Cheshire East Safeguarding Children Partnership (CESCP)

Local Child Safeguarding Practice Review (LCSPR)

Child K

Independent Reviewer: Vicky Buchanan

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Learning identified from considering Child K

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1. Introduction

1.1 The Cheshire East Safeguarding Children Partnership (CESCP) agreed to undertake a Local Child Safeguarding Practice Review (LCSPR) by considering a case to be referred to as Child K. They recognised that lessons could be learned from reviewing the practice in the case, with the aim of better safeguarding the children of Cheshire East.

1.2 Child K was a 17 year old child in the care of Cheshire East local authority at the time of the review. She had been subject to a care order under s31 of Children Act 1989[1] since 2007. A care order places the child in the care of a designated local authority. This requires the local authority to provide accommodation for him or her, to maintain and safeguard him or her, to promote his or her welfare and to give effect to or act in accordance with the other welfare responsibilities set out in the Children Act 1989. It gives the local authority shared parental responsibility for the child and the power to determine the extent to which the child's parents and others with parental responsibility may exercise their responsibility, where this is necessary to safeguard or promote the child's welfare.

1.3 This review focusses on the period between 13 June 2021 and 26 January 2022 when Child K was experiencing significant difficulties in her life that resulted in her being exposed to significant and serious harm. Child K's care experience is characterised by placement moves due to disruption and break downs from a young age, though there have been some periods of stability. Prior to December 2020 Child K had experienced approximately two years of stability, living with her long-term foster carers and finishing year 11 in the summer term of 2020. Child K moved to semi – independent accommodation in December 2020 due to the placement with her foster carers breaking down. Positively her foster carers still have a relationship with her, helped in an emergency and continue to support her. Due to concerns about and recognition of increasing exposure to risk and break down of the semi – independent placement, Child K was moved to a residential placement in June 2021.

1.4 In summary, the increased concerns for the welfare of Child K included several serious and life-threatening attempts to self-harm requiring resuscitation on at least two occasions. These included her accessing medication from another resident in one of her placements, use of ligatures and climbing a pylon. She had also stated her intention of wanting to complete suicide before her 18th birthday. Child K was frequently missing from placements with another child in the care of another local authority. There were increasing concerns about exposure to child sexual exploitation, substance misuse and criminal behaviour including carrying a knife. Her vulnerability was recognised by the professionals working with her, they were concerned about risks she was being exposed to, her erratic behaviour and her lack of awareness about the dangers she was exposed to. She was described as impulsive.

[1] The Children Act 1989 guidance and regulations (publishing.service.gov.uk)

1.5 Her presenting behaviours made identifying and engaging an appropriate placement to meet her needs very challenging and she had somewhere in the region of nine placements during the review period, including extended stays on acute hospital wards as no suitable placement could be identified to facilitate a safe discharge.

1.6 Child K was made subject to a Deprivation of Liberty Safeguard (DOLs)[2] on 2 December 2021 and moved to her current placement in January 2022. She is no longer subject to a Deprivation of Liberty Safeguard and is making steady progress. Risks have considerably reduced though remain present and plans are well underway to support transition to adult services.

1.7 The review considered the professional involvement with Child K and her mother to identify learning for wider systems and practice in cases where children are experiencing significant contextual safeguarding issues, including child sexual exploitation, self- harm and how these impact on placements, professionals' approach to safety plans and multi–agency management of risk.

1.8 These are the key lines of enquiry that were explored to inform the learning in this review.

- The impact of suitable placement availability in meeting identified needs, including the local availability of Mental Health Provision and or provision under CQC additional support, secure placements, and Ofsted registered providers.
- The significant number of incidents of serious harm in a short space of time and impact of lack of suitable placement.
- Information sharing by foster carers where issues of potential concerns are raised by children.
- How well agencies worked together to share information as not all partners aware of significant events.
- Police custody use of Vulnerable Person Assessments (VPAs) as part of their risk assessment
- How professionals worked together when opinions on diagnosis differed and how this impacted on planning and the support received. How confident were agencies to escalate concerns?
- What wraparound support was available when placements were not meeting needs, to mitigate identified risk and how did being placed out of area hinder or support care needs?
- To what extent has the current Covid-19 crisis impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs?

[2] Deprivation of liberty safeguards: resources - GOV.UK (www.gov.uk)

1.9 Good practice was also identified as part of the review process, examples of this include:

- The pharmacy that Child K presented to when she was missing from her placement, for her medication and the morning after pill. They realised she was a child in care and arranged for her to return the next day for her medication, they contacted her placement who were able to locate her the following day and return her to her placement. Cheshire East Safeguarding Children's Partnership may want to consider acknowledging this good practice from a community resource.
- The tenacity of individual workers, in locating Child K when she was missing, including her social worker going to London to try and locate her and return her to a safe placement.
- Local services remaining in contact with Child K, e.g., local Child and Adolescent Mental Health Service (CAMHS) visiting when she was on an acute ward in another area
- The Independent Reviewing Officer was not satisfied with the legal advice that children's social care had received about the appropriateness of a Deprivation of Liberty Safeguard order and sought independent legal advice which resulted in an application being made.
- Joint working with another local authority as Child K was frequently missing and with another child who was looked after by the other local authority.

2. The Process

2.1 An independent lead reviewer[3] was commissioned to work alongside local professionals to undertake the review. Information provided to the rapid review meeting was considered, there was a decision to extend the time frame being considered beyond the rapid review and Terms of Reference were updated to reflect this. Individual agency chronologies including analysis were requested from all involved. These identified important single agency learning.

2.2 Professionals involved at the time were involved in discussions about the case and the wider systems, a practitioner event was held virtually in July 2022 using video technology, facilitated by the independent lead reviewer. Follow up conversations were undertaken with practitioners who did not attend the event.

2.3 A parallel review was undertaken by NHS England chaired and sponsored by the Chief Officer of NHS, Wirral CCG. This review was focussed on understanding the experience of Child K and her admission to acute hospital services at time of crisis. Learning was identified and has been considered and where appropriate

[3] Vicky Buchanan is an independent social work and safeguarding consultant. She is a lead reviewer undertaking Child Safeguarding Practice reviews and is entirely independent of the Cheshire East Safeguarding Children's Partnership.

referenced as part of this review. The NHS review included strategic leaders across agencies who have accepted the specific learning and agreed actions going forward to improve how agencies work together, particularly in relation to children with significant complexity of needs.

2.4 Child K is aware of this review and the lead independent reviewer had the opportunity to meet with her with the support of her personal advisor to share the contents of the review and include her views. Child K said she agreed with the review and recommendations and showed understanding and insight into her situation. Child K's views have been referenced in the report and Cheshire East Safeguarding Children's Partnership is very grateful to Child K for her input. Children's social care have also made attempts to engage mother in the review but to date this has not been successful, the independent reviewer did arrange a meeting with mother, but she did not attend.

3. The Learning

3.1 The learning identified for the system and partnership is as follows:

Learning Point 1 : Multi – agency planning meetings should provide an opportunity for information sharing , development of safety plans, co-ordination of care planning and appropriate professional challenge. When children are the subject of numerous meetings the most appropriate forum for this should be agreed.

3.2 During the six-month period of this review there were numerous significant incidents involving Child K, placement moves and evidence of professionals working relentlessly to keep her safe. Examples of this include the social worker travelling significant distances when Child K was missing and the local Child and Adolescent Mental Health Service maintaining contact with her even when she was placed out of area.

3.3 Child K was a cared for child at the time of this review. As such she was subject to care planning regulations. Cheshire East's Care planning policy[4], states *"For Cared for Children, a Child and Family assessment should be undertaken at a minimum of every 12 months. It is also essential to undertake a Child and Family assessment prior to any change in the care plan, following placement disruptions or for placements at risk of disruption, prior to discharge of a care order and as part of the section 47 process".*

3.4 In Child K's circumstances this did not happen. The reasons for this are complex, Child K's circumstances were changing on an almost daily basis during the review period and professionals involved were reacting and responding to the presenting issues. During the review period there were, based on the chronologies provided,

[4] Cheshire East Care Planning Policy, Children in Care 2019

in the region of 23 multi – agency meetings to discuss Child K. These were a mixture of Strategy Meetings, Missing from Home Trigger meetings, Contextual Safeguarding meetings, professionals' meetings, escalation meetings, secure panel meetings, risk management meetings, etc. An average of one multi – agency meeting a week. However, there does not appear to have been a planned co-ordinated meeting where all the issues were considered and discussed and an over – arching plan developed to meet her needs.

3.5 To help understand the frequency of incidents, in July 2021, for example, Child K was missing 18 times, moved placement twice, was linked to police anti – social behaviour criminal damage and affray, her mother was released from prison, she met with her Child and Adolescent Mental Health Service worker on 3 occasions and a statutory visit was undertaken by her social worker. What is also evident throughout the review period is that despite what was going on for Child K she did maintain contact and a relationship with her Child and Adolescent Mental Health Service worker and her social worker, as well as other professionals.

3.6 The meetings detailed above were often reactive meetings called around a specific issue. It is also clear that not all professionals were invited to all meetings, despite the key role that the Child and Adolescent Mental Health Service worker was undertaking and the ongoing relationship she had with Child K she was not consistently invited to all meetings. This hindered opportunities for full sharing of information, shared understanding of risk and steps needed to mitigate risk and provide the right level of support for Child K.

3.7 It is usual practice when children are subject to Child Protection Planning or Child In Need Planning (CiN), processes for core group or Child In Need planning meetings to take place at least every six weeks, this did not happen for Child K. Regular multi – agency planning meetings would have provided opportunity for professionals to come together in a pre - planned way, to develop an overarching plan for Child K, review and reflect on that plan and change it as appropriate in a proactive way. There is no evidence that this happened. It may have been helpful to invite colleagues who work predominantly in frontline safeguarding services to support and provide advice on the plan and include colleagues from adults' services given Child K's age. There is also potential to enhance the role of the Independent Reviewing Officer, providing independent chair and appropriate support and challenge similar to the role of a Child Protection Conference Chair. This would have potentially provided a 'back -stop' to ensure that all agencies were aware of what had been happening for Child K and an opportunity for information sharing and proactive planning and development of a safeguarding plan, given the numerous incidents that were taking place.

3.8 A proactive approach to care planning for Child K may have also supported greater understanding of professional roles, allowed opportunity to discuss and understand why certain decisions had been made, for example why Mental Health Assessments hadn't concluded that Child K needed to be detained under

the Mental Health Act or why a welfare secure placement could not be sourced, and may have helped to ensure professionals were working together collaboratively rather than pulling in different directions at times. In the practitioner's event there was an honest and candid discussion about how agencies retreated to silo approaches, everyone was very worried about Child K, however, children's social care felt that as she was a cared for child they were seen by others as responsible for finding a placement and they also described a lack of confidence in navigating mental health processes and legislation. Cheshire East's Corporate Parenting strategy[5] states, *"Corporate Parenting is the term used to describe our collective responsibility to ensure the best outcomes for children in the care of Cheshire East Council, and those young people who have left our care. All agencies within the local authority have a responsibility and role to play in enriching the lives of these children and young people, who are amongst the most vulnerable in our borough".*

3.9 There is little evidence that all agencies worked together to support the placement planning process. It is also evident that professionals became 'frozen' when the solution they thought was in Child K's best interest was not forthcoming, a robust care planning process could have supported a collective approach to potential solutions. There is no evidence to suggest that any professional raised a challenge to the lack of care planning approach.

Learning Point 2 : Appropriate placement identification needs to be supported by a co-ordinated multi -agency approach and consideration of joint commissioning particularly when children and young people have complex and multiple needs.

3.10 Throughout the period of the review Child K experienced significant instability of placements with placement breakdowns and emergency placements. As stated earlier, there were approximately nine placements during the period including two extended stays on acute hospital wards. The responsibility for identifying placements was predominantly with children's social care. Some of these placements were unregulated and managers in children's social care were open about making placement decisions that were the 'least worst option'. There is little evidence of multi – agency decision making or joint risk mitigation in these placement decisions.

3.11 The lack of stability for Child K is highly likely to have significantly impacted on her and be directly related to her escalating exposure to risk and harm from both herself and others. Child K's placement experience during this period of just over six months is as follows;

3.12 A move from semi – independent provision to residential placement, this was felt to be a good placement for Child K and was potentially the right decision to increase the level of support to Child K as semi – independent could not meet her

[5] corporate-parenting-strategy.pdf (cheshireeast.gov.uk)

needs and manage the level of risk which, was increasing at this time. Child K told the independent reviewer that this residential placement was the right placement at the wrong time. It is reported that this placement was ended by the provider because of the increasing missing from home episodes, the impact on other child in placement and concerns about how this would be viewed by the regulator. The providers continued to support Child K by securing a holiday let and providing continuity of care whilst another placement was identified. A secure panel was held, and it was felt that the criteria was not met and more needed to be done to support Child K in the community, which does seem appropriate at this point. Several weeks later no alternative placement had been identified, feedback from providers approached is that they believed the risk was too high to manage despite children's social care being clear about the additional support they were willing to provide.

3.13 A decision was taken to secure an agency to provide care for Child K and an ex – children's home was identified by the local authority and it was recognised that this was in effect an unregulated placement, i.e., not registered with either OFSTED or CQC. It was acknowledged that this was a less than ideal arrangement and was seen as a short-term solution. Child K remained at this placement for approximately three weeks during this time her missing incidents increased and there were concerns about the young people she was associating with.

3.14 Child K then moved to another property with the same agency, the agency was intending to seek registration as a children's home at this property. At this time her mother was due to be released from prison. During this period Child K continued to be missing and concerns for her safety were increasing, she was appropriately referred to be considered at the contextual safeguarding meeting. There was concern about the quality of the care being provided to Child K and the suitability of the placement. Child K was detained in custody as a result of criminal damage and assault, she was believed to have taken substances, children's social care requested a Mental Health Act Assessment[6] whilst detained, the medical practitioner in police custody did not deem that this was necessary. The Child and Adolescent Mental Health Service practitioner has reflected on the missed opportunity to work with children's social care to undertake a joint formulation around understanding of risk. A professionals meeting was held prior to her release from custody and a safety plan was put in place. There is evidence that the safety plan was regularly reviewed, however risk was not reducing, and concerns remained about the placements ability to meet her needs. She continued to be frequently missing and associating with other young people, using substances and alcohol, and involved in criminality. A potential placement was identified, however, following a visit to the placement both Child K and her social worker did not deem it suitable. During this time Child K reconnected with her mother and she started staying overnight with her mother and placement with parent regulations were initiated.

[6] Mental Health Act - NHS (www.nhs.uk)

3.15 Children's social care acknowledged that the decision and plan to place Child K with her mother was finely balanced, but also acknowledged that Child K would gravitate there regardless and felt that the best approach was to support this placement. Child K told the independent reviewer that she would not have gone anywhere else at that time. The regulated residential placement that had been identified was at a distance and it was felt that risk could potentially increase if Child K was gravitating back to mothers and missing in an unfamiliar location. Whilst this decision is understandable it may have been helpful to explore further with the residential placement how they would support and facilitate regular contact, with a plan to move to mothers in the longer term if this went well. Child K did move in with mother of her own volition, prior to this being agreed and regulated. The Independent Reviewing Officer visited her at mother's and did have a number of concerns, not least that mother had not parented Child K since she was 3 years old and had not had contact since she was 4 years old but did support the placement as to that point, residential care had not reduced her risk. Placement with parent regulations were followed, seeking the views of partners as to the suitability of the placement.

3.16 For a short period, the situation appeared to be working well. Child K's reported missing episodes reduced, however within 2 weeks she had reported that her mother was drinking, and over the next two weeks concerns escalated again with Child K reported missing, a rape allegation was made by another young person on Child K's behalf which Child K denied. However, there was clear evidence of child sexual exploitation for which she received money and drugs. Child K was found by police and arrested for possession of drugs and carrying a weapon. During this time Child K also alleged that mother supplied her with class A drugs. This was investigated by police and there was insufficient evidence to progress, and no further action was taken against mother. As a result, the placement with mother was no longer viable. Unfortunately, the placement with mother lasted barely a month and for a period there was no contact between Child K and her mother, however they are now rebuilding their relationship.

3.17 During this time in custody Child K attempted to ligature with her tracksuit bottoms, this was not reported to agencies for several days and was not included in the police Vulnerable Persons Assessment (VPA) notification to children's social care. The police have reviewed this issue and have taken action to ensure that this does not happen in future, this action includes a directive from the Superintendent that as well as a Vulnerable Persons Assessment being completed by the arresting officer for all children and young people who are arrested, it is now also the responsibility for the Custody Sergeant to ensure a further Vulnerable Persons Assessment is submitted where a further safeguarding or vulnerability issue becomes evident during detention. Cheshire East Safeguarding Children's Partnership should seek assurance that this is now embedded in practice.

3.18 On release from custody, Child K was temporarily placed with her previous foster carer, however this could only be very short term as she had previously made an allegation against the male carer, and he was away at the time. It is apparent that the foster carer was not fully aware of the escalation in concerns since she had last cared for Child K, for example that Child K had been carrying a knife at the time of her arrest and of the ligature whilst in police custody. Children's social care must ensure that all up to date information is made available to emergency placements, even if they have previous knowledge of the child, to ensure that they can care for them safely. The foster carer was aware that Child K was using substances but did not pass this information on. Children's social care need to ensure that information sharing between them, and foster carers is robust, two way and foster carers training is clear about expectations.

3.19 Despite extensive searches children's social care were unable to identify a placement and Child K was placed in an emergency bed via a commissioned provider who provide 16 plus accommodation to young people as well as adults, though there is separate accommodation. Children's social care were aware that this was not an ideal placement but had exhausted all other options, a safety plan and support package was in place to mitigate risks in the placement and her foster carer agreed to continue to support her whilst there. Two days later there is an attempt to self-harm, (laceration requiring to be glued at A&E) and there are some concerns raised by the provider about Child K associating with some older men drinking. The following day Child K is admitted to hospital due to a serious overdose as result of purchasing controlled substances from another resident, she was found unconscious. Children's social care gave instruction to the hospital that Child K was not to be discharged until a CAMHs assessment was undertaken. Whilst in hospital Child K made another attempt on her life and she was found unconscious due to ligature. Following a Mental Capacity Assessment, it was deemed that she did not have capacity at that time and should not be allowed to leave the hospital. A second attempt to ligature was made whilst in hospital, 1:1 staffing was put in place as part of the safety plan whilst in hospital. A Mental Health Act assessment was conducted, and Child K was not detained. This was in compliance with NICE guidance, though, 1:1 staffing remained in place. A strategy meeting was also held which included adult services. Whilst in hospital Child K disclosed that she has been the victim of sexual harm and appropriate action was taken including informing the police.

3.20 A secure placement panel and Looked After Review took place the following day and it was agreed that a secure placement was appropriate. However, the local authority was unable to find a secure bed. At the time the local authority was trying to identify a secure placement, nationally there were 65 requests with only 2 beds available and only one of the two was for a female. Three days after her admission to hospital Child K absconded and was found climbing a pylon, as a result of this she was detained under s136 of Mental Health Act. CAMHS Tier 4 Outreach Team completed an assessment on the ward, the outcome of which was, there was no evidence of mood disorder or psychotic illness that required an

inpatient bed, advice was to continue assessment and formulation in the community and that the priority was unmet social care need. The head of service for children's social care contacted Child and Adolescent Mental Health Service, whilst it was accepted that tier 4 was not appropriate there were no suggestions forthcoming about what type of resource might meet Child K's needs.

3.21 Child K was deemed medically fit for discharge, but no placements were available who were willing to support the level of risk and she was too young to consider an adult placement. It was therefore agreed to provide additional support whilst she was on the ward from the agency that has supported her in unregulated placements. A 16+ placement was eventually identified which was unregulated but had experience of working with children moving out of tier 4 placements. The placement was restrictive and 1:1. A mental capacity assessment was undertaken which deemed that Child K did have capacity to consent to the placement and she did consent and agree to placement. Child K moved to the placement the following day – 11 days after admission. However, there was no multi – agency planning meeting held to support discharge, which is a missed opportunity to co-ordinate the care package and approach in the community which was particularly worrying given the placement was out of area.

3.22 Child K went missing from placement the following day but did return. The longer-term plan was to move Child K back to the local authority area with the provider and as a result of this plan, local Child and Adolescent Mental Health Service remained in contact with Child K maintaining the relationship, which was good practice. Five days after placement Child K was admitted to hospital following an overdose of paracetamol, she was discharged four days later. On this occasion a planning meeting was held to support discharge, a mental health act assessment was requested but deemed unnecessary.

3.23 Over the next few days and weeks Child K's risk continued to escalate with missing episodes, exposure to child sexual exploitation and substance misuse. Approximately three weeks after being placed Child K is again admitted to hospital following an attempt to ligature, she was found unconscious, and her lips were blue. A Mental Health Act Assessment did not deem that Child K was detainable but did deem that she lacked capacity[7] to consent to discharge. The local authority applied to the court for a Deprivation of Liberty Safeguards (DOLS) which was granted but with the condition that the placement was trained in restraint which the current placement was not. Child K told the independent reviewer that she did not agree with the Deprivation of Liberty Safeguards and in particular the detailed information that was shared with her mother through the court process. Attempts were made to source suitably trained staff to support placement, but none were available. Carers from her placement continued to support Child K on the ward. The placement then stated they were unable to continue with placement due to insurance issues and the Deprivation of Liberty Safeguards being in being place.

[7] Mental Capacity Act - NHS (www.nhs.uk)

3.24 Child K spent approximately two months as an inpatient. During this time her behaviour continued to cause concern, Child K told the independent reviewer that being in the hospital setting added to her trauma. There were a number of multi-agency meetings during this time, including senior representatives from agencies, she was assessed under the Mental Health Act on a number of occasions following escalation of risk including absconding and barricading herself in bathroom and was consistently deemed not to require tier 4 bed or detention. However, following a further incident approximately six weeks after admission Child K was detained under section 2 of the Mental Health Act, however it was still deemed that admission to tier 4 was not appropriate. Searches by both health agencies and children's social care determined there were no tier 4 or secure placements available nationally. Child K's admission continued over the Christmas period, just prior to Christmas a potential adult placement was identified, however additional staffing support was needed, as this was in the midst of the Covid pandemic when Omicron cases were soaring and absence rates were high, no support could be identified to support safe transfer.

3.25 Child K was eventually transferred to a female adult mental health ward shortly after Christmas with additional agency nursing support and support from staff from her previous placement who she knew, she remained detained under s2 of the Mental Health Act. Professionals involved with Child K all acknowledge that these hospital environments were not appropriate given her age and level of vulnerability.

3.26 Early in the new year a potential placement was identified, a Mental Health Tribunal was adjourned until a high court hearing about Deprivation of Liberty Safeguards (DOLS) was heard, it was agreed that on discharge Deprivation of Liberty Safeguards could facilitate the move to placement and as such s2 Mental Health Act detention was no longer needed.

3.27 Approximately two weeks later Child K moved to her placement where she has made steady progress and Deprivation of Liberty Safeguards is no longer required. Practitioners and managers involved with Child K were able to identify a number of factors which may have impacted on the relative success of this placement. There was a consensus that there was more of a co-ordinated approach to planning including a plan to transition her to the placement, there was closer adherence to the plan by all involved and partners worked together collaboratively. The placement also had the support of a psychiatrist and psychologist and was much more equipped to meet her needs.

3.28 As referenced earlier in this report as a result of Child K's experience the NHS led a review which focussed on the learning from Child K's experience. The review of learning from Child K's experiences did not taken place in isolation. The themes that have emerged from the review have resonance in the wider system and compliment work already underway to respond to similar cases and to the North

West Child and Adolescent Mental Health Service review.[8] The review considered there were three key thematic areas in which action from learning needed to take place – escalation, accountability and anticipatory care. The review also acknowledged that the acute trust where Child K spent 5 weeks provided the best care they could under the circumstances and also acknowledged that agencies worked hard together to move Child K to a more appropriate placement.

3.29 As a result of this review an agreed approach has been implemented in Cheshire East that has been successful in other areas, the introduction of Gateway Meetings and Risk Stratification Tools. The new care model supports and strengthens the existing pathways within community CAMHS through the establishment of a 'Gateway Meeting' and the implementation of a 'risk stratification tool' to identify children who may be at increased risk of requiring a Child and Adolescent Mental Health Service Tier 4 intervention.

3.30 The Risk Stratification Tool will provide a consistent, evidence-based approach to the early identification of children and families who may need additional support and interventions to minimise the potential of an avoidable admission to a Child and Adolescent Mental Health Service Tier 4 hospital bed. The tool will facilitate an early and coordinated multi-agency response to the child and their family.

3.31 The Gateway Meeting will discuss young people's unmet health, education and social care needs and any escalating risk and will ensure that:

- The system takes collective responsibility for the care and welfare of their young people.
- Any identified unmet needs will be met as a matter of urgency to prevent a Tier 4 Child and Adolescent Mental Health Service admission which is a restrictive practice with potential negative side effects for the young person.
- Any young people who are already in a Tier 4 Child and Adolescent Mental Health Service unit will be supported to leave as soon as medically fit to do so by the system ensuring that their needs and care plan are considered during their inpatient stay.

3.32 Cheshire East Safeguarding Children's Partnership will need to seek assurance that these processes are having a positive impact following implementation in September 2022. Professionals involved in this review have reported that early indications are that this approach is having a positive impact.

3.33 Local authorities are required, under s22G of the Children Act 1989, to publish an annual Sufficiency Statement for children in care and Cheshire East's current

[8] Cheshire and Merseyside ICP CYPMH Gateway :: Cheshire and Wirral Partnership NHS Foundation Trust (cwp.nhs.uk)

statement covers the period, 2021 to 2023[9]. It does not specifically address the approach to placements for children in similar circumstances to Child K i.e. being exposed to significant risk due to contextual safeguarding, self-harm and missing episodes. It is also focusses on what the local authority commissions and how they shape the care market, it is less clear about multi – agency approaches and joint commissioning arrangements for the most complex and vulnerable children and how agencies will work together to identify placements and manage risk.

3.34 The independent review of children's social care[10] acknowledges the problems, stating *"… the ability to provide tailored home environments for children is being constrained, rather than supported by, a highly complex web of standards and legislation"* and this was found to be the case when Cheshire East's local authority placements team described their extensive efforts to secure a suitable placement for Child K. They described daily searches for placements, including secure placements, approaching over one hundred providers. They described providers being reluctant to accept the level of risk, expressing worry about how they would be viewed by the inspectorate and the impact on other children in their care despite the local authority providing assurance about the multi – agency support that can be offered.

3.35 The placement team also raised the impact of the Covid 19 pandemic, which included providers experiencing high levels of absence at times and struggling to source additional staff when needed. It is has felt that this has eased somewhat over recent months and they have also seen an increase in providers responding to need and developing solo placements for example, and more responsive placement opportunities opening up to meet the needs of children.

Learning Point 3 : Frontline workers who are working with children in the context of significant risk need working conditions and a culture that promotes well-being and safe care , and that creates a safe supportive environment.

3.36 Throughout this review, references have been made to good practice and workers who went the extra mile to maintain a positive relationship with Child K and worked extremely hard to keep her safe despite the many challenges. It is testament to them and this relational practice that Child K has made progress and her risk has reduced.

3.37 The practitioner event highlighted the level of anxiety and worry that Child K evoked in those who worked with her with a real fear that she would take her own life even if this was not the intention. It is described in this report how chaotic Child K's experience was and how professionals were constantly reacting to the escalation of risk she was being exposed to. Child K told the independent reviewer that professionals made emotional decisions about her and gave the example of increasing staff ratios whilst an inpatient in hospital setting.

[9] sufficiency-statement-21-23-final.docx (live.com)
[10] Independent review of children's social care - GOV.UK (www.gov.uk)

3.38 Whilst individuals described being supported by their line manager for example, there was a lack of a systemic approach to this. Colleagues in Child and Adolescent Mental Health Service described their Team around the Team approach which supports workers dealing with significant risk and it would be helpful to explore a Team around the multi–agency Team approach when working with the high level of risk that Child K was exposed to.

3.39 The practitioner event was the first time the frontline workers involved with Child K came together to 'de -brief' and talk about what happened and how they felt. It provided an opportunity to explore what they could have done differently had they been given this opportunity earlier and how it may have fostered a better working relationship and understanding of decisions and actions by agencies and professionals. Practitioners described at times feeling like 'battle lines' had been drawn and children's social care being left to manage the situation for example when asking health colleagues about appropriate placements and no suggestions were forthcoming.

3.40 Research in Practice (RiP)[11] describe vicarious trauma as *"the cumulative effect of working with children and families who have experienced trauma".* They describe how vicarious trauma can occur over a period of time or from a single traumatic experience. Research in Practice describe how practitioners may be unaware they are struggling with the impact of the work that they do, it is therefore crucial to create reflective spaces. Reflective learning needs to be embedded in the multi – agency partnership, with leaders and managers modelling reflective practice personally, to reduce the risk of vicarious trauma which can impair decision making.

4. Conclusions and Recommendations

4.1 This local Children's Safeguarding Practice Review has considered the learning from Child K's case and identified learning that will be helpful for the wider system. Whilst there has been good practice identified, vulnerabilities have been exposed in practice, particularly in relation care planning and a multi approach to identification of placements.

4.2 Single agency actions have been identified during the review and recommendations agreed to address these, for example the police's use of Vulnerable Person's Assessments in custody. There has been excellent cooperation with this review from partner agencies and in particular the openness and honesty of the practitioners, which was essential in establishing the learning from this case.

[11] Embedding a trauma-informed approach to support staff wellbeing in children's social care: Strategic Briefing (2021) | Research in Practice

4.3 Having considered the learning from this review that has not been addressed by single agency actions, the following additional recommendations are made to ensure improvement actions are taken.

Recommendation 1:

Cheshire East Safeguarding Children's Partnership to seek assurance that when children are cared for and there are significant safeguarding risks, care planning meetings take place at a frequency that reflects the needs of the child. Where there are significant safeguarding risks these meeting should have enhanced oversight by a senior manager in children's social care. These meeting should involve the Independent Reviewing Officer to contribute to planning and to offer scrutiny. Professionals must challenge and hold each other to account to ensure that these meetings take place.

Recommendation 2:

Cheshire East Safeguarding Children's Partnership should seek assurance that the partnership, understands each other's roles and works collaboratively to ensure the child is at the centre of all decision making. To support this, the development of a briefing or joint training that explains Mental Health Act Assessments, Deprivation of Liberty Safeguards, Tier 4 Child and Adolescent Mental Health Service and Secure Welfare will help enhance practitioners understanding and enable them to hold each other to account.

Recommendation 3:

Cheshire East Safeguarding Children's Partnership should seek assurance that whenever a child is admitted to hospital following a significant incident, a multi – agency meeting is held to formulate and agree the multi – agency safeguarding plan and holistic plan of support prior to discharge.

Recommendation 4:

Cheshire East Safeguarding Children's Partnership should seek assurance that Gateway Meetings and the use of the risk stratification tool recently implemented, have the desired effect of supporting co-ordination of multi – agency plans for high-risk children to be safely supported in community settings.

Recommendation 5:

Cheshire East Safeguarding Children's Partnership should consider developing a multi -agency Team around the Team approach to support frontline practitioners who are working with high-risk children, to support reflective practice, reduce risk of vicarious trauma for practitioners and improve decision making.

Recommendation 6:

Cheshire East Safeguarding Children's Partnership should consider asking the Corporate Parenting Board to review the current sufficiency statement to ensure it addresses multi – agency approaches to joint commissioning arrangements for the most complex and vulnerable children where there are significant

safeguarding concerns and how agencies will work together to identify placements and manage risk.