and ensure the use of Safeguarding Template. • CIN/Core Group Minutes/CP Plans/Care Plans to be saved within child's record and discussed at supervision sessions.
Identification of lead Trust health professional.	• Upon notification of child/young person becoming known to the CSE service, there should be discussion re: who will be the most appropriate lead health professional. This discussion should include any Trust professionals involved with the case, and should be clearly documented within the health records. The co-ordination of care will then be the responsibility of the identified practitioner. • Clear documentation using case record tab 'Other professionals' involved. Use of the 'additional information' box on case records clearly stating who the lead health professional is for the Trust.
The Trust's Safeguarding Team Vulnerable Young People's Portfolio Group & High Risk Cases.	To attend interagency forum to discuss high risk cases and prevent duplication amongst health professionals.
Information sharing – improve the lack of interagency liaison.	• To ensure that there is liaison between inter agency professionals and multi-agency professionals, to ensure that relevant information is shared within a timely manner. • Attendance at meetings to be by the most appropriate health professional and actively chasing minutes from meetings if not received within a timely manner.

Recommendation	Detailed actions
	• CSE Nurse has access to Children's Social Care Protocol database and the Trust's ECR recording system to ensure information sharing. • In the absence of any electronic system, verbal communication will be undertaken.
CSE Nurse record of meetings/minutes.	• In involvement with child/young person, CSE Nurse to contact social worker informing of involvement and that they should be invited to meetings. • If minutes not received, CSE Nurse/admin support to actively chase up with Children's Social Care, to record within the ECR record of the child that this has been actioned. Received minutes to be saved in health records.
Adequate record keeping on child's records -health systems and Protocol (Children's Social Care).	For the Specialist Nurse Care Leavers (SNCL) to record on both the Trust's ECR recording system and CSC's Protocol recording system.
Formalise Young People's Information Sharing Agreements.	• Agree and Formalise Information Sharing Agreement with Youth Justice Services. • Establish clear links and referral pathways for Young People in custody.
Ratification and Implementation of Strategic Operating Procedures (SOP) for the Criminal Justice Liaison & Diversion (CJL&D) Services.	To have the current draft SOP ratified and available to support and guide all CJL&D service staff.
For individual reflection and team learning - to ensure CJL&D practitioners to take all possible measures to accurately identify those individuals referred by seeking collaborative information.	• Facilitate individual reflective learning. • Establish collaborative confirmation and checks as routine practice through team meetings and management and clinical supervision.
Consideration of child's wishes and feelings/child's voice.	To ensure that all information is recorded on the relevant recording system and that it is clearly documented that the child has been consulted with and their views considered.
Specialist Nurse for Care Leavers (SNCL) remit is to be clarified as 18 – 25 year old care leavers.	All members of staff are made aware of SNCL remit - Children 0-19 remain the responsibility of the child family health service.
Transition for care leavers approaching 18 to be undertaken in a multi -agency forum.	SNCL to liaise with relevant health professionals to complete handover to ensure smooth transition of health care needs.

NHS Hospitals Trust

Recommendation	Detailed actions
To ensure Child Adolescent Mental Health Services (CAMHS) are informed of all children under their care who attend the Emergency Department (ED), Urgent Care Centres (UCC) or Minor Injury Unit (MIU).	Confirm that the method of flagging patients who are under the care of CAMHS is in place. Reinforce flagging method across ED, UCC and MIU and CAMHS.
Hospital Trust Safeguarding Team share information with key clinicians involved with individual children.	Hospital Trust to review current information sharing systems and processes to ensure all information is shared appropriately.
All allegations of rape/sexual assault must be reported to the police. Responsibility lies with the practitioner and /or manager to whom the abuse is disclosed.	Raise Staff awareness of this requirement via: - safeguarding children training - safeguarding children policy - safeguarding intranet page - Trust forums, including the Internal Safeguarding Board.
To review current referral pathways for children with alcohol or drug misuse, and to include criteria for CAMHS referral within those pathways.	Review current Standard Operating Procedure (SOP) Include criteria for CAMHS referral. Raise Staff awareness of this requirement via: - safeguarding children training - safeguarding children policy - safeguarding intranet page - Trust forums, including the Internal Safeguarding Board.
To ensure information-sharing processes are in place for children at risk of CSE.	Review and strengthen existing processes for flagging children on the special register for CSE. Review information-sharing pathways to ensure information is shared appropriately both within the Hospital Trust and external agencies, such as the CSE Team.

Family Support Service

Recommendation	Detailed actions
Revised management arrangements for family support service.	• Clear management structure • Clarity of roles and responsibilities/reporting arrangements • Clarify of decision making responsibilities • Ongoing management training
Management oversight	• Clear organisational expectations • Processes in place to evident oversight • Staff clear about safeguarding processes
Decision making and escalation	• Escalation policy to be implemented • Staff to be made aware of this
Case closure/change of interventions	• To be discussed with manager • To be clearly evidenced in case record

Recommendation	Detailed actions
Wishes and feelings of young people	• All staff to be aware of importance of young people's views • Documentation amended to evidence views • Participation promoted

Substance Misuse Recovery Service 1

Recommendation	Detailed actions
Consider management sign off for complex / non-engagers receiving non-structured interventions.	• Inform staff within training sessions. • Ensure induction for new practitioners incorporates learning from SCR.

Substance Misuse Recovery Service 2

Recommendation	Detailed actions
Implement a young person's missed appointment checklist.	• The service to review how centrally designed tools, such as the Missed Appointments Checklist are used within the service, and are young person specific. • Develop a plan for implementing their use with all staff.
Implement a local engagement and transfer process and pathway.	• Local guidance to be developed to support the effective and timely handover of service users from one worker to another to limit impact and ensure continuity of care. • The service to review how it works with young people when they are moved into a secure placement and/or in to, or out of area.
Risk Pack to be available and to be used within service.	The service to schedule time to run a workshop with staff utilising the 'Risk Pack' resources to improve risk management techniques and encourage professional curiosity.
Staff to be re-trained on "safeguarding for young people".	All young people staff to arrange, and time to be protected, to attend the organisation's specific Safeguarding Young People training.
Improved record keeping and competence of staff.	• Improve competence of record keeping via a workshop, for staff - including referencing defensible decision making in relation to actions taken. • Guidance to be developed for staff to refer to.
Management plan in place for all service users that have a family member, carer or significant other employed within the service.	For there to be management plans produced for service users, where family members are employed within service - to ensure boundaries, safe and appropriate information sharing - with the service

Recommendation	Detailed actions
	user at the heart of what we do to understand the possible impact/barriers this might produce in a person engaging with services. To ensure that alternatives are considered.
Increase resources available to complete thorough safeguarding reviews.	• Additional Designated safeguarding lead (DSL) to be identified, specific for young people's service within BwD - to oversee reviews and supervision. • Template to be developed for use within safeguarding supervision by DSL.

Youth Justice Service

Recommendation	Detailed actions
Review of the Multi-Agency Risk Management Meetings (MARMM) Process and Intensive Support Service (ISS) Provision.	Determine what triggers a MARMM and what the YJS ISS offer is.
Briefings to other teams on YJS services.	Team briefings on developments and responsibilities of the YJS.
The development of an integrated adolescent strategy for vulnerable adolescents.	Leads from the service to develop a more coordinated response based on innovative ideas and best practice.
Better understanding of Learning Difficulties e.g. Dyspraxia.	Need for both training and understanding the BwD offer and referral route.