Child Safeguarding Practice Review - *Child F*

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Stockport Safeguarding Children Partnership

Purpose and Governance of the Review

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- The case of child F was referred to the Safeguarding partnership in 2020. It was deemed to be a notifiable incident and the Rapid Review panel agreed to progress a Child Safeguarding Practice Review
- As F was thought to be a unique case, the initial action was to undertake a desktop review to see if this was a system issue or an individual failure by a provider
- The desktop review confirmed that F was a unique case, but also identified that there were national issues in securing suitable placements for complex young people
- It was then agreed to hold a practitioner event to look at the learning points specifically from the Rapid Review and

Desktop Review

- The review sought to explore the Transforming Care Pathways and the role of the responsible commissioner with reference to
    - Care, Education and Treatment Review (CETR)
    - Dynamic Support Database (DSD)
- Care planning and role of the IRO
- Availability of placements
- Transfer of records
- System learning

Practitioner Event Participants

Job Role	Agency	Job Role	Agency
Senior Practitioner	Stockport Family	**Complex Case Manager Mental Health and Learning Disability**	CCG
Transition Social Worker	Adult Social Care	**Training Manager**	Safeguarding Children Unit
Personal Adviser	Leaving Care Team Stockport Family	**Senior Mental Health Practitioner**	CAMHS
Senior Social Work Practitioner	CWD Team Stockport Family	**Service Lead for Safeguarding**	Safeguarding Children Unit
Service Leader	CWD Team Stockport Family	**CSS Manager, Strategy and Commissioning**	SMBC
Safeguarding Partnerships Manager	Safeguarding Children Unit	**Safeguarding Lead**	NW Ambulance Service
Named Nurse for Looked After Children	Stockport NHS FT	**Designated Nurse for Safeguarding Children**	Stockport CCG
IRO	Stockport Family	**Phoenix Team Sergeant**	Greater Manchester Police
Service Leader	ASPIRE Complex Safeguarding Service, Stockport Family	**Team Leader**	CWD Team Stockport Family
Operational Manager	Youth Justice Service, Stockport Family	**ACT Senior Practitioner**	ASPIRE Complex Safeguarding Service, Stockport Family
MASSH Sergeant	Greater Manchester Police	**Head of Safeguarding**	Pennine Care Foundation Trust

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Pen picture

- F is 18 years of age. Her hair colour often changes, and she enjoys trying out different styles and colours. F has her own style and an infectious smile. F has a good sense of humour and enjoys having a laugh with people.
- F enjoys music and singing and is very talented. F often writes her own music and poems. F has recorded some of her songs and has performed at events.
- F also enjoys movies, horse care, dancing, cooking, swimming, martial arts, boxing, rugby and as she says "the usual teenage stuff." F has a pet rabbit at her home and at her parent's home she has a dog.
- F is a very caring and thoughtful person and often wants to help others. F can be very articulate and will voice her opinions, wishes and feelings with support.

Contextual Information

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- F was diagnosed with Tourette's syndrome at 2 years old
- In junior years F presented with OCD behaviours and sensory difficulties an Autism Diagnostic Observation Schedule (ADOS) assessment was undertaken
- When F was 7-9 years old concerns were raised by F's mother that she was struggling to manage F's behaviours as she would hurt herself and others
- F was later diagnosed with ASD, vocal and tic disorder, Compulsive Behaviour and Intrusive Thoughts consistent with diagnosis of Obsessive-Compulsive Disorder (OCD)
- When F was 12 years old she took an intentional overdose. From that age F struggled with her mental health and emotional wellbeing
- Between the ages of 12-14 F entered and left the care of the Local Authority under s.20 of the Children Act 1989 on a number of occasions. F experienced several placement moves due to them breaking down. This led to F's education being interrupted as she wasn't consistently accessing education in one area
- F was sexually exploited when she was 12 years old which impacted her significantly and led to this type of harm continuing for several years of her childhood
- The last time F entered the care of the Local Authority and remained in their care was from the age of 14 F as her mother felt unable to keep her safe and F also wanted to be accommodated. The relationship between F and her mother was difficult at the time
- F continued to experience placement moves. Her disability and vulnerability to sexual exploitation led to her being subjected to Deprivation of Liberty Safeguards (DOLS) through the court of protection to keep her safe. This would be usual practice to ensure safety

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What happened

- F was a 17-year-old with a diagnosis of Autistic Spectrum Disorder, poor executive functioning, OCD, Tourette's syndrome with both verbal and physical tics and anxiety. F was a cared for child and was placed in supported accommodation in Birmingham when her previous placement broke down. A Deprivation of Liberty Safeguard (DoLS) was in place due to the need to restrict her movement and activities for her own protection.
- F was placed in a 16+ CQC registered placement in Birmingham. F's complex needs required 2:1 staffing 24/7. This was commissioned by Stockport council in the placement. In addition, a DoLS was sought to enable the placement to implement additional restriction measures to keep her safe.
- The placement did not consistently provide 2:1 staffing 24/7 or implement the DoLS as agreed. This meant F was able to go missing from home or from the care of staff. During one unauthorised absence, on 31st of October 2020, F was assaulted by a male whilst missing from care.
- There were a variety of meetings during the short length of the placement to address the issues emerging, however this resulted in Stockport council ending the placement on safeguarding grounds, as despite placement assurances, no changes were made to how the providers were delivering the care needed by F.
- F moved to live with her aunt under a regulation 24 placement. Unfortunately, due to the strain of caring for F and meeting her needs, this arrangement ended and F then returned to the care of parents, whilst an alternative suitable placement was identified.
- The sexual assault was reported to the police and is currently under investigation after representations were made on F's behalf to have the matter reconsidered. Stockport Metropolitan Borough Council (SMBC) requested a Care, Education and treatment Review (CETR) was held given the repeat crisis attendances at A&E at the time.
- The failure to keep F safe appears to be due to the placement not providing adequate staff or implementing the DoLS measures as they were commissioned to provide. The placement company director has accepted this. SMBC commissioning team advised the Care Quality Commission (CQC) of the events and the social worker notified the Designated officer (previously referred to as the LADO) in Birmingham who completed an investigation.

Learning from desktop review

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- A sample of 10 looked after children with multiple needs were selected. These comprised 8 females and 2 males, with ages ranging between 12 and 16. F was also to be reviewed to enable the comparison. Therefore 11 children were included in the audit in total.
- The desktop audit was conducted by the two Quality Assurance Officers (QAO) within the Stockport Safeguarding Partnership. The audit sought to establish the following:
- **The needs of the child** *(Within the system, the additional field was used to establish the child's Disabilities, Category of Need, and to establish an overview of Missing Person records).*
- **The stability of placements** *(Within the system, the CLA field was used to establish the placements the child has attended and to understand the time the child has been housed at the placement).*
- **The planning of placements** *(Within the system, The Placement Plan was used to review the decision making when selecting a placement as well as identifying the reasons for change of placement).*

Learning from desktop review

- F was a unique case whose behaviour was compounded by external factors. Her needs were multiple, potentially increasing the difficulty of finding a placement which could address all her needs. The other cases audited appeared to have informed decision-making around placement planning based on the needs of the child, required location and placement facilities and expertise.
- The greater use of outside area locations may suggest a lack of local availability or a lack of local specialist facilities. In the main, children included within the audit appeared to be settled in their placements and had not required many moves. In F's placement history 67% of placements were outside of Stockport.
- In some instances, auditing these cases was problematic due to the lack of historical placement plans which may have been linked to the migration of a new information management system (Liquid Logic)
- Other specific issues included; Individuals' complete plans differently, some plans appeared to be prepopulated from a former plan, potentially allowing information to be inaccurate to the new plan if it had not been updated, linked addresses were not always shown on the initial personal detail page, placement detail was not easily drilled down, and placement plans did not always show as completed which may be linked to the approval process.
- This implied a lack of robustness of Placement Planning within Liquid Logic as the pathway of planning and decision-making did not always follow the same structure.

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Practitioner Event

- A practitioner event was held in December 2021 to bring together professionals involved in F's care
- There was multi-agency representation and those who contributed can be seen on page 3
- The event reviewed the life span of F and significant events in her life and care to set the context of historical information and the event that led to the review taking place
- The practitioners were asked 6 key questions that were informed by the initial Rapid Review, Desktop Review to inform a group discussion. The discussion was rich and well informed by various practitioners' specialisms and knowledge
- The event was facilitated and chaired by the Safeguarding Partnerships Manager in the Safeguarding Unit
- Participants completed an evaluation form following the event

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Practitioner Event

We asked the following questions;

1. Using F as an example – what have we learnt about commissioning placements for high needs children?
2. Using F as an example what have we learnt about the Care Education and Treatment Review (CETR*) and Dynamic Support Database (DSD)?
3. What do we need to know or how do we need to act to ensure that records are transferred to the appropriate service when a child moves?
4. How will we ensure that out of area police forces know about complex children who move out the area when there is vulnerability to exploitation and how will we know this system is working?
5. How do we assure ourselves that the care plan is a comprehensive multi-agency plan with clear owners for actions for children?
6. Are there any learning themes that you have identified today that you feel should be noted?

*Appendix item

Learning

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- Practitioners didn’t always understand health pathways and what they mean or how to access them for children with complex needs
- There was evidence of strong multi-agency working and there was a lot of care and concern for F. However, it was not clear that there was co-ordination between all the services working with F. This appeared to be due to a lack of knowledge of processes and policy within various health systems
- There was confusion over multiple and changing diagnoses for F in the context of what this means for F and access to services or placement provision
- Information sharing and file sharing challenges with systems were noted
- Throughout the placement, there were signs that the placement was not fulfilling its responsibilities, a risk assessment should have been undertaken to understand whether it was safe for F to continue to be cared for by the provision
- Professionals working with F were not clear on the Dynamic Support Database (DSD)and the Care Education and Treatment Review (CETR) process

Learning – Availability of Placements

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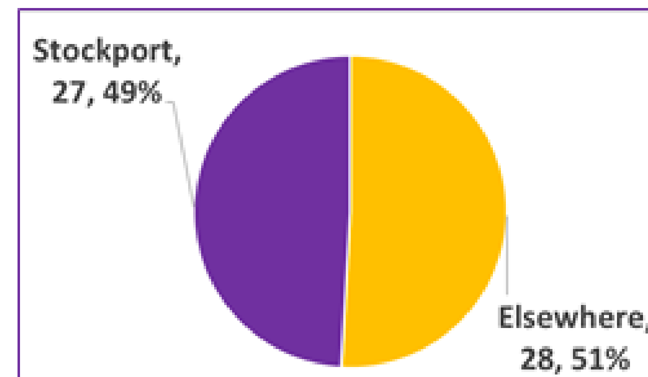
A wider review of placement availability from the desktop review highlighted the following learning;

- Where there was evidence of placement planning, the planning considered the needs of the child, and searches often considered multiple locations. Planning also considered the reasons for the moves. In most cases there was adequate time for another placement to be found, however, there were instances where children had to be moved quickly and foster care was used whilst a longer-term placement was being sought.
- Missing episodes from placements appear to be linked to a variety of reasons such as external factors (e.g. F's mother diagnosed with a serious illness); child's behaviour patterns (e.g. being unable to manage a situation or deviation from the weekly plan), and the child being unsettled. These episodes also formed part of the placement planning , finding suitable placements that understand and can manage behaviour patterns and in one case, being placed in a rural location to minimise risk to the child.
- Most placements were located outside of the Stockport area. (For F, the split was Stockport 33%:67% Elsewhere).
- The graph below shows the split in location of the placements for the other children included in the desktop review:



What has worked well

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- The Staying Safe Panel that is facilitated by the Aspire Complex Safeguarding Service will support with the processes of transferring of information for children like F in the future
- Systems have changed in children's social care with the Aspire Complex Safeguarding Service, which would offer a different and improved service to F or a child of similar complexity.
- The Clinical Commissioning Group (CCG) has put in place all the mechanisms required for a Dynamic Support Database for relevant children in Stockport, including training.
- Regular meetings have been set up where the Dynamic Support Database will be reviewed and actions agreed.
- The Achieving Change Together (ACT) approach has made a significant difference to F, she has a trusted relationship with her worker, is safe and doing well.
- The reform and implementation of the Staying Safe Panel within children's social care offers assurance that information is being shared between agencies. The panel is made up of various agencies who are statutory or relevant agencies in safeguarding children

Parent Feedback

- F's mother believed that the placement was sought in a 'rush' for her daughter as her former placement had broken down and another needed to be sought quickly. Due to the placement availability at the time, there was limited choice, and she feels that this is an issue generally, in terms of finding appropriate placements.
- F's mother wasn't sure why her daughter was placed approx. 3 miles away from a male who was a risk to her (of sexual exploitation) at the time and thinks something more should have been done in relation to this as she thought it was a risk and F went on to meet him during her time there as he wasn't far away.
- F's mother noted several incidents where the placement were not adhering to the DoLS of 2:1 staffing during her visits, which was fed back to Children's Social Care. She feels that action could have been taken sooner to move her daughter to a safer placement as providers were failing to provide the required care. This ultimately led to her collecting F and taking her home as she didn't feel that the placement was keeping her safe.
- F's mothers experience of this time in her daughter's life was that it was 'chaotic' as it felt that information was not being shared effectively between agencies and there were too many people involved.

Actions and next steps

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- There will be dip sampling (random selection of cases identified for review) of the transforming care hospital discharge and Dynamic Support Database (DSD) information that is held to ensure processes are working effectively for children with complex needs
- Following DSD reviews, all professionals will complete the necessary actions to maintain an up-to-date DSD
- The CCG will review the DSD Database to ensure it’s up to date and effective
- Childrens Social Care will receive training from the Complex Case Manager for Mental Health and Learning Disability, in relation to the DSD, CETR and the new role of the CPA related processes for children with complex needs
- The challenges associated with commissioning specialist placements and availability of these will be raised with the National Panel as this is not unique to Stockport and is a national issue of importance
- A universal information sharing system would benefit agencies in ensuring robust information sharing. This is noted to be an issue of national importance which will be shared with the National Panel
- Children’s Social Care, the CCG and the Commissioning team are in the process of reviewing arrangements to ensure that external placements will provide the best possible service for children with complex needs and agree a way to manage this should concerns arise that they are not meeting agreed expectations.
- A 7-minute briefing paper will be developed to inform learning events for practitioners to disseminate learning from this review
- The Partnership Training Manager will arrange and facilitate learning circles to disseminate learning from this review

Actions and next steps continued

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- Future auditing work and the action plan arising from this review will be monitored through the Practice Improvement Partnership, Quality Assurance Partnership and Learning from Practice group.
- Systems have now changed and anyone on the Dynamic Support Database (DSD) will now be eligible for a Care Programme Approach (CPA)* which would help practitioners to have a better understanding of a child's needs and service access. All cases will have an allocated professional from Children's Social Care who provide feedback and attend multi-agency meetings. These are the Greater Manchester minimum standards for the DSD.
- The process of ensuring health attendance at reviews for cared for children who reside outside of the borough needs to be reviewed. It is recommended that Children's Social Care and the Independent Reviewing Officers service review this process. It would be beneficial for an email to be sent to the Stockport LAC health team for advice and support with identifying an appropriate health colleague to attend in these circumstances.

*appendix item

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Appendix

- Care Programme Approach Position Statement NHS England
- Care and Treatment Reviews (CETRs) Policy and Guidance