Serious Case Review

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On behalf of an unnamed local safeguarding children board

Local Child Safeguarding Practice Review

(LCSPR)

Child A

Agreed by the Local Authority Safeguarding Board

21st January 2021

Independent reviewer: Nicki Petitt

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1 Introduction

1.1.1 The Local Authority Safeguarding Board agreed to undertake a Local Child Safeguarding Practice Review (LCSPR) by considering the case of a 16-year-old girl to be known as Child A. They recognised the potential that lessons could be learned from this case about the way that agencies work together to safeguard children in the Local Authority.

1.1.2 Child A was detained under section 2 of the mental health act[1] in November 2019 following an incident where she stated she intended to jump from a bridge. She had been the subject of a child protection plan[2] and was a child in care[3] at the time. Child A was well known to mental health services and was at risk of sexual abuse through exploitation both online and in the community.

1.1.3 Learning has been identified in this review regarding:

- Assessing and planning when needing to respond to crises.
- Consideration of the trauma a child has experienced and ongoing risk, however they present.
- Working with families who are hard to engage, including fathers/male partners.
- Respectful professional challenge.
- The importance of reflective supervision.
- The need to build relationships.
- The law in relation to CSE, particularly the relevance to children aged 16 and 17.
- Providing services to a child living outside of their home area.
- Accessing a mental health assessment.

2 Process

2.1.1 An independent lead reviewer was commissioned[4] to work alongside a panel of local professionals who met on a regular basis to undertake the review, despite the impact of COVID 19. Chronologies and an analysis of partner agencies involvement and the effectiveness of their

[1] Mental Health Act 1983
[2] Category emotional harm
[3] S20 voluntary care Children Act 1989
[4] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the Local Authority

practice were requested from all those involved, and professionals involved at the time were meaningfully involved in discussions about the case.[5]

2.1.2 The lead reviewer has spoken to Child A.[6] Engagement was also planned with Child A's parents in order to identify any learning regarding systems and practice from their point of view. They chose not to meet with the lead reviewer.

2.1.3 This report has been written with the intention that it will be published, and only contains the information about Child A and her family that is required to identify the learning from this case. The review will be published anonymously on the NSPCC library, in order to protect the identity of Child A and her family as the area where they live is a small unitary authority.

3 Case Information

3.1.1 Child A lived with her family prior to coming into the care[7] of the Local Authority early in November 2019. No concerns had been shared with partner agencies until February 2019 when advice was sought by the family about Child A and her self-harm.

3.1.2 Over the next nine months concerns for Child A increased. There were a number of reports of self harm and behaviours perceived by her family and professionals as attempts to take her life. Child A spent six weeks in an inpatient mental health unit for young people during 2019. Whilst an in-patient Child A made disclosures suggesting she had been a victim of sexual exploitation (CSE) by older men. Concerns of this type escalated over the coming months.

3.1.3 Child A was made the subject of a Child Protection Plan (CPP) following her discharge from the mental health unit due to concerns about her mental health, the risk of CSE and the fraught relationships at home which appear to have predated the professional concerns about Child A. This was followed by the commencement of pre-proceedings work under the Public Law Outline (PLO) in September 2019.

3.1.4 Late in October 2019 Child A went missing and was found in another area with a man who was arrested for sexually assaulting her. A temporary placement was found in that local authority area and she was accommodated under S20, which her parents agreed to. Having spent just over two weeks in the placement, Child A went missing and a suicide note was found in her room. She was subsequently found some 50 miles away voicing her intention to kill herself. She was taken to hospital, assessed and sectioned under S2 of the Mental Health Act 1983. Child A then spent a significant amount of time in a specialist mental health hospital and is continuing to receive support.

4 Analysis and learning

4.1 Due to the response to Covid-19 practitioner participation sessions[8] were held in July 2020 using video technology. From the information shared during the Rapid Review, in the information

[5] It was originally planned to hold a large consultation event with all of the professionals involved. The impact of the Covid-19 pandemic led to a change of plan and smaller consultation sessions were held with those involved via virtual meetings
[6] This was by telephone at Child A's request.
[7] S20 Children Act 1989

provided by agencies, during the consultations with professionals involved at the time and when speaking to Child A, the review has identified the following areas for analysis:

4.2 Assessments and planning

4.2.1 The manner in which Child A's needs became known to services was untypical in the experience of those working with older children with complex needs, in that she was not known to any professional other than those providing universal services until she was in year 11 of school. The serious concerns for her mental health, the significant risk of exploitation, the concerns about the difficult relationships at home and the allegations she made about her care from her parents emerged over a relatively short period. Those involved described the amount of time they spent working with Child A in order to build the required relationships, assess her needs and the risk, and to keep her safe. The impact on professionals of a child going missing and being at high risk of self-harming and CSE should not be underestimated. Having to react to the emerging risks from different forms of serious harm made planned work very difficult, and required the needs of Child A to be managed alongside concerns for her sibling and their existing caseloads.

4.2.2 The focus on Child A's mental health and then the identified risk of sexual exploitation dominated the work undertaken by professionals as they potentially posed an immediate risk and were regularly of most concern. There were a number of incidents during the period reviewed requiring urgent responses, which made planned work difficult on occasion. For example, within days of her discharge from the mental health unit in the summer of 2019 Child A took an overdose and went missing from home. The review considered a hypothesis that the concerns about care in the home for Child A and her sibling were not given adequate focus due to the amount of work required in responding to the frequency of urgent events on the case. As stated within the agencies analysis of practice 'responding to multiple, serious crises in the present, arguably left little space to do the gentle work of gradually uncovering the past.' While this was indeed to a certain extent the reality, it has been found that those involved managed, on most occasions, to balance responding to crises with the need for planned and child focused work.

4.2.3 As well as the frequent need to respond to unexpected crises, there were difficulties in engaging the family. The family were undoubtedly reluctant to work with professionals, and most reported finding the parents difficult to engage with a pattern of appointments being cancelled, a refusal to allow professionals into the home unless it was planned in advance, and reluctance by the parents to reflect on their roles as parents in their daughter's difficulties, preferring to see the issue as hers and not theirs. Mother was said to be a strong influence in meetings. Professionals recognised the need to meet with Father alone and made attempts to do so. They were largely unsuccessful in achieving this.

4.2.4 The family had very little contact with professionals before Child A engaged in self harm and suicidal behaviour and it is also possible that an assumption was made that there had been no

[8] Four groups were organised chronologically. Each group considered a period of professional involvement with the Child A and her family. Some professionals attended more than one session.

reason for any concern relating to any past events. This lack of a known family history of abuse or neglect, the families relative affluence, the children's academic achievements and the parent's articulate arguments about why Child A was having the problems she had (initially blaming the stress of her upcoming GCSEs) meant that initially the suggested response was the provision of support for her from CAMHS. When it emerged that Child A was actually very unhappy at home and that her relationships with her parents were fractured, it made engaging with the family challenging for professionals and there was a lack of meaningful compliance. The decision to step up the case from a child in need plan to a child protection plan in the summer of 2019 (not long after her discharge from the mental health unit) then the step up to using the Public Law Outline later in 2019 was not just due to the increasing concerns about Child A's risk of being exploited or her self-harm, it was also due to the limits enforced by the parents when it came to meaningful engagement with family therapy, assessments, a family group conference and other attempts to progress the matter.

4.2.5 Child A was not able to consistently communicate her views about being at home and how she felt about her parents. She used a diary as a way of communicating with professionals and took opportunities to share this with professionals including her support worker, the social worker and nursing staff in the accident and emergency department. Those who saw the diaries told the review about the heartfelt prose that Child A produced as a way of expressing her serious distress and concerns, and demonstrated another form by which she attempted to communicate with professionals. Those working with Child A considered that such communications rarely went as far as making specific allegations about her home life that would enable the police or CSC to pursue specific enquiries, however enough was known about Child A's life to assess that she was suffering significant emotional harm. These concerns could have led to a meaningful exploration about whether an investigation and child protection response was required using the evidence that was available around three months prior to the ICPC[9].

4.2.6 The need for family therapy was identified in the initial assessment by CAMHS in early 2019. When Child A later had a period as an inpatient in 2019 there was reportedly an attempt to hold family sessions, but the parents did not engage. It appeared that the period while Child A was an inpatient would have been a good opportunity for professionals both in the unit and in the community to work with the family on the concerns that had been identified at the time. However, when a child is an inpatient within a mental health hospital, community CAMHS does not work with the child or family, only taking on responsibility again when the patient is discharged. Resources and systems mean that community CAMHS need to prioritise those in the community. This is a

[9] In 2019 there was a Joint Targeted Area Inspection of the multi-agency response to sexual abuse in the family in a number of different local authority areas, including the Local Authority. It found that 'in some instances, decision-making is overly influenced by children's views and police investigations are not taken further as the child did not wish this. Although this shows appropriate consideration of children's wishes and feelings, in a small number of cases this means any wider potential risk from perpetrators to other children is not fully explored.

systemic issue which has an impact on the consistency of important therapeutic relationships for children who have regular inpatient stays.

4.2.7 As the parents did not engage with what was offered in the unit, and it was not offered when Child A was at home, family therapy remained an unmet need throughout the timeframe being considered by the review. Child A and her sibling had been assessed as children in need and plans commenced early in 2020. The family worker who was initially allocated the case and the social worker who became involved as a co-worker around this time tried to engage with the family prior to Child A's discharge from hospital. There were obstacles when it came to engagement which included a lack of insight into the impact of their behaviour on the children, a refusal to discuss their own childhoods or mental health and the parent's view that they did not require support from children's social care.

4.2.8 Professionals working with the family reported that they sometimes found the parents intimidating. While the professionals supported each other and were able to recognise that this was a way of the family avoiding scrutiny and professional persistence, it remained difficult for those involved to be transparent about their views regarding the parent's own issues in the face of denial. For professionals it is a difficult balance between trying to ensure the on-going engagement of parents in order to support and protect children, with the need to challenge them and address concerns and potential parenting deficits. In this case there was a need to keep the parents engaged in order to try and facilitate improvements for Child A and her sibling, but resulted in professionals not always being as forthright as they wanted to be. There was also concern about what the alternative might be for Child A and if she would actually be any safer in foster or residential care, along with the view that further evidence was likely to be required in order to take any assertive legal action.

4.2.9 Extended family members were concerned about Child A and her sibling, and shared information with the social worker. They were seen as potential support system for Child A and possible alternative carers if this was required on a short-term basis. A family group conference (FGC) was arranged but significantly delayed due to the time Child A spent in the mental health unit and then due to the parent's ambivalence about the benefits of the process. By the time it was convened an initial child protection conference had been arranged for the following week and the FGC was not therefore considered to be as helpful as professionals had first hoped. The meeting did provide a helpful insight into the family dynamics and level of family dispute at that point in time however.

4.2.10 <u>Learning</u>

- When there is a constant need to respond to urgent matters, it is essential to ensure that opportunities to assess, plan and reflect are not lost.
- Professional bias must be acknowledged and managed when working with a child who appears capable and articulate, ensuring that the level of trauma and risk is assessed,

informs an understanding of the child's capacity and that plans are made which address the risks.

- Working with parents who can be challenging and intimidating is difficult for professionals.
- Professionals need to identify when parents blame their child for difficulties, and provide support but also respectful challenge.
- Reflective supervision is important for all professionals working with highly complex families; this should include inter-disciplinary group supervision if there are a number of professionals providing services.
- Every effort should be made to engage with fathers or male partners as equal parents.
- When a child does not want to share their allegations with the police or withdraws them, consideration should still be given to whether a criminal investigation is required and whether there is a need to safeguard the child through other proceedings[10].

4.3 Responding to missing episodes and concerns about the risk of exploitation

4.3.1 It was not until Child A was an inpatient in the mental health unit in July 2019 that it emerged she was at risk of CSE. It was during this period of hospitalisation she began to partially disclose historic incidents that appeared to be sexually abusive from peers and adults unknown to the family. Her disclosures were historic and prior to the timeframe being considered by the review. She also admitted to currently contacting men on-line. It was unknown if this abuse could be a cause of her self-harming and suicidal ideation, or if it was her existing vulnerability that led to her being at risk of such harm. Understanding the impact of the trauma associated with these factors remained a constant challenge for professionals working with Child A.

4.3.2 The 2016 Triennial Review of SCRs identified a number of risk factors that increase young people's vulnerability to CSE. "Experience of neglect, parental failure to protect, and time spent in care feature strongly, as do emotional and behavioural difficulties, school disruption, going missing from home, school and care, substance misuse, low levels of self-esteem and seeking affection and approval often in risky places."[11] These common vulnerabilities to CSE were well known to the professionals involved with Child A and it is clear that despite the concerns about her mental health and low self-esteem, most of the suggested vulnerabilities did not appear to feature in her case. This accounts for why the risk of such harm was not assessed or identified before she made her first disclosures.

[10] In 2019 there was a Joint Targeted Area Inspection of the multi-agency response to sexual abuse in the family in a number of different local authority areas, including the Local Authority. It found that 'in some instances, decision-making is overly influenced by children's views and police investigations are not taken further as the child did not wish this. Although this shows appropriate consideration of children's wishes and feelings, in a small number of cases this means any wider potential risk from perpetrators to other children is not fully explored.

[11] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 DfE. Pg 119

4.3.3 Once the risk of CSE was identified, Child A's vulnerability to exploitation dominated the contact with her by professionals in the community. She was allocated a worker in the Child Exploitation[12] team who worked closely with Child A and with her social worker and CAMHS worker in order to prevent an escalation of the known risk of exploitation. The Child exploitation worker was a particularly significant professional relationship for Child A. This specialist CSE provision supported the social worker to work with the wider family and undertake assessments and child protection planning. The Child exploitation worker also worked with the CAMHS worker to provide support regarding Child A's mental health difficulties, which continued at this time, and with the school to concentrate on supporting Child A with the transition to sixth form and A levels. There was evidence of a strong multi-agency team around Child A and good communication. Over the course of the next few months the system determined that there needed to be a large number of meetings, including strategy meetings and MACE (multi-agency child exploitation) meetings around specific CSE concerns and allegations. Child A told her allocated workers about her plans to meet men and this enabled a certain amount of preventative and disruptive work to be undertaken by the police and CSC including the Child Exploitation team. As a result, Child A was the subject of an effective CSE assessment and a comprehensive safety plan was devised. She told the review that her vulnerability to exploitation during the period being considered by the review was in large part due to her perceived unmet mental health needs, her feelings of hopelessness and the thought that she was not being taken seriously.

4.3.4 As Child A was over 16 years old it was not possible to use a number of the possible CSE disruption tactics such as Child Abduction Warning Notices or criminal charges relating to underage sex, even if Child A had provided details of those she was planning to meet. Largely however, her age did not impact on the professional view of the risk to Child A. It has been identified that there was some confusion in advice provided by the police regarding consent and the legislation for 16 and 17 years old children. The law[13] is clear that it is illegal to pay for sexual services or to incite the sexual exploitation of a child under 18, and was therefore relevant to Child A at that time. A recommendation has been made in the Thames Valley Police IMR that aims for sexual exploitation to be more robustly recorded as a crime when the circumstances of the offence are met, and for needs to be better awareness that children aged 16 and 17 are vulnerable to CSE and of the legislation regarding this.

4.3.5 The review has found that an understanding of contextual safeguarding was developing in the Local Authority at the time being considered. In 2017 the University of Bedford and the Contextual Safeguarding Network published an overview of the operational, strategic and contextual framework of Contextual Safeguarding[14] which is an approach to 'understanding and responding to young people's experiences of significant harm outside of their families'. Traditionally child protection services and systems are focused on risk from and within families, but contextual

[12] The Local Authority's child exploitation team is within children's social care and works closely with the police to provide a service to children who are at risk of or a victim of exploitation.
[13] Sexual Offences Act 2003
[14] https://contextualsafeguarding.org.uk/assets/documents/Contextual-Safeguarding-Briefing.pdf

safeguarding stresses that professionals need to consider not just safeguarding issues within the home but also abuse within the child's social contexts. As children subjected to CSE are not necessarily abused by those who raise them, there have been a number of calls for systems to reflect this.

4.3.6 The review asked if those involved at the time considered whether the treatment of Child A from her parents, such as not allowing her age appropriate independence, was due to their concerns about keeping her safe from exploitation and whether professionals adequately understood and considered contextual safeguarding. It was found that contextual safeguarding was considered by those involved at the time and there is evidence that those working with Child A understood the impact of external factors when it came to considering Child A's risk from CSE. However it was also rightly identified that the issues at home could in part account for Child A's distress and increased vulnerability to CSE.

4.3.7 The case has raised issues about strategy discussion systems and practice in the Local Authority. The actions agreed at strategy discussions/meetings were not always SMART[15] in this case and were often not completed. This appears to be due to the strategy meeting process and forms completed being incident led, due to the high number of meetings in this case because of new concerning incidents, and due to the time required to complete tasks, such as seeking information about potential adult perpetrators. Those informing the review believe this is an issue more generally when it comes to strategy meetings held in the area. A need has been identified for actions from strategy meetings to be reviewed either as a specific review or as part of a core group meeting if the child is already subject to a child protection plan. An action has commenced to ensure that in future S47 investigations will not be signed off until all tasks from the strategy meeting are completed. In this case it has also been noted that the record/decisions of the meetings are not consistently shared with attendees, and this will also be addressed by the plan for improvement described above.

4.3.8 Good practice has been identified regarding the preventative work undertaken with Child A in regard to the risk of CSE. There is no doubt she was made aware of both the general risks and her own vulnerability to this type of abuse. The CSE screening tool was completed with Child A and her Social Worker as a joint discussion, which gave Child A significant opportunity to share her views and describe her lived experience, and for her to consider the risk indicators. There was particularly good practice from the Child Exploitation team. The allocated worker knew Child A well and had undertaken a number of return interviews following missing periods. She recognised patterns of behaviour and identified increasing risks over the period of her involvement. This led to effective joint work with the police and the allocated social worker. Child A told the review that her most significant professional relationship at the time was with the Child Exploitation worker who provided her with the time and opportunity to speak about what was worrying her and who had the skills to facilitate meaningful engagement.

[15] Specific, measurable, attainable, realistic and time bound.

4.3.9 Learning:

- The time and opportunity to build relationships is vital to enable professionals to work in a meaningful way with children who are at risk of exploitation.
- Professionals need to be clear about the law in relation to CSE, particularly its relevance to children aged 16 and 17.
- Relationships and good communication between professionals helps to prevent and disrupt CSE.

4.4 Communication and information sharing across areas

4.4.1 There were a number of examples of good practice when it came to professionals sharing information, communicating well and developing good relationships in this case. This is often a challenge when a child moves to another part of the country, as was the case for Child A in later in 2019. Child A had travelled independently a distance of 80 miles to meet an older man. Following a joint agency response, she was located and found with the man. She subsequently reported he had raped her and he was arrested. Child A stated she did not want to move back to her home area and it was decided that a short-term placement be provided within the local authority area in which she was found. This was also considered to be a good choice due to the significant concerns about the risks posed to Child A from an adult man nearer to home. Staff were aware of the difficulties in finding somewhere for children of Child A's age to live, which reflects wider issues about the general shortage of placements for 16 and 17 year old and for Child A. The process of being safeguarded resulted in her spending many hours at a police station while decisions were made and a placement found.

4.4.2 Before Child A was transported to her placement, she spent all day with a number of professionals, including police and nurses at the SARC (sexual assault referral centre). During this period there was a strategy discussion held jointly with professionals responsible for Child A in the Local Authority and a plan was made to investigate the allegations and keep Child A safe. CAMHS in the Local Authority advised that she should be accommodated in a Tier 4 mental health unit, and the nurses at the SARC agreed that a mental health assessment was required. The nurse who spent much of the day with Child A was extremely concerned about her mental health and risk of serious self-harm, believing she intended to take her own life that day. The police officer in attendance however thought that while Child A was nervous and very upset, they did not consider she was a risk to herself or others and did not meet the criteria for S136[16] of the Mental Health Act, a provision available to the police if they have serious concerns. There appeared to be some confusion on the day about whether Child A needed an assessment of her mental health or a Mental Health Act[17] assessment. The process being followed on the day was for an assessment by CAMHS for a child with a mental health crisis (of the type which would happen in A&E) rather than

[16] Section **136** of the Mental Health Act 1983 allows you to be taken to a place of safety, if a police officer is concerned that you may have a **mental disorder** and should be seen by a **mental health** professional.
[17] The Mental Health Act 1983 is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

an assessment under the Mental Health Act which would consider if Child A needed to be detained in hospital for urgent assessment and treatment for a mental health disorder and whether she was at risk of harm to herself or others. It appears that no one involved on that day in the Local Authority (via telephone) or within the area where she had been found clarified the exact nature of the required assessment. It is not known if Child A should in fact have had a MHA assessment that day, as this was not pursued at the time. The focus was on getting a CAMHS assessment, which was not successful due to there being no capacity to attend the SARC to undertake an assessment. Child A told the review that she feels that she did require a MHA assessment and that she was actively and seriously planning to take her own life on that day and in the weeks that followed.

4.4.3 No mental health assessment of any type was completed until a week later. It was thought inappropriate for Child A to be taken to A&E as requested, because there was a chance Child A would abscond and because she required the sensitive support being provided to her at the SARC. The CAMHS Initial Core Assessment (ICA) undertaken the following week followed a request from the social worker in the Local Authority and was undertaken by the CAMHS Intensive Support Service and community team local to her placement. The social worker has told the review that there were significant difficulties in being able to arrange this assessment, including basic challenges such as being able to obtain the correct telephone number to call.

4.4.4 Child A was not thought to be in a mental health crisis by the time the assessment took place. The assessment found Child A to be a medium risk. The IMR completed for this review has stated that a number of high-risk areas were identified at that time and were evident in her recent history, and that the assessment may not have been fully trauma informed. At that time there was no communication between those who assessed her and professionals in the Local Authority which would have limited any understanding of her case history. The IMR provided by CAMHS in that area has identified learning in relation to this and a recommendation has been made.

4.4.5 Planning in regard to the risk of CSE continued while Child A was in this placement. This proved challenging as there are positive relationships between the Make Safe team and the neighbourhood and central police teams covering the Local Authority that were not in place with the relevant agencies in the locality of her placement. Staff caring for Child A were briefed regarding what to do if Child A went missing and they were part of the updated and detailed 'missing trigger plan'. On the day of the serious incident there was a concerted effort by all of those involved to find Child A and to ensure her safety, which was aided by the plan.

4.4.6 Her care in the placement was good and there was effective communication with professionals in the Local Authority. It was complex to ensure she had appropriate educational provision, but efforts were made to ensure she continued to receive educational input. The review was told that Child A's school provided her with work and there was a plan to get Child A a tutor to help her to keep up with her A level subjects, although when speaking to the lead reviewer Child A disputed this, stating she does not recall having any contact from her school. There is no doubt that Child A

missed a significant amount of academic work during her first term of year 12 due to the on-going concerns about her mental health, the missing episodes and then the move to another area. The school had previously shown their commitment to Child A including admitting her to the sixth form and adapting her timetable so that she could attend part-time. They also provided coordinated support following the incident that led to this review when Child A was in hospital. Child A had a personal education plan (PEP) put in place following her initial looked after review.

4.4.7 Learning:

- There are difficulties in providing timely services to a child who is living outside of their home area, due to the lack of local information and contacts. Face to face meetings should be held as often as is practicable to ensure optimum information sharing, ownership and governance.
- All professionals need to be aware of the options available when a child is in need of an urgent mental health assessment. This should include knowledge of when a Mental Health Act assessment might be suitable and how to access such an assessment.
- It is important for a child who is placed in another area to keep as many of the key professional relationships from their home area as possible, while ensuring their needs are also being met in the placement area.

4.5 Voice of the child

4.5.1 Children need to be provided with different ways to enable their voice to be heard, and professionals need to critically reflect on what is said and what children may be trying to communicate by their behaviour. Understanding the lived experience of the child is central to protective safeguarding work. Child A had contact with professionals on an almost daily basis throughout the timeframe considered by the review. Some developed a close and meaningful relationship with a child who appeared in need of adult time and attention. Child A was always encouraged to share her views and was regularly given the opportunity to communicate with professionals who knew her well. She had a voice and it was sought. These relationships had a significant impact on the day of the serious incident when Child A was in contact with a professional she knew and trusted.

4.5.2 Child A's views were considered (including through access to her diary) when undertaking assessments, when building a relationship with Child A and when providing support and therapeutic interventions. She was regularly offered the support of an advocate. Her behaviour was considered to reflect her situation and professionals worked hard to understand her world and lived experience. For example she was observed to be very quiet when her mother was around. There was an understanding that her behaviour was likely to be linked to past trauma, but Child A was always very guarded with what she shared. Professionals faced a dilemma when Child A stated she did not want her parents to be told her views and wishes and when she retracted or minimised previous allegations. The period of 6 weeks in the mental health unit in the summer of 2019 was not enough time for Child A to build trust with the staff and very little was achieved in

terms of understanding her lived experience. Child A told the review that she felt that her needs were not met and that she did not feel safe or listened to while in the unit. The detail of this has been fed back to the appropriate partner agency.

4.5.3 Child A was on the CAMHS central waiting list for individual and family therapy from early 2019 and she remained there at the time of the incident 10 months later, with no identified therapist assigned. However, the CAMHS duty lead took a holding role in the interim and showed a clear commitment to Child A. They were an active member of the team supporting her and they knew Child A and her family well. The CAMHS worker responded to crises and provided direct work to Child A, often tailoring his approach to meet her needs. The system, while not ideal, enabled an on-going relationship to develop between the duty CAMHS worker and the family. At the initial child protection conference (ICPC) there was a concern that Child A's mental health needs had not been assessed and responded to sufficiently and in a timely way, despite the involvement of CAMHS and her time as an inpatient. Child A told the review that she was aware that the CAMHS worker was temporary and that she interpreted this as the organisation not caring about her enough for her to be given a permanent worker. She said that she did not feel able to share this view at the time, and mainly sat in silence during sessions.

4.5.4 Those who do not work in mental health services told the review that they did not fully understand the processes, systems and thresholds for CAMHS services, and that they had a general lack of confidence regarding working with mental health issues. Capacity and demand is a known issue for all CAMHS services. Increasing numbers of children require support to address their mental health.[18] The Office for National Statistics reported in September 2018 that growing numbers of teenagers in England and Wales are killing themselves. Fifty-six girls and women aged between 15 and 19 killed themselves in 2017, the highest number since records began in 1981. The suicide rate among that group, 3.5 per 100,000 people, was also the highest on record, having been 2.1 per 100,000 in 2010. The school that Child A attends has emotional wellbeing support for children, but they have a waiting list and can only provide a fixed period of support for up to 6 weeks.

4.5.5 There were many professionals in the Local Authority who tried hard to get to know Child A and who did much to meet her needs. While looked after, Child A was placed out of the area and was provided with care and support at the unit where she lived. She had been well supported at the SARC in that area following the disclosure she made. By considering the records kept at the time and from speaking to those involved, it is clear that Child A wanted support and received services as soon as the extent of her difficulties emerged. Capacity and demand had an impact, and there were issues with some of the services provided, but on the whole the response to Child A's needs and the risks she faced was good. With hindsight Child A has said that she was unable to be honest about her feelings and the extent of her illness. It was only following the incident and her spending a significant amount of time in a mental health setting that the seriousness of Child A's

[18] 9.7% in 1999. 11.2% in 2018

mental health difficulties became evident. She told the review that the inpatient care and support provided following the incident was exceptionally good.

4.5.6 Learning

- Under-pressure systems, like community CAMHS and children's social care, need to ensure that the right people are in the right place to build relationships with children and to understand their needs and the risks to which they are exposed. They need the requisite skills and experience to do this complex work and to be well supported. They can then respond to the needs of children with complex needs.

4.6 Learning from Child A herself

4.6.1 As part of this review the lead reviewer spoke to Child A. As described by the professionals who know her, she is bright, articulate and sensitive. She was keen to share her views and has given permission for the following statements to be included in this report. They should be considered by all professionals working with young people.

- *There is always a reason for a child's behaviour*
- *It is hard for a child to find the words. Be patient and give them your time*
- *If a child withdraws allegations it doesn't mean they are not true, it probably means they are scared*
- *If a child says they want to die, don't say 'you don't', as they will probably want to prove you wrong.*

5 Conclusion and recommendations

5.1.1 At the time of the serious incident, Child A was found by police some distance away from her placement and it was the view of those who assessed her that she intended to take her life. She was extremely vulnerable and unhappy. Despite the good relationships she had with a number of the professionals involved and how hard they worked to keep her safe, Child A remained at risk of suicide, self-harm and exploitation. While it was impossible not to focus on and respond to the immediate risks that occurred on a frequent basis, those involved recognised the impact of Child A's history and worked with the hypothesis that the family environment was the primary causal factor in Child A's behavioural presentation. Engaging with the family to address this was a constant challenge, but those involved were persistent and tenacious, showing the family they were not going to go away while Child A was at risk.

5.1.2 The Child Safeguarding Practice Review Panel stated in their annual report 2018-19 that the 'complexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners'. It asks, 'how do we help people talk to each other within a context of high-risk, high-volume and limited resource, often when practitioners are fearful of reprisals from families, employers and society at large?' This case shows that good information sharing, open communication between professionals and embedded relationships between the professionals working with a child can make a positive difference, but it also exposes the vulnerabilities when

recourses are limited, when there is limited understanding of some parts of the system, and when a child moves to another area.

5.1.3 Single agency learning has been identified during the review and a number of recommendations have been agreed to address these, including single agency SMART action plans.

5.1.4 There has been excellent cooperation with this review from the partner agencies in both areas, which was essential in establishing the learning from this case.

5.1.5 Having considered the learning from this review that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvements.

Recommendation 1:

That this report is shared with the Children's Safeguarding Partnership in the area in which Child A was placed and that they provide feedback on the progress of any recommendations from their partner agencies that have contributed to this review.

Recommendation 2:

The Local Authority Safeguarding Board should ensure that professionals in its partner agencies have an understanding of mental health systems, in order that non-mental health staff are confident regarding what is required on a case by case basis and how vulnerable children can access the correct support.

Recommendation 3:

The Local Authority Safeguarding Board to consider how professionals in the specific relevant partner agencies are supported to work with families who resist offers of help and support, including when the appropriate use of authority is necessary to safeguard children.

Recommendation 4:

That the Local Authority Safeguarding Board asks its partner agencies to use the direct words of Child A when training professionals and in supervision in order to provide an understanding of the impact of systems and practice on children who have mental health concerns and who are at risk of exploitation.