Logo North Somerset Safeguarding Children Partnership

# **Local Child Safeguarding Practice Review (LCSPR)**

# **KATRINA**

(Assigned Pseudonym)

**Overview Report v4**

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**Presented to North Somerset Safeguarding Children Partnership (NSSCP) XXXXXXX**

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**CONTENTS**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 1 | [Introduction & Circumstances Leading to the Review](#Introduction) | 3 |
| 2 | [Methodology and Scope](#Method) | 3 |
| 3 | [Family Engagement](#Family) | 3 |
| 4 | [Background prior to the scoping period](#Background) | 3 |
| 5 | [Issues](#KeyE) facing Katrina | 4 |
| 6 | [Thematic Analysis](#Thematic) | 8 |
| 7. | [Conclusion](#Concl) | 28 |
| 8 | [Recommendations](#Recs) | 30 |
|  | Appendices  [Appendix 1: Terms of Reference **(Redacted for publication**](#App1)**)** | 32 |

1. **Introduction and Circumstances Leading to the Review**
   1. This LCSPR relates to a young person, Katrina, who attempted suicide by jumping from a high building. Katrina was 17 and a child in care[[1]](#footnote-1) at the time of the incident. Katrina survived and has recovered well from the multiple injuries she sustained.
   2. The requirement for a LCSPR was agreed at a Rapid Review Meeting of key professionals from the Safeguarding Partners and other relevant agencies. The National Child Safeguarding Practice Review Panel agreed that the circumstances met the criteria for a LSCPR on 30 June 2020.
2. **Methodology and Scope**
   1. The LCSPR covers the period **13 months prior to the attempted suicide.** Agencies were also asked to include anything of significance outside of that timeframe.
   2. Full Terms of Reference, rationale for the scope and methodology for this LCSPR can be found in Appendix 1.
3. **Family Engagement**
   1. A key part of undertaking a LCSPR is to gather the views of family regarding the services they received from agencies and share findings of the review with them prior to publication. It was not possible to meet Katrina face to face in the early stages of the review process due to the ongoing national response to a pandemic, so the author spoke to Katrina over the phone. Her views and comments have been included throughout the report were relevant; Katrina agrees with much of the report’s findings. Katrina stated that although her relationships with professionals were sometimes difficult, she did not blame anyone for what happened to her. The author was able to meet face to face with Katrina, supported by her leaving care worker once Covid restrictions were eased, to feedback on the final. This meeting and the input that Katrina has had as a whole has been extremely beneficial to the review process. It is fair to say that this type of involvement and insight into the life of a young person who experienced what she did is rare. This was for a range of reasons. Katrina is now an adult who has great insight into the person that she was and the issues that she experienced. Young people who take the action that she took to end her life would rarely survive. The author therefore believes that what Katrina has to say, should be heard and be at the centre of learning from this review. Katrina stated that she hopes that this report will help others and wanted people to know that she has reconciled with her parents, and they have a good relationship, has started a new job, and has plans to move into her own property to continue her journey to independence. Katrina told the author that she is now starting a new chapter of her life and that she wishes to put all of this behind her.

# **Background Prior to Scoping Period**

* 1. The brief information presented in this section will aid the review to understand the background and context with which Katrina came to the attention of services within the later timeframe of the review.
  2. Katrina was the second child of young parents (19 and 21 at the time of her birth); her older sibling was two years old when she was born, Katrina’s younger sibling was born when she was 12. Katrina is of White British origin.
  3. Katrina became known to Children’s Social Care as a Child in Need[[2]](#footnote-2) when she was six, nine and 11 years old. These were related to concerns over physical and emotional harm at home. Katrina was referred to Child and Adolescent Mental Health Service (CAMHS) and attended eight sessions of Cognitive Behaviour Therapy to help her to manage anger and anxiety. A further children’s social care referral resulted in child protection procedures for six months when Katrina was 12, stepped down to Child in Need, and ending involvement after three months.
  4. Eight weeks later children’s social care resumed services, and Katrina spent a few weeks in foster care before returning home voluntarily. There was a further CAMHS referral at around this time but having received no response from the family, Katrina was not seen; the social worker was made aware. Katrina and her family continued to receive support as a Child in Need for three months and then services ended.
  5. Four months later further concerns were raised with Katrina going missing. A missing episode three months later resulted in Katrina going back into the care of the local authority and at this point she expressed a wish to remain in long term foster care. Katrina was now 14 years old.
  6. During this period of being a child in care, Katrina received direct work from a family support worker to help build her self-esteem and understand her life story and identity. Katrina was beginning to show signs of self-harm, scratching her arms. During this time Katrina was not accessing full time education.
  7. Two further CAMHS referrals were made in this period but the issues that had been referred did not meet the criteria for a service, so advice and alternative signposting were given.
  8. Katrina went missing for the first time from foster care after 15 months. On return, she stated that she was being bullied at school and that she was feeling low and wanted to end her life. A CAMHS referral was made, and Katrina was placed on the waiting list to be seen.
  9. Katrina returned home around her 16th Birthday. Children’s Social Care ended their involvement after three months when Katrina and family reported that home life was going well and that they no longer required social care support.

1. **Issues facing Katrina within the review period**
   1. For the purposes of analysing and understanding practice and systems related to professional interactions with Katrina, her story during the 13 months prior to the attempted suicide will be briefly summarised in this section.
   2. Due to the multiple contacts with agencies, often many contacts within a day, it is not possible to go into any events in detail. What is helpful for the review, is to understand the issues that Katrina faced in the review period. The outcomes of interventions and contacts that resulted from the issues facing Katrina will be analysed in detail in section six of this report. This will include exploration of some of the systems that were in place for professionals to respond to the concerns and circumstances facing Katrina. This will then generate key themes for learning and lead to recommendations.
   3. For purposes of a timeline and to keep Katrina’s story anonymous, the 13 months of the timeframe will be referred to by month number e.g., month 1 being the start of the review period etc.   
        
      **Child in care**
   4. Katrina had returned home to her parents and was living at home at the start of the review period. Following increasing concerns of substance misuse, going missing, and threats to harm herself, her family stated that they could not keep her safe at home and that they had a younger child to consider. Katrina became a child in care again from month four and did not return home to live throughout the remainder of the review period.
   5. Katrina had stated she could stay with a friend whilst a placement was found but was placed into an emergency placement with foster carers after being found in a doorway. At the beginning of month six, Katrina was placed with a host in supported lodging.
   6. During her time as a child in care there were appropriate health assessments[[3]](#footnote-3) and statutory reviews[[4]](#footnote-4). At first there were concerns expressed by the Independent Reviewing Officer (IRO) [[5]](#footnote-5) that care plans were not completed, and the pathway plan had not been agreed. These were resolved. The IRO did have associated concerns regarding plans for Katrina and her regular placement moves which were analysed in the social care agency review report and has led to learning and recommendations relating to use of dispute resolution.
   7. Due to Katrina’s age, the pathway plan was for her to transition to supported living arrangements. It appeared that several commissioned provider placements, although having initially stated that they could look after Katrina and had skill sets to manage her presenting issues, they were not able to do this. This led to multiple placement breakdowns. At one point this resulted in Katrina being placed 30 miles away (Area 2). Although this was not ideal there were some hopes that this would prevent Katrina being in her hometown where she knew many people with whom she drank and bought drugs from. Despite this hope, there was a constant draw back to her hometown and she often went missing and was found there.
   8. Placements often gave very little notice of her having to leave. This type of action resulted in Katrina being in a bed and breakfast and then a hotel over Christmas time.
   9. Following this, a placement was found at a supported living placement that offered a high level of support with the aim of moving Katrina to more independence. Katrina lived there from month 10 for the remainder of the review period.

**Mental Health**

* 1. As is seen above, Katrina expressed concerns about how she was feeling. Katrina had previously been referred to CAMHs prior to the timeframe of the review but had been discharged as the previous foster placement was out of area.
  2. A further referral to CAMHs was made in month 2 following an overdose requiring treatment. Throughout the timeframe of the review Katrina began to present more and more frequently to services indicating self-harm from overdoses. Katrina was found in various states of distress and with concerns for her well-being. Katrina also threatened to go to high buildings to jump and in the final month went to such places on four occasions prior to the fifth one when she did jump.
  3. Katrina was offered the services of CAMHS on several occasions. Katrina only attended a few appointments as she found it difficult to engage and was not sure how CAMHS could help her. There was an occasion where Katrina was offered a CAMHs appointment with a male worker; Katrina had identified that she would like a female worker as males were a negative trigger for her. The main offer from CAMHs was for therapies to help her manage and regulate her distress and emotions.
  4. During the timeframe of the review the police received 45 contacts regarding concerns for Katrina’s mental well-being. On nine occasions she was detained under s136 Mental Health Act[[6]](#footnote-6) and taken to a place of safety for further assessment, or hospital if she required physical healthcare treatment, usually for overdoses, prior to being assessed.
  5. None of the Mental Health Act Assessments[[7]](#footnote-7) carried out, as required when detained under s136, resulted in Katrina being further detained as she was not found to be suffering from a mental disorder.   
      **Substance misuse and offending**
  6. Katrina misused substances throughout the review period. Katrina had been referred to substance misuse services prior to the review period but services had not been able to engage with her. Katrina’s misuse of substances made her more vulnerable as, when she was under the influence of substances, she was often not in control of her behaviour.
  7. Katrina used substances to blank out and help her cope with her emotions. As a result of her substance misuse Katrina often found herself causing criminal damage and verbally abusing staff in the town centre. This resulted in her receiving Community Resolution for criminal damage then a Referral Order for theft, numerous assaults and criminal damage. As a result Katrina was required to engage with the Youth Offending Service (YOS), including the Substance Advice Service. Katrina had two workers from YOS, a social worker and a worker from the substance advice service. These services were able to engage fairly well with Katrina, but her substance use did not diminish although she was given lots of advice and support regarding staying safe.
  8. As things escalated following the Christmas period, Katrina’s substance misuse increased and there was a shift to the use of Class A drugs, significantly increasing her risk of harm. Katrina’s drug use also increased in terms of numbers of days a week she used drugs. Previously it had been evenings and weekends but after Christmas, professionals reported her under the influence of drugs most of the times she was seen.
  9. As Katrina continued to use drugs, she was increasingly being drawn into the circles of dealers and other adults from the drug using fraternity. These relationships were not helpful to Katrina. Towards the middle and end of the review period, Katrina was staying with an adult male. This man was known to the police and although there were some disclosures from Katrina that caused concerns that the relationship was inappropriate and that there was a risk of sexual exploitation, Katrina did not want to make a complaint as she did not want to create issues within that family. Due to the serious risks that this posed, the information was shared with police under child protection procedures and led to a strategy discussion.  
       
     **Missing Incidents**
  10. Katrina went missing on numerous occasions. Her missing episodes had started before the period under review. Most of her missing incidents were reported to the police. Sometimes Katrina would go missing on several occasions in one day; she would be found and then go missing again. Missing incidents were sometimes reported by housing providers when Katrina was very quickly found and sometimes it took longer for her to be found. Katrina would sometimes appear to be more stable for a few weeks with no missing episodes and then something would trigger missing episodes starting again.
  11. Katrina’s missing episodes linked with other activities and issues mentioned above.  
        
      **Sexual Assaults**
  12. Katrina reported that she had been raped on two occasions during the review timeframe and one just prior to the timeframe. All had been initially reported by third parties. On the first occasion, that was prior to the timeframe of the review, Katrina did not want to take any further action and would not give the police any information. On the other two occasions, Katrina did want to take action. She was supported to attend a Sexual Assault Referral Centre[[8]](#footnote-8) for examination and follow up and was supported by an Independent Sexual Violence Advocate (ISVA)[[9]](#footnote-9). Neither of the reports were able to be taken forward for prosecution of perpetrators because of lack of evidence. This naturally had a negative impact on Katrina.

# **THEMATIC ANALYSIS**

* 1. The analysis section takes a strengths-based approach identifying what went well, if and how those strengths can be move up the scale to make practice stronger and then building a picture of areas where learning has occurred. Systems and services that worked with Katrina have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review.
  2. During this review process it is very clear that the professionals that were involved with Katrina worked passionately to try to keep her safe. In most of the areas for learning it is the systems that professionals worked in that made it very challenging to attain their goal.   
       
     **Impact of Adverse Childhood Experiences[[10]](#footnote-10)**
  3. Katrina had first become a ‘Child in Need’ receiving support from Children’s Social Care when she was six years old. From then on, she continued to have periods of support as a Child in Need throughout her young childhood. The concerns were due to emotional harm and allegations of physical harm. Although there were disclosures later, there was no evidence of physical harm. Katrina’s actions caused issues in the family leading to her becoming a child in care for a period of over a year prior to the review period.
  4. It is not clear what life was like at home for young Katrina but the fact that she had become a child in care whilst her siblings remained at home must have been a very difficult situation for Katrina.
  5. Harm that occurs to a child and other negative experiences either at home or elsewhere are known as Adverse Childhood Experiences. As well as the issues that led to her being a child in need and a child in care at a younger age, Katrina also stated that she was a victim of bullying at school and was later subject to sexual assaults and rape. All these experiences before the age of 18 had an impact on Katrina’s psychological state and resulting displays of actions that indicated distress; as the traumas increased, so did Katrina’s health harming behaviours[[11]](#footnote-11) .
  6. These traumas are known to result in ‘toxic stress’ where the continuous release of the stress hormone cortisol impacts on the developing brain. Continual responses to stress, when not balanced with protective factors lead to a maladaptive and destructive response and is linked with the health harming behaviours that Katrina displayed. The more traumas a child experiences and the longer they go on for, the more likely it is that there will be long term physical and mental health problems.
  7. Professionals working with Katrina displayed that they understood the reasons for Katrina’s difficulties. Becoming a child in care for the third time in the period under review would have added to her trauma.
  8. It is known that in response to these harms and traumas, professionals need to offer Trauma Informed Care. (TIC)[[12]](#footnote-12). The main purpose of TIC is to increase professionals’ awareness of how trauma can negatively impact on children so that practices that might be inadvertently adding to trauma can be avoided. In using TIC, the sensitivity of professionals enables children to see them as trustworthy and feel safe to disclose abusive experiences. Additionally, practices which give children back choice, and some controls are viewed to be particularly valuable.
  9. The most recent Triennial Analysis of Serious Case Reviews[[13]](#footnote-13) identified that children in care are very likely to have suffered significant harm and trauma, will have trouble coping and will need nurturing care. The Triennial analysis therefore highlights the need for this be considered in assessments and support plans requiring trauma informed practice.
  10. When working with Katrina there were some good examples of this. Professionals used various methods to keep in touch with Katrina and to remined her of her appointments. Katrina was also able to drop into some services when she needed support. Some professionals offered last minute appointments and moved things in their diaries to accommodate seeing her. This was particularly the case for college who had a welfare drop-in service, YOS substance advice worker and social worker, and the Children’s Social Care Resource Service (Now known as the Child in Care Service).
  11. Some other services are not commissioned in a way to allow this flexibility. This was particularly true of CAMHs. At the time of this review period, CAMHs were offered by a different NHS organisation. The service was based on clinical appointments at a CAMHs venue with very set criteria for discharge for non-attendance or engagement, outreach type approaches that are more in line with TIC were not commissioned. To offer more TIC, CAMHs are now investing in a more outreach approach; there is hope that this will better meet the needs of young people like Katrina. This approach would allow much stronger practice along the TIC approach and is therefore identified learning. Due to the frustration expressed by services regarding what CAMHs could offer at the time and the importance of robust multi agency working, the changes that are underway are discussed in the multi-agency working section of this report.
  12. From the initial assessment that was undertaken with CAMHs, it was identified that Katrina required therapies to help her identify her stressors and manage her emotions based on the experiences she had been through. Katrina identified that she did not see what this would achieve, and CAMHs were not able to engage her further with any therapy. There was no other therapy or therapeutic experiences on offer from CAMHS.
  13. During the research that the author undertook for this review, Equine Assisted Psychotherapy came up on several searches regarding treating and supporting children and adolescents who have experienced trauma[[14]](#footnote-14). The use of horses has been long known to be therapeutic to children with physical and learning disabilities, so it can be seen how this could be beneficial to those who have experienced trauma. There is no guarantee that this would have benefitted Katrina, but research does show the benefits particularly for those who struggle to form positive relationships and in building resilience.
  14. Services of this nature are available to be commissioned in the locality with various funding pathways that can be accessed. It is right that there would need to be an agreement from a young person to commit and engage and it would not be possible for young people to utilise these services whilst under the influence of substances. This and other practical based therapies such as art therapy, wild swimming, surf therapy and forest bathing were not offered to Katrina. It is likely that less ‘formal’ type therapies for children suffering significant impact of trauma fits in with more trauma informed approaches and would make practice in this area stronger. Katrina agreed with this stating that expecting her to sit and talk was difficult. She could not talk ‘on demand’ and agreed that practical therapies would have been much better for her. This will be discussed further in the section on multi-agency working later in this report.

It is important to note that choir groups were investigated and alternative therapy through charities by the housing provider. This led to Katrina being offered counselling through a local charity, but she did not attend. Given what Katrina stated about talking on demand, it is understandable why she would not have attended.

* 1. It was noted during the workshops that at one point there were some 12 services working with Katrina. It is fair to say that these were not all continuously working with her as some were responding at points of crisis. It was clear that this was difficult for Katrina to understand. Some of the impact of this will be looked later in this report, but for the purposes of TIC, Katrina was often left to attend appointments by herself on time and with no reminders (notwithstanding the acknowledgement of some services trying to address this). In the case of CAMHs appointments, the social worker did attend some; Katrina would then be offered further appointments that she did not attend. This resulted in Katrina being seen on very few occasions by CAMHs, other than when in crisis; Katrina needed to understand that it was the impact of the traumas that she experienced that was the reason for her difficulties and that the offer of therapies from CAMHs could help her manage her emotions more easily. Katrina stated that she was a child at the time, had many appointments and had little control over her life and should not have been expected to attend these appointments unsupported. Katrina stated that if she had a 16-year-old daughter she would not expect them to get themselves to various places on time. Katrina stated that she would then be told that she was not engaging. On occasions Katrina would be messaged or phoned by professionals to remind her of appointments. Katrina stated that reliance on this needed to be through her social worker who always had an up-to-date number as she always lost or broke her phones and her number kept changing.
  2. All the professionals that were involved in this review were exceptionally sensitive to Katrina’s needs and treated her with respect no matter how she presented. Police and YOS dealt with her fairly when she began offending and understood the issues behind the observed behaviour. Use of Section 136 of the Mental Health Act was strong practice rather than her being arrested and overly criminalised for her presentations. Again, this is in line with TIC and shows evidence of strong practice. The impact of the continual use of 136 will be further analysed in the multi-agency working section later in this report.
  3. Whilst this was true, Katrina commented that some professionals’ use of language had an impact on her. Katrina stated that when she was in crisis, being told to ‘calm down’ was not helpful. She stated she thought that some professionals talked ‘at’ her and did not show true empathy. Katrina also stated that she had the impression that some professionals thought that she was attention seeking. This suggests that even if this was not the intention of professionals, this is how it came across. It is important learning when considering TIC that body language and careful use of spoken language is required to build a trusting relationship.
  4. Alongside TIC is a need for protective factors. Protective factors can be those such as positive relationships and identifying something that a young person can focus on.
  5. Katrina did not have the protective factors that a secure home and parents can offer. Early attempts at family support did not seemed to have given the family confidence to continue to support Katrina. On each occasion that Katrina went home to live it was not sustained and her parents stated that they could not have her living at home. It did not seem that there were later assertive efforts at formal family mediation although there were many conversations with the family and Katrina did continue to have some contact with her mother. It may have been that earlier attempts for mediation with the family may have enabled better relationships later. This type of mediation work is now more common than it was when Katrina was younger. When speaking to the author, Katrina agreed that there could have been more efforts by professionals to try and reconcile family differences. Katrina did acknowledge that she often stated that she did not want to go back home and that maybe professionals were doing as she requested. This is suggestive then of professionals needing to carefully consider what the child states they want and maybe offer a challenge. It may have been that Katrina stated this because it was better to state that than for her family to consistently say that she could not return.
  6. There were several attempts to introduce positive relationships from professionals. Katrina developed good relationships with the third social worker and her YOS workers. One of the Police officers, who became a case manager for Katrina, was also starting to develop a positive relationship with Katrina and at one point, following a missing episode, went to Katrina’s room, chatted, and helped her tidy her room. These are the things that a parent may do, Katrina desperately missed having her parents in her life. Katrina commented that her main sources of support were only available during office hours; it was identified by professionals that Katrina’s self-harming behaviours were worse at weekends (prior to escalation after month nine) and offers insights into what Katrina needed and expressed she wanted. Katrina told the author that there would be numbers for crisis services left with her but much of this was telephone support. Katrina stated that talking to Samaritans was not what she needed; she needed comforting when in crisis and that could not happen over the phone.
  7. In a recent review of evidence,[[15]](#footnote-15) being able to form relationships with a trusted adult is the key for both practical and emotional support and therefore is seen as highly valuable. This was also identified by the Triennial Analysis of Serious Case Reviews mentioned previously as being key to young people being able to develop a capacity to trust. The Triennial Analysis identifies the importance of relationship-based work as key to working with young people and adds strength to the need for intensive consideration of how professionals can offer more TIC to strengthen future practice.
  8. Katrina’s friendships with her peers did not really offer her any protective factors as they were not always positive ones. They may have had strong bonds, but these friends were also possibly suffering the impacts of trauma with some certainly undertaking similar health harming activities.
  9. Katrina was drawn into the circles of people that were likely to be exploitative, offering her drugs in return for favours such as housework; an example of this was highlighted in section five of this report.
  10. Referrals to disrupt that relationship, following the strategy discussion, were made to Operation Topaz[[16]](#footnote-16). A child abduction warning notice could not be used as Katrina was over 16 and was not subject to a Full Care Order[[17]](#footnote-17) as her child in care status was Section 20[[18]](#footnote-18). Other avenues for disruption were being looked at but the attempted suicide happened before any work was undertaken.
  11. Whilst Katrina did not have many protective factors in her younger life that would counterbalance any trauma, it was important to try and build her resilience to give her more positive things to focus on[[19]](#footnote-19). Other articles related to building resilience identify that education, employment and focus on interests and activities can build positives in a young person’s life and can lead to building relationships. Katrina told the author that the number of appointments that she often had would have disrupted and chance of attendance of any of these options.
  12. Katrina did show an interest in a choir and did have employment as a waitress when she was in Area 2, neither of these were sustained. It is not clear how much support she had to continue these activities. Katrina had signed up for year two of college, but she did not attend and was removed from her courses. It is of note that the college now has an active engagement programme that seeks to assertively work with those who find it hard to engage with education and that this is having some positive impacts.
  13. What was a clear issue for Katrina was that she had no structure to her day. The substance advice worker talked at length with Katrina about changing her routine, stopping relationships with negative people, and doing more meaningful activities, such as going to the gym through the go4life scheme, attending college, different distraction activities, seeing her auntie to see her horses. The YOS social worker also had discussions with Katrina about the importance of routine and the impact that healthy eating and sleep can have on emotional health. Despite this it did not appear that this, or the work undertaken by other professionals led to a sustained resolution to this.
  14. As discussed previously, the situation at Christmas was additional trauma and although she did see her mother on Christmas Day, she was largely excluded from family celebrations. After Christmas her distress led to increased substance and alcohol misuse.
  15. Ultimately Katrina’s health harming behaviours became more significant with overdoses and then moving to threats to jump from high buildings which she eventually succeeded in doing.
  16. Suicide attempts and completion in young people is triggered by many things, traumas being one of them. Identification of those at risk can be complex. A recent thematic review of suicidal ideation and suicides in young people[[20]](#footnote-20) noted that once a person has self-harmed, their risk of completing suicide is 49 times greater than the general population. The review suggests concepts such as discrete trigger events and trigger event phases may offer opportunities to increase supervision and closely manage risk. The thematic review identifies that it is rarely one key event that triggers a suicidal act but that these single event triggers often occur amongst a backdrop of other issues facing a young person and that professionals should consider the wider trigger event phases to be of concern. The evidence reviewed in the thematic review identifies that it is now thought that suicide risk builds over time and that professionals should consider ‘the rising tide of risk and concern’ alongside evidence of the triggers observed.
  17. Katrina’s story can be exactly seen within this framework. Her initial rejection from parents and background of traumas, her rejection from a placement that she thought she had confidence in, being homeless at Christmas, finding out that the rape charge would not proceed led to an increase in missing episodes and self-harm that led to a suicide attempt that nearly succeeded.
  18. Katrina told the author that she was so tired with everything. Every day she would face a new problem and she had had enough.
  19. Professionals need to be skilled in recognising this and managing the risk. Professionals working with Katrina were very proactive in responding to each incident, what they did not seem to be able to do to prevent the increasing self-harm and missing episodes.   
        
        
      **Katrina as a Child in Care**

**Points for strengthening practice**

* Understanding ACEs helps services to respond sensitively and appropriately to children and young people using Trauma Informed Care.
* Services that can be flexible and person centred are more likely to be able to engage with those who have experienced trauma.
* Trauma Informed Care includes using sensitive language, showing genuine empathy with body language appropriately supporting this persona.
* Wider offers of different therapies that are practical in nature may suit some young people more than more cognitively office-based therapies. Whilst these may be costly there is likely to be cost benefit by improving outcomes.
* Observing for Trigger Event Phases may help support the recognition of the’ rising tide of concern’ and allow for more robust risk assessment and management
  1. Katrina spent much of her life as a child in need or a child in care. Despite all her difficulties, she was reported to be a bright, sweet, lovely girl who was very caring and was always willing to help her peers when they were in need. The chronology for this review provides evidence of this on several occasions.
  2. When a 16- or 17-year-old comes into care under Section 20, parents retain parental responsibility but the older the young person is the more they will have rights to make decisions for themselves in conjunction with professionals. In Katrina’s case it does not appear that her parents were able to be actively engaged in her care and decision making. Katrina was therefore reliant on professionals for the support that parents would usually give to a young person of this age group. This is particularly true of the local authority social care who were responsible for her care, pathway planning, future goals, and outcomes.
  3. As mentioned previously, Katrina had come into care just two weeks before her 17th Birthday. She had difficult relationships with her parents and may not have been able to develop the life skills that other young people may have had. As identified, previous and ongoing trauma would have made it difficult for Katrina to form relationships, and particularly with adults who were professionals.
  4. The reviewing process for young people in care did not progress as smoothly as it might. There were delays in pathway planning and care plans being developed and there was information missing. During the workshops the author did not get the impression that Katrina was fully involved and engaged in her own pathway planning. Katrina told the author that she often found out about meetings about her afterwards and was not always up to date with what was happening. Katrina stated that she would be told that she would be invited to the next meeting but that never materialised. This fits in with the previous section regarding TIC where it is important that professionals actively engage with a young person and ensure that they are enabled to be involved with meetings that are about them.
  5. The IRO was not kept updated as they might have been regarding placement moves and was seeking out care plans that there had been no evidence of. The reason for this was that the situation with Katrina was changing daily, the social work team that initially managed Katrina’s move into care was the referral and assessment team, who are well placed to manage the initial assessment and planning. Due to Katrina’s age and needs, a decision was made that Katrina’s care would be moved to the long-term team for children in care as this would enable relationship building rather than a further change of worker. Whilst this rationale was understandable and sensible, the impact was that this did not support the care plans being put in place as this would usually have been undertaken by a different team in the initial phase.
  6. It has been mentioned throughout the review that Katrina had many expectations placed upon her to manage her life and to attend numerous appointments. Katrina was reminded about appointments by text messages and phone calls but the appointments that she was physically supported to attend were few. Given that Katrina was only just 17 this was a big ask, particularly as her issues meant that she was living a chaotic lifestyle that she told the author she felt that she had little control over.
  7. A very recent report by the Social Care Ombudsman[[21]](#footnote-21) reminds us that:

*“we are the parents for these children and young people and the way to think about that is what would I want for my child”*

* 1. Whilst this is the desire of those that work with children and young people in care, it can be affected by the resources available within local authorities. The author would suggest, however, that there should be firmer plans in place to support young people to attend appointments and support them to navigate processes that some adults would find difficult. This could be a shared task and will be further discussed in the multi-agency working section.
  2. Katrina faced multiple accommodation moves. As part of her pathway plan and as part of the local authority’s responsibility to provide accommodation to all 16- and 17-year-olds who require it, Katrina was initially in an emergency foster placement. This lasted longer than usual whilst suitable supported lodging could be found. Supported lodging is like foster care but there is more freedom to be independent whilst having the support of a host within whose home the young person lives. From there Katrina then moved to supported living arrangements as a way of her gaining more independence whilst being supported to gain more life skills. These arrangements often involve 24-hour support and is usually for more than one young person.
  3. Whilst all the placements that Katrina went to live should have been staffed by skilled carers who could support her difficult emotions and behaviours, these broke down very quickly with various reasons being given by providers that the placements could not continue.
  4. Of particular concern and causing a great deal of distress for Katrina and her social care workers, was the out of area placement. Whilst local authorities are tasked with placing young people locally, there was no local accommodation available. It was thought though, that this might in fact be a positive placement in that it would take Katrina away from the local areas where all the negative aspects of her life were and where she was constantly missing and seeking out drugs.
  5. Unfortunately, Katrina continued to be drawn back to the local area and constantly went missing back to the local area.
  6. Katrina did, however, start to build a positive relationship with the supported living manager and as the placement continued there was a slightly more settled period. It was agreed at the workshops that this had the potential to be a more settled time. Katrina had found a job as a waitress during this time.
  7. Katrina then reported a further rape. Katrina received supportive help from health services and agreed to receiving ongoing support from a Children and Young People’s Independent Sexual Violence Advisor (CHISVA)[[22]](#footnote-22). The assault though, triggered a further escalation in Katrina’s display of emotions and after an altercation at the supported living accommodation, she was given immediate notice to leave. Despite the efforts of the social care team to negotiate around this so that Katrina could stay, the notice was not reconsidered, and Katrina was made homeless. It is significant that this was nine days before Christmas. Despite the extensive searches there was no supported living or any other accommodation available and, in an emergency, Katrina was placed in a bed and breakfast. Katrina refused to stay there stating that it was dirty, which the social worker had agreed it was. Katrina then spent the night on the street and was placed in a budget hotel the next day. Arrangements were made for a foster carer to offer Katrina to join their family for Christmas dinner, but Katrina declined; Katrina asked the author ‘who would want to spend Christmas day with total strangers’. Katrina did see her mother on Christmas day.
  8. This situation was appalling for Katrina. It can only be imagined that she may have felt rejected again as a placement that she thought was positive gave notice immediately there were issues. Katrina told the author that this was a difficult time for her and believed that she had been made homeless by children’s social care. Katrina agreed that on occasions her recollections were hazy; social care staff involved at the time have met with Katrina to ensure that she understands what happened so that she can seek resolution for herself regarding understanding the facts of this difficult time. The detail of the incident was discussed at the workshops and the action of the provider was considered to be very harsh. Katrina. During the further meeting with the author, Katrina continued to disagree with this version of events but has moved to the next chapter of her life.
  9. It was stated during the workshop that North Somerset had problems with private providers during that period. There is a national issue with a shortage of providers that can accommodate adolescents with complex behaviours. It is known that to move a young person away from their local network is not beneficial and makes them more vulnerable, but due to the national shortage there are limited placements locally that are able to be sought, particularly in an emergency. In the out of county placement, there were issues related to the skills that staff appeared to have in managing Katrina’s presentations that led to an immediate ending of that placement. The author would consider that those young people requiring this type of accommodation are more likely to have complex issues and require skilled management and support.
  10. The UK government in its cross-government strategy to support young people leaving care [[23]](#footnote-23) , set out that accommodation providers must have the necessary skills to support young people. Local authorities also have the responsibility to have enough accommodation for its cohort of young people needing accommodation. The strategy also sets out that young people should only be in a bed and breakfast in exceptional circumstances and for a maximum of 48 hours.
  11. The local authority has recognised the issues that some providers were presenting and have tightened their commissioning arrangements for supported living accommodation providers and will continue to monitor the matching of young people to the right placement, the quality of care and support that is provided as well as providing enough accommodation.
  12. The impact of being homeless in a B and B and then a hotel at a time when she had experienced a rape was the starting point for Katrina’s life to spiral negatively and therefore the learning here is crucial.
  13. A further option that was considered was the application for secure accommodation under Section 25 Children Act 1989. Indeed, Katrina herself stated that ‘they’ needed to ‘lock [her] up’ so that she could get her life back on track. The law related to secure accommodation for 16- and 17-year-olds is very complicated with plenty of case law usually falling in favour of not granting secure accommodation orders. Section 25 only applies to in care children and excludes those who are 16 years and over, in a community provision under Section 20 Children Act. The only way this would have been possible would be if Katrina had a Care Order in place. Once a young person has reached 17 years a Care Order is not possible; Katrina had only been a Child in care for two weeks and therefore a Care Order would have had to have been applied for immediately that she had come into care.
  14. Secure accommodation is a deprivation of a young person’s liberty and as such breaches Article 5 of the Human Rights Act unless the circumstances allow for a lawful detention. It is likely therefore that the Family Court or an application for an inherent jurisdiction to the high court would not have resulted in a Secure Accommodation Order being granted.
  15. The meeting with the legal advisors was lengthy and felt to be robust by those that attended. It was also noted during the workshops that even if an order had been granted, there were many other children and young people across the country waiting for secure accommodation and many of those met exactly the criteria for secure accommodation.
  16. In conclusion of this section the experience of Katrina as a young person in care did not lead to positive outcomes, not because of the workers that were involved but because of the systems that did not allow professionals to offer the best care that they could as if she was a child of their own.

**Katrina’s relationships with professionals**

**Points for strengthening practice**

* Clarity of roles and responsibilities when a child comes into care of the local authority provides reassurance to the young person that their needs are being carefully considered.
* Early plans, goals and pathway planning can ensure that a young person feels engaged as soon as they come into care.
* Careful attention to the practical support that a 17-year-old might need in terms of support for attending services’ appointments ensures that the parental role for a child in care is continued.
* The mantra “what would I want for my child” can remind professionals and organisations of their corporate parenting role.
* Commissioning of quality placements with skills to care for those significantly affected by trauma is as important as commissioning the right number of places.
* Early engagement of legal advisers is important when a child comes into care when they are approaching 17.
  1. As discussed previously Katrina did not have a positive relationship with her parents at that time and relied on the adults around her to offer what would usually be available at home. Katrina needed to rely on the relationships that she formed with professionals in their role as corporate parents. Whilst the local authority ultimately takes the lead responsibility as the corporate parent, this role is for all professionals working with children and young people in care as identified in the government’s strategy mentioned previously.
  2. Katrina was a likeable young person and did form relationships with professionals easily. Katrina told the author that she liked the professionals that worked with her but that they did not always seem to know how to help her or talk to her (as discussed previously in this report). However, there were many of these relationships and there did not appear to be one key coordinator that everyone else reported back to. This should have been the social worker and on most occasions the social worker was seen in this role but not by all on all occasions. The Triennial Analysis also identifies that a key lead professional needs to be recognised by everyone else involved and coordinate and receive feedback on what each other professional in undertaking. There was no one person in CAMHs that Katrina could relate to and this may have been a missed opportunity to improve engagement with her. Katrina did not see what CAMHS would achieve for her. The outreach model that CAMHs are moving towards may offer this opportunity. This would be beneficial to young people like Katrina who need to be able to build trusting relationships.
  3. Despite positive relationships, very few were able to make a difference for Katrina. Katrina complained that the people she relied on only worked weekdays 9-5 and outside of that time she was on her own. This suggests that most of the accommodation hosts and managers did not appear to have been able to be that trusted person out of hours apart from the manager of the out of area placement who she did have a positive relationship with. Unfortunately, this person was not able to support Katrina following the incident where she ended up homeless and this had a negative impact on her and could be seen as a discrete trigger event that developed into a trigger event phase for Katrina.
  4. Those that enabled the most effective responses from Katrina were those that came as part of her Referral Order. At this point those appointments became statutory and therefore Katrina needed to comply with them. The two workers were able to offer flexibility between the services to ensure that Katrina attended at least one appointment as required and appeared to have formed trusting and positive relationships with Katrina. There were clear boundaries set and Katrina mostly responded to these well.
  5. There were many other examples of positive and less positive relationships, however those that Katrina formed the best relationships with were those where time was able to be given and those that understood the way Katrina reacted to situations and took time to understand the person behind the persona.
  6. Albeit that this review has suggested that there are more difficulties the more professionals that are added into a person’s life, however the Children In care Nursing Service were not as involved as they might have been. The CCG representative for the review suggested that the service was being developed to become far more involved and to be a port of call for all other professionals. This may well work because, along with the child in care children’s team in Children’s Social Care, this is the only service that offers its services to children in care only and therefore have particular expertise in understanding the needs of this group of young people.

**Points for strengthening practice**

* Strategies for forming effective working relationships with young people are similar to those of parenting an adolescent: Clear boundaries, support when needed as well as allowing some independence that is non-critical of mistakes.
* Setting ‘ground rules’ for relationships can support young people to understand the role of professionals.
* Corporate parenting needs to be available 24 hours a day and seven days a week; it is out of office hours that young people are most vulnerable i.e., weekdays after 5pm and weekends.

**Managing Risk: Multi agency working, coordination and communication.**

* 1. In bringing together the previous elements, this section will look at how the professionals working with Katrina coordinated their care of her and communicated with others. The considerable issues that Katrina, a 17-year-old who was a child in care under Section 20 of the Children Act, was facing cannot be underestimated. There are examples of excellent multiagency working and communication in the work that was undertaken with Katrina. Inevitably though, with so many agencies involved and the situation and risk changing regularly, sometimes even within a 24-hour period, there are areas for strengthening practice with the way in which services were coordinating care, working, and communicating together.
  2. In month one, a safeguarding referral was received via the NSPCC mainly in respect of Katrina’s younger sibling. When children’s social care contacted Katrina’s mother, she reported ongoing issues between her eldest child and another individual. She informed social care that this was a malicious referral and that she knew who it had come from. Katrina’s mother stated that although there had previously been children’s social care involvement with Katrina, that all was well, and that Katrina was attending college and there were no issues. Children’s social care contacted the college. Information was shared from the college that Katrina was doing a childcare course but that her attendance was poor, that Katrina was her mum’s carer, that she used her wages to support the household, that she had reported a sexual encounter with a 20-year-old and that there were arguments with parents. As the younger sibling’s school reported no concerns, and the information received from college did not meet the threshold for social care intervention, no further action was taken.
  3. The multi-agency working and communication regarding this was discussed in the workshops. It was highlighted that this did give some insight into what life was like for Katrina at home, something that professionals felt that they did not really understand. This information was checked with college and information shared with the police but given that this was a child who had previously been a child in care on two occasions and that other agencies may still have been involved, information gathering from e.g., the GP and to see which other services were involved might have been useful. It may have been also a missed opportunity to check in with Katrina to get an update on how things were from her perspective. The sexual encounter reported by college probably related to the rape that had not been shared with Children’s Social Care; this was not picked up as an issue of concern by Children’s Social Care or questioned any further.
  4. Safeguarding responses must be multi agency especially when the threshold for section 47 may be reached. Single agency decision making is not best practice as there may be risks and issues not known about and therefore not be considered.
  5. Safeguarding adolescents can be complex. The older the adolescent, the more involved they are in decision making and this is rightly so. After the age of 16, The Mental Capacity Act comes into effect. This requires that where a person has an impairment of the brain or mind that is affecting their decision-making ability, then they should be either supported to make the decision where possible or that best interest decisions can be made. After 16 adolescents may make decisions that they do not want specific issues investigated or that they feel that they can manage their own safety. In Katrina’s case, her decision making would have been impaired at times when she was under the influence of alcohol or drugs, however there was no evidence that, when not under the influence, that she did not have capacity if she was supported to understand the consequences of her decisions. The Mental Capacity Act states that a person should be assumed to have capacity unless there is a concern regarding an effect of the mind or brain impacting on that capacity.
  6. As the Children Act can be used less and less in a young person of 17 as discussed previously, the Mental Capacity Act is applied and interfaces more with the Mental Health Act. Those assessments did not indicate that Katrina had a mental health diagnosis other than when she was under the influence of substances. On each of her Mental Health Act assessments, her Mental Capacity was assessed to ensure that she understood and agree decisions regarding her residence, care and treatment. These capacity assessments were always undertaken once the effect of any substances had worn off as is required, at these times Katrina was chatty and engaging and displayed that she had capacity. It would have been useful to highlight the issue of mental capacity when meetings such as strategy meetings were being undertaken to provide evidence that it had been considered and recorded in all assessments. As it was assessed that Katrina had capacity to make her own decisions, there is no evidence that the Mental Capacity Act was a framework that could have afforded her safety.
  7. This transition period to being an adult is a difficult one. Once a young person reaches 18 there is a different approach to safeguarding. This right to self-determination in adolescents is a delicate balance against the right to protection under the Children Act and other frameworks available to multiagency partners working with adolescents. It is of note that Katrina told the author that up until last year she felt so young and had no idea what was in her best interests. She knows that some of the things that she requested, on looking back, were a bad idea.
  8. Although the child in care system has been discussed previously, it is also important to consider how the multi-agency ‘team’ of professionals working with Katrina were able to feed into her reviews. It is of note that at a point where Katrina had been discharged from CAMHs, this was not known to the IRO. It was explained by Katrina’s IRO that the first review is always difficult as it is often not clear who is working with a young person. The first meeting is required to take place four weeks after the young person becomes a child in care. It is the young person’s review and therefore there is consultation with the young person prior to the review date regarding who they want to be involved. Whilst it is important that this is the case, it is also important that the IRO understands who is working with the young person and what their current role is. This helps with the building of the care plan and pathway plan. The IRO stated at the workshops that there is now a pre review consultation form sent to each agency involved so that even if they are not physically present at the review, then the information regarding their involvement is included at least for the second and subsequent reviews. If required, this can lead to a conversation between the IRO and those agencies that the young person has not requested to attend their review. This should enable greater multi agency focus within the pathway and care plan.
  9. From information identified by CAMHS, Katrina had attended an appointment at the start of the month that she become a child in care (month four). Having attended the first assessment appointment, Katrina was offered weekly sessions to help her develop strategies to manage her low mood anxiety and suicide attempts. Katrina defaulted the first of these sessions but was given a further appointment three days later, by this time Katrina was a child in care, having gone into care two weeks previously. On this occasion Katrina attended with her friend. This appointment was documented as ‘not constructive’. Katrina failed to attend a further appointment eight days later and was discharged back to her GP. CAMHS have identified some date errors but it is clear regarding the discharge. Katrina had talked about foster care, but it was not clear to CAMHs if this was current, she had stated that Social Care had found her a flat.
  10. It appears therefore, that this is why the IRO and social worker were not aware that CAMHs had not been able to engage with Katrina. The discharge letter was sent to the GP and Katrina’s parents. It does sound like the second attended appointment was difficult, however, understanding Katrina’s status as a child in care was important when considering information sharing. Katrina’s pathway plan was based on her getting support from CAMHs.
  11. Being curious to question and understand the whole circumstances facing a young person is important if we are to safeguard adolescents; Katrina had just become a child in care for the third time, possibly feeling rejection; this would have been a very emotionally unsettling time for her. CAMHS have identified in their agency review report that there should have been more demonstration of this ‘professional curiosity’ to understand Katrina’s care and living situation and communication regarding the intended discharge.
  12. The reports of rape that Katrina made did not have the multi-agency response that they should have. On the first occasion that was outside the scope of the review, Katrina’s right to not want to support a prosecution was respected and a decision was made that this allegation would not progress. This allegation did not lead to any referral to children’s social care as a child protection issue or to health colleagues for post assault support. This has been effectively analysed and recognised as a missed opportunity for a multi-agency response for the police and has been addressed by recommendations and action as a result. This shows good use of the Rapid Review element of a Child Safeguarding Practice Review and has led to immediate improvement actions.
  13. Linked to this were the further two reports of rape where, although the referrals were made to health partners for support on one occasion, there was no strategy meeting as a result of sharing information with children’s social care on either occasion. There was no challenge from other professionals who knew of these reports and leads to wider system learning regarding safeguarding adolescents. It appears that it was Katrina’s age and mental capacity that led professionals down a different pathway than they would have gone regarding a younger child.
  14. There were excellent responses to Katrina’s missing episodes with police and social care in particular working hard to share information and locate Katrina as soon as possible. Katrina going missing in a small town where most police and many town centre workers knew her often helped to locate her swiftly.
  15. Locating Katrina when she was missing was very resource intensive; there was some learning here in that on occasions Katrina was not exactly missing and was found in her bedroom, had gone for walks and on one occasion was at college. Whilst some of the missing episodes were initially reported by parents who can be advised of what to do if they believe their child is missing, once Katrina became a child in care again, it was mostly housing providers who alerted the police. The police report for this review identified a concern regarding an apparent lack of preliminary checks that were undertaken by housing providers prior to police contact and there is therefore learning for multi-agency working regarding individual organisation missing person processes.
  16. This review also highlighted that the College that Katrina was attending was generally disconnected from other agencies that were working with her. College, when she attended, offered Katrina a listening service and support for housing and wellbeing via their welfare drop ins. Within the workshops, professionals identified that this was a missed opportunity to work more closely with college to keep Katrina safe, interested and occupied as discussed in the previous section. Katrina’s post 16 education does not appear to have been considered as part of her a child in care and pathway plan; this might have been a prompt to include college.
  17. Further learning regarding multi agency working has occurred related to Katrina absconding from a hospital emergency department when she had taken an overdose. Katrina had been seen by the substance advice worker when it had been clear that she had taken an overdose. The Police officer who was known to Katrina and the substance advice worker accompanied Katrina in the ambulance to the hospital. Whilst the substance advice worker was trying to find someone else to take over from them at the hospital as it was late, Katrina absconded. It became apparent from information discussed within the review that there had been discussion that Katrina was at high risk of absconsion. Hospital staff had assumed that the substance advice worker would be responsible for observing Katrina. Katrina appeared to have feigned sleep when the substance advice worker went to make phone calls. Learning relates to services needing to communicate a plan for keeping young people in these circumstances safe until treated and fit for discharge. The hospital did not appear to understand the remit of the substance advice worker; the substance advice worker did not know who could take over from them and had assumed the hospital would be able to observe Katrina whilst the situation was resolved. The hospital has recognised this as learning and have made recommendations about this situation.
  18. As time went on and things were escalating, further assumptions were made as to what was likely to happen because of Katrina’s numerous mental health assessments that were being undertaken as part of her detentions under s136. There were hopes by non-mental health staff that Katrina would be able to be detained to an impatient mental health facility for further assessment and treatment. On each occasion the Mental Health Act assessments were undertaken in line with the requirements of the Act; Katrina was not found to be suffering from any mental health illness that required detention under the Mental Health Act. At each moment that she was assessed, after recovering from the effects of alcohol and substances, she was engaging and showed clarity in her thinking and did not show signs that she was immediate risk of harm to herself or others or that she had a mental health disorder.
  19. CAMHS professionals have explained that even if Katrina had been detained there would have been several issues with this, and it would not have solved the longer-term issues of her emotional dysregulation that she suffered from the trauma experiences.
* A CAMHs tier four bed would have had to have been found and this, especially in an emergency, could have meant a bed at the other end of the country.
* The tier four environment would have been difficult and distressing for a person with the issues that Katrina was facing.
* After two or three days, Katrina may have been much more settled and would have been discharged from the tier four bed as having no reason for detention to continue.   
  1. This appeared to frustrate other professionals at times and identified a gap in the understanding of how far the powers of an Approved Mental Health Professionals (AMHPs)[[24]](#footnote-24) and assessing doctors using the Mental Health Act can go and is learning from this review.
  2. Non mental health professionals found that this ‘revolving door’ element of the use of s136 difficult to manage. Each time Katrina was released from the s 136 arrangements were made for her to return safely to her accommodation, but on occasions it would not be long before s136 was actioned again. When these assessments were out of hours it was the Emergency Duty Team for Social Care that received the feedback. This would be added to the records so that the day services could review the outcomes. The Police, on occasions, found it difficult to keep up with the results of assessments. Learning for future practice identifies that there needs to be a pathway for feedback of results of each Mental Health Act assessment to all those that a person is likely to come into contact within an emergency.
  3. It was noted that although the professionals undertaking assessments are independent and making assessments ‘in the moment’, they do gather as much information as possible related to the person they are assessing but that they will never know everything about a person. As the AMHP service is an all-age service, it is usual to use a CAMHs psychiatrist as one of the S12 doctors[[25]](#footnote-25) where a child or young person is being assessed; this mostly happened for Katrina’s assessments. It was a feature of concern, however that the AMHPs service did not feel fully included in the care that was being offered to Katrina and did not understand the wider picture that might have been helpful especially as the service did get to know Katrina quite well. So, whilst the section 12 doctors were independent it might have been helpful for the AMHP service as well as Emergency Duty Team (social care out of hours) to have been more involved in the multi-agency meetings and plans. AMHPs involved in this review stated that they would welcome this in cases that are very complex and who they were called out to regularly. Professionals identified that by attending each other’s services team meetings may help and support working together and to understand each other’s roles more effectively. A further resolution to this is considered later in this section.
  4. It is of note that information related to an individual child is summarised on the front page of the children electronic record within children’s social care. This information would include emergency plans and any current safety plans. This can be accessed via the emergency duty team who receive handovers from the day teams on any children that are likely to come to the attention of out of hours services. This is utilised by the AMHP service and would be enhanced by regular meetings as described above.
  5. There was some excellent working together when Katrina moved to the final accommodation placement, this was a private provider that offered more support. Resource cuts within private providers over a long period of time had reduced staffing capacity than that which had previously been available, but this was a provider that appeared to be able to be fully engaged in trying to support Katrina. As concerns were escalating the key agencies (accommodation provider, social worker, police, YOS social worker and substance advice worker) met regularly to update each other and to share information and continually update plans. YOS convened multi-agency risk management meetings when there was escalating risk. They all found that this was very supportive and ensured that they were all up to date with every occurrence. Ultimately this did not make a difference to Katrina as risk was spiralling as discussed previously. It was considered during the review that provider resources being more reactive to sudden changing needs, may have supported Katrina better and is something to consider for the future.
  6. At times Katrina’s child in care reviews and multi-agency meetings outcomes made suggestions regarding additional professionals and services that might help her. Although these ideas were based on sound rationale, the author suggests that adding more professionals to an already complex situation needed careful consideration.
  7. Suggestions from the workshops indicated that there needed to be a platform for senior managers to come together to help support front line workers and hold the risk at a higher level across all agencies with regular access to legal advice. A system such as the Complex Needs Strategy meeting might be helpful in children who present with the complexities that Katrina did. It may be one of the criteria for a Complex Needs Strategy meeting to take place when ‘trigger event phases’ are identified. The author also suggests that in situations of this nature, as well as multi agency meetings, multi-agency supervision that is independently facilitated can be helpful.
  8. This review has highlighted the lack of a framework for all agencies to get together regularly to review plans and interventions regularly for children in care where there is no child in need or child protection plan. A suggestion was to use the ‘core group’ model for children in care where cases were complex. The Triennial Analysis indicates that the ability for all agencies to keep up to date with what each agency has tried and achieved is crucial to ensuring that there is a whole picture of a child, especially when they are cared for away from home. The author has considered this alongside other elements highlighted by the Triennial Analysis in supporting adolescents with health harming and risky behaviours. Identifying and providing clarity on the person who is in the lead role as well as identifying who has the best ability and capacity to develop relationships with a young person could all be monitored and fed back to a core group for children in care It may be therefore that where there has been a complex needs strategy meeting called for a child in care, that core groups meeting regularly would increase the multi-agency working and understanding and also ensure that all agencies are involved, including those that are out of hours and may be on the fringes of the services that surround a young person. Virtual meeting technology may also enhance attendance at such meetings.
  9. Several services reported to the review, changes that have been undertaken as a result of the need for continuous improvement to the experience of young people.
  10. As stated previously there has been a change in the provider of CAMHs services in North Somerset. There has been some investment by the commissioners and restructuring by the provider to give the ability to make some changes to the way services are structured and delivered. All of this in in the early stages with a focus on recruiting staff for be able to deliver these services. The provider of CAMHS also provides services in other areas locally and has a desire to make sure that the services on offer in North Somerset can be like the offer in the other areas. Although more investment and commissioning agreements are required, there have been some changes already i.e. A CAMHS crisis line that is staffed 24 hours a day seven days a week for children and young people, their parents and carers and professionals to access. This has been viewed as very helpful by those that have used the service. There is some limited outreach available out of hours. Further developments underway are the introduction of a tier two service working with the voluntary sector and schools as well as a specialist CAMHS substance misuse service. With so much change, it will be important that all partners are apporasied of progess.
  11. The Children in Care Nursing Service has indicated that they could be more involved with children who present with these types of issues to offer more coordination and could offer closer contact with young people. There has been a proposal that fits the Health Action Plan, to increase the visibility of the Children in Care Nursing Service. This work will identify how the nurses will be able to have more opportunities to build longer term relationships with children in care and undertake more joining up with the social worker. The children in care nurses tend to stay in role for lengthy periods and therefore offer a good opportunity to be able to build longer term relationships to support children in care.

**Points for strengthening practice**

* The concept of being professionally curious about a young person is ever important and particularly where there is a complex background and risk may not be fully understood.
* Information gathering and sharing from all agencies enables a more robust Child in care Review, care, and pathway plans.
* Understanding that a child or young person is in Care is important for all those offering services. Liaison with the young person’s social worker/IRO is imperative to ensure that not being able to engage does not lead to immediate discharge.
* Initial searches locally and checks with schools and colleges may prevent full resource triggers when a child or young person is missing.
* Safeguarding older adolescents still meets the same thresholds as a younger child. The balance of self-determination and transition against protection under the Children Act may change the amount of involvement the young person has, but levels of protection are the same.
* Ensuring educational settings for young people post 16 are fully engaged in the multi-agency team around the young person allows solutions for information sharing and additional support from those settings to be included in plans.
* In situations where young people are at risk of absconsion during medical treatment, immediate planning enables clarity of roles and responsibilities to keep a young person safe.
* There is a place for professional resolution of differences of opinion even where legislation (MHA) is being applied to assess risk of harm.
* A platform/framework for senior management across agencies to be involved in complex cases may help and support practitioners where there is a ‘rising tide of concern’ that is likely to lead to considerable harm. Recognition of ‘Tigger Event Phases’ being a criteria for such a response.
* Regular Child in Care Core Groups for complex cases would provide a framework for all professionals to come together regularly to review risks, plans and interventions where professional resolution of disputes could be the cultural norm.

**Impact of Pandemic restrictions on Katrina**

* 1. When a global pandemic hit, it meant that many services stopped face to face contacts and the country went into lockdown. Essential services were maintained but in a very different way than Katrina was used to.
  2. Most professionals were told to work from home, and they had telephone conversations only with children and young people. The child in care service centre that Katrina was used to attending whenever she needed to talk to someone, or she had an issue, was closed for drop ins. Katrina was now to get her money every two weeks instead of weekly. Katrina expressed her concern at this as it meant that she had more money to buy drugs and felt that would be negative.
  3. The only regular service that maintained face to face contact was the YOS that included the social worker and the substance advice worker. Even this though was by appointment only and there was no drop in facility. As concerns for Katrina escalated, YOS offered twice weekly face to face appointments as well as daily phone contact.
  4. Katina did comment that the access to drugs was greatly reduced in this time period, and she saw that as a positive. The impact on those who were already struggling with mental health issues has been widely discussed across all media and social platforms and cannot be underestimated. The impact on Katrina on top of everything else was significant.
  5. This was not helped by a phone call from the police to inform Katrina that the Crown Prosecution Service threshold was not met; the police did not have enough evidence to take her reported rape cases to CPS and there could be no further action. This was done with the best intentions to ensure that Katrina was notified as soon as possible and could not be undertaken face to face. Katrina hung up on the officer, so a letter was written with a full explanation. There was a lot of support for Katrina from her social worker when this news was received by Katrina. This, understandably, had a devastating impact and would not have happened this way had it not been for the pandemic. Despite the pandemic, the method of delivery of such news and the language within any letter needs to be young person friendly. The police have analysed this well and have shared this learning within the force via a recommendation within their single agency report.
  6. It was unfortunate for Katrina that at the time of the first national lockdown services were not prepared and were not used to using video and other digital technology to maintain contacts. It was also felt that there were no ways to undertake safe contact. Whilst most services have contingency and emergency plans for IT outages and other emergencies, a pandemic that would have the impact that it did, was unprecedented and contingency planning had not been undertaken for such circumstances.
  7. Since the first national lockdown, services have learned a lot regarding the ways of keeping in touch virtually but are also better able to risk assess who needs to have face to face contact and how that can be managed in a safe way using outdoor spaces, personal protective equipment and handwashing. The lockdown in progress during the time of writing this report sees a very different approach to maintaining contact with vulnerable and at-risk young people within various services.

**Points for strengthening practice**

* The learning from the first national lockdown is important; services to those who are particularly vulnerable can be maintained during any future pandemic situation with careful management of infection control risks.

1. **CONCLUSION**
   1. In considering the summary and conclusion of this review it is useful to consider the Triennial Analysis of challenge and complexity. The continued use of the pathways to harm, pathways to protection model is a useful framework to use for this.
   2. The ‘context’ that Katrina came to be requiring of services to protect her was as a young person who had experienced trauma throughout her life as identified in this report.
   3. The ‘pathways to harm’ came from her vulnerabilities and reactions to those traumas, that resulted in her health harming behaviours which escalated over the identified period. Professionals working with Katrina worked incredibly hard to keep her safe. Legislation both under the Children Act, the Mental Capacity Act and the Mental Health Act did not afford the protections that professionals felt they should have and felt powerless to challenge these positions.
   4. When speaking with the author Katrina stated that nothing would have stopped, her jumping from the building on that day other than not being able to access it. Katrina said that she had threatened to end her life several times and she saw this as a cry for help that was not heard. Katrina informed the author that a comment from a professional after the incident was that ‘we never thought you would do it’. Katrina told the author that increasingly she had had enough of being told what to do but that nothing was helping her. In her mind, at that time, her world had ended, and she could see no way out.
   5. The review has considered issues such as securing or detaining Katrina to keep her safe. Neither of these options were viable in Katrina’s case. It is the other ‘pathways to protection’ that may well support young people in the future to gain the services required, delivered using trauma informed approaches and thinking laterally about systems and processes to engage with trauma affected young people supported by a network of services that work in a well-coordinated way.
   6. The ‘pathways to protection’ identified in this report in working with Katrina and those with similar needs in the future are as follows.

* Continuing to offer formal family mediation as a way of supporting every opportunity for a young person to return home and ensuring that whilst that child is out of the home, living elsewhere that supporting the continuation of family relationships and family time is a key task where it is at all possible.
* Adequate exploration of available resources and commissioning of services that can respond to the needs of young people that have been impacted by trauma to strengthen the systems that professionals are working in.
* Prompt development of care plans with goals in achievable steps that are understood by all.
* Where there is a ‘rising tide of concern’ recognition of key ‘Trigger Event Phases’, the engagement of senior managers from key organisations in a complex needs strategy meeting may enable the risk to be shared at a more senior level where resources could carefully consider, and challenge may be more common and accepted.
* Complex needs strategy meetings leading to Child in care Core Groups ensuring all services in and out of hours are engaged and are up to date with planning and interventions.
* Recognition of the importance of commissioning and offering relationship-based services; working to build trusting relationships for those affected by trauma both within normal working hours and out of hours.
* Emphasis on a lead professional that is known to all and coordinates communications.
* Encouragement of the use of professional resolution where there are concerns that frameworks and legislation are not improving situations and safety and there are disagreements regarding ways forward and professional roles and responsibilities. This will support all professionals to understand limitations of practice and commissioning.
* Good quality accommodation provision with staff skilled to manage those with complex needs and risky behaviours and where moves are necessary that these are planned in a way that is a positive experience for young people.
* Ensuring the mental health pathway for children and young people in urgent and emergency situations e.g., s.136 is clear with outcomes communicated to all.
* Ensuring difficult messages are delivered in a person-centred way that limits negative impact
* Impacts of service limitations due to major incidents are learned from and incorporated into future service provision.
* All organisations offering a corporate parenting role.
* Ensuring that there is an overarching suicide strategy and plan in the locality that is up to date and seeks to address the learning from this review.   
  1. As a result of the pathways to protection, there could be professionals who may feel more supported to be innovative in thinking what can be done as opposed to what cannot be done. Equipping Professionals with the tools to carry out their professional role as corporate parent to support young people into adulthood.

1. **RECOMMENDATIONS**
   1. The findings identified above has been included in learning points throughout this report and lead to recommendations for improvement.
   2. Where agencies have made their own recommendations in their Agency Review Reports, NSSCP should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

**Getting to the heart of the learning**

* 1. Katrina was a child in care because her family felt unable to support her who suffered significant impact of trauma. Katrina used health harming behaviours to numb feelings that led to increasing suicidal ideation. Katrina could not engage with traditional CAMHs clinical appointments in a meaningful way and could see no way forward. Services were not set up to manage this complex situation effectively from a multi-agency perspective.
  2. The following multi agency recommendations are made to the NSSCP because of the learning in this case:

1. **Suicide Prevention Strategy** 
   1. NSSCP must undertake to contact Public Health in the locality to identify if there is a current local and/or regional suicide prevention strategy and action plan that meets the needs of children and young people in the locality. Actions such as a small multi agency working party to carry out early investigations may be helpful. If there is not current strategy, then one should be developed as soon as possible.
   2. Dependant on the above recommendation the NSSCP must consider how the learning from this CSPR and other similar reviews can either be used to develop or feed into the Suicide Prevention Strategy and action plan and whether a subgroup that focusses on Children and Young People would be a benefit to ensure the specific needs of children are met under the wider strategy.
   3. In this work, NSSCP should ensure that the issues raised regarding the repeated use of s136 is addressed by ensuring that there are other mechanisms for police, social care, mental health services etc to work effectively together especially out of hours where children and young people are presenting with suicidal and other self-harming behaviours.
2. **Responding to Trauma:**
   1. NSSCP should identify ways of briefing relevant agencies on the importance of training or refresher activities in respect of Trauma Informed Approaches. Agencies should have mechanism in place to ensure this training improves outcomes for Children and Young People.
   2. NSSCP should seek assurance from relevant agencies that if a needs assessment identifies that alternative practical based therapies are more appropriate, that these are explored, in line with the child’s wishes and feelings, resourced and provided where provision is available.
   3. NSSCP should ask that ongoing updates are provided from CAMHs, and Commissioners related to current and intended changes and improvement to modernising CAMHs services for North Somerset in a format that can be disseminated to professionals, children, young People and families that need to be aware of this.
3. **Children in Care Services**
   1. NSSCP should identify ways of briefing relevant agencies regarding facts about Children in Care.
   2. Due to the number of positive changes made to services since the time of this review, NSSCP should undertake an appreciative enquiry activity to demonstrate the effectiveness that the support offered to children and young people in care demonstrates positive outcomes for that group. The enquiry should include what is working well, what has already been improved and what needs strengthening in the system. Elements of the enquiry should include:   
      1. Multi agency working and communication that includes key partners e.g. Social Care, CAMHS, Police, Looked After Children Nursing Service etc.
      2. Maintaining family contact and building family relationships
      3. Quality and sufficiency of accommodation for children in care post 16
      4. Response to missing incidents by private accommodation providers.

* 1. NSSCP should engage with other SCPs in the area to explore resolutions to the issues that this and other similar reviews have highlighted regarding the need to have an effective out of hours service that meets the needs of children and young people who are in crisis. Various national models for ‘time out’ type facilities should be given serious consideration.

1. **Multi Agency Working around children in care**
   1. NSSCP should update the multi-agency Professional Resolution Guidance providing clarity of when the guidance can be used and by who. Clarity of recording in the child’s record of attempts at resolution should be included. The guidance should be widely disseminated and be easily accessible on the partnership website.
   2. NSSCP should explore options for a framework to bring professionals together regularly where there is a child with complex needs whose presentation to many agencies changes rapidly. This needs to be outside of the Children in Care statutory review process. Models that incorporate a senior management level Complex Needs Strategy meetings and Children in Care Complex Needs Core Groups should be considered.
2. **All learning for this CSPR.**

NSSCP should identify ways to ensure that the learning from this review is disseminated to all agencies via methods that are likely to have an impact e.g., seven-minute briefings, podcasts, videos.

**Appendix One Terms of Reference (REDACTED)**

**Local Child Safeguarding Practice Review (LCSPR)**

**Katrina**

**Terms of Reference and Planning Document**

1. **Introduction:**

The agreement for a (LCSPR) was agreed at a Rapid Review Meeting of key professionals from the Safeguarding Partners and other relevant agencies on 05 June 2020. The National Child Safeguarding Practice Review Panel agreed that the circumstances met the criteria for a LSCPR on 30 June 2020.

LCSPRs are undertaken by North Somerset Safeguarding Children Partnership (NSSCP) arrangements for safeguarding and promoting the welfare of children, in line with the requirements of the Children Act 2004 (as amended by the Children and Social Work Act 2017) and, the statutory requirements set out in Chapter Four ‘Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote welfare of children 2018’

Serious child safeguarding cases are those in which:

* abuse or neglect of a child is known or suspected and
* the child has died or been seriously harmed

Safeguarding partners must make arrangements to:

* identify serious child safeguarding cases which raise issues of importance in relation to the area and
* commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families. Safeguarding partners must consider the following criteria and guidance when determining whether to carry out a local child safeguarding practice review.

Whether the case:

* highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
* highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
* highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
* is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:

* where the safeguarding partners have cause for concern about the actions of a single agency
* where there has been no agency involvement, and this gives the safeguarding partners cause for concern
* where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
* where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Some cases may not meet the definition of a ‘serious child safeguarding case’, but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been ‘near miss’ events. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances.

The Rapid Review meeting agreed that this case was a near miss and that there were issues of how agencies worked together. It was agreed that there was indication of relevant learning for the local area.

1. **Case summary**

Katrina jumped from the roof of a car park (in North Somerset) in a suicide attempt, having texted staff at her supported accommodation saying she ‘is done, and am going to the car park right now’. Police officers attended the location. Katrina jumped off the roof as the officers were trying to engage with her. She was taken to hospital with multiple fractures to her legs and pelvis and suspected internal bleeding. Since then she has undergone surgery. After being in ICU and spending some time in hospital she is now at home recovering.

In the past year Katrina had been missing multiple times and had reported suicidal thoughts on several occasions. Katrina had been found on the roof of the car park on other occasions previously. Concerns were raised that Katrina had been the victim of sexual assault and rape, but no charges were able to be brought against alleged perpetrators. More recently Katrina was thought to be the victim of sexual exploitation. Katrina is known to misuse drugs and alcohol.

In reviewing the information provided for the rapid review NSSCP is undertaking this child safeguarding practice review in order to understand what this case can tell us about:

* Factors which were preventing Katrina’s access to services.
* The extent to which assessments were undertaken in a holistic way at significant points in the chronology. There is concern that assessments did not consider the wider picture.
* The recording and sharing of risk assessments.
* The ways agencies have worked together, particularly in planning service provision
* The identification of a Lead Agency
* The extent to which the learning from the local Serious Case Review “Darry” has been evident

1. **Scope**

The LCSPR will cover the period **of 13 months prior to the date of the attempted suicide.** Agencies will also be asked to include anything of significance outside of that timeframe.

1. **Methodology**

This LSCPR will be undertaken using a hybrid methodology that will analyse the complex circumstances that practitioners work in and provide opportunities for shared learning and lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and well-being of children.

Agencies will be asked to review their own involvement with the family and to produce an Agency Review Report. This will be followed by the sharing of the reports in order that learning can be shared and analysed considering the view of the professionals that were involved at the time. Due to Covid- 19 restrictions, this process will involve small, themed Practitioner Reflection and Learning Workshops via video conferencing to ensure practitioner and first line manager involvement in the review. This methodology considers the requirements in Working Together 2018. Copies of the review report will be shared with professionals involved and asked for feedback prior to being sent to the Review Panel.

1. **Areas of consideration:**

In addition to the scoping period, agencies are asked to provide any relevant background information that they consider will be important in setting the context for the later situation. Agencies will be asked to analyse practice generally in this case Also, the following questions should be addressed:

1. **Assessment and Care**
   * + What legislative and other frameworks did your agency use to assess, care for and protect Katrina? E.g. Various Criminal Law Acts, Children Act, Mental Health Act, Mental Capacity Act, Risk frameworks (This list is not exhaustive).
     + How did these frameworks interface with each other? Analyse how practitioners used these frameworks effectively as well as any gaps you identify. (if it is helpful analyse each framework separately and then summarise the interface).
     + How much did history inform assessment and care delivery?
     + How well did assessment and identified need lead to onward referrals for additional support regarding the challenges that Katrina faced?
2. **Age Related Care**
   * + Please analyse the impact on practice of Katrina’s age during the period under review.
     + How well was the balance between enabling transition to adulthood and providing protection managed.
3. **Missing episodes**
   * + Other than what you have identified above please analyse the effectiveness of your agency’s involvement in the management of Katrina’s missing episodes?
4. **Safeguarding**
   * + How well were safeguarding thresholds applied? Please analyse this both from a single and multiagency perspective.
     + What advice and supervision was sought by practitioners?
5. **Family Involvement**
   * + What was your agency’s understanding of the relationship between Katrina and her family? How were Katrina’s family involved and updated in her assessments and care planning?
6. **Multi agency working**
   * + Summarise and analyse how well agencies worked together to protect Katrina from the challenges she faced.
7. **Covid 19 Impact**
   * + Following the national response to the Covid- 19 pandemic, please analyse the impact on Katrina of any changes to services and/or practice
8. **Strong Practice**
   * + Please identify examples of strong practice, both single and multi-agency, throughout your report.
9. **Family Engagement**

An important part of LCSPR is the involvement of family members so that their thoughts and viewpoints can be incorporated, both to the review itself, and any learning. The NSSCP will need to consider the appropriate point at which to inform the family of the review that considers the current circumstances. The overview author will contact relevant family members once agreed and authorised.

1. **Overview Author and Review Panel**

NSSCP have commissioned Karen Rees, an Independent Safeguarding Consultant to undertake this LCSPR who will work with a review panel formed of senior managers from agencies that delivered services to Katrina.

* Prepare and submit a chronology of agency involvement for their organisation
* Consider all written information, refine the questions for the review and agree which practitioners should be invited to assist the review process.
* Feedback to their own organisation any immediate single agency issues that need to be addressed.
* Work together with the panel to review the totality of the information gathered, contribute to the analysis, findings and recommendations, and identify issues for the Safeguarding Children Board.
* Agree a final draft of the report.
* The CSPR subgroup will quality assure the review and process

1. **Organisations to be involved with the review:**

* Council: Independent Safeguarding and Reviewing Officer
* Council: Youth Offending and Prevention Service
* Council: Children in Care Team
* Police
* Care & Health NHS Trust
* CCG
* Two Hospitals NHS Trusts
* Approved Mental Health Service
* Emergency Duty Team
* CAMHS
* Ambulance Service NHS Trust

1. **Timeline for Review:** The LCSPR will follow the following timeline allows for extra time for several themed workshops (

|  |  |
| --- | --- |
| Scoping Meeting | 18th August 2020 |
| TOR Finalised | 4th September 2020 |
| Authors’ briefing | 14th October 2020 |
| Agency Reports due | 27th November 2020 |
| Author to QA and identify themes from reports | 30th Nov-4th Dec 2020 |
| All reports and Workshop Information circulated to those who will attend. | 14th December 2020 |
| Mini Themed Workshops x4 (potentially) | 5th January 2021 AM  6th January 2021 PM  12th January 2021 AM  13th January 2021 PM |
| Overview Report V1 Circulated to workshop attendees | 12th February 2021 |
| Feedback from workshop attendees due | 26th February 2021 |
| Overview Report V2 Circulated to workshop attendees and review panel | 12th March 2021 |
| Panel meeting 1 | TBC |
| V3 to panel | TBC |
| Panel meeting 2 to formulate recommendations and make final amends for approval | TBC |
| Final virtual approval | TBC |
| Presentation to NSCPP | TBC |

1. **Child in care/Looked after child.** A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer.

   Looked after children are:

   * living with foster parents
   * living in a residential children's home or
   * living in residential settings like schools or secure units.

   <https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children#:~:text=A%20child%20who%20has%20been,children%20and%20young%20people%20prefer.&text=But%20in%20general%2C%20looked%20after,living%20with%20foster%20parents> [↑](#footnote-ref-1)
2. Section 17 Children Act (1989) Provision of services to children in need and their families [↑](#footnote-ref-2)
3. The local authority that looks after the child must arrange for them to have a **health assessment** as required by The Care Planning, Placement and Case Review (England) Regulations 2010. The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife and must be undertaken every six months where a child is under five. [↑](#footnote-ref-3)
4. **A child in care review** is a regular meeting that brings together those people who are closely concerned with the care of the child and the child, where age appropriate. It is an opportunity to:

   * review the child’s care plan
   * discuss the child’s progress
   * make plans for the future.

   [↑](#footnote-ref-4)
5. **Independent reviewing officer** (IRO)The person who makes sure that the health and welfare of looked-after children and young people are prioritised, that they have completed and accurate care plans in place (which are regularly reviewed and updated), that any physical, emotional health or wellbeing needs or assessments identified by their care plans are met or completed, and that their views and wishes, and those of their families, are heard. [↑](#footnote-ref-5)
6. **Section 136** gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them. The person will then be assessed by an approved mental health practitioner and a doctor. [↑](#footnote-ref-6)
7. **A Mental Health Act Assessment** is an assessment to decide whether a person should be detained in hospital under the Mental Health Act to make sure you receive care and medical treatment for a mental disorder. The people carrying out the assessment will consider other community-based options that might help, such as support and treatment at home. The assessors will try to consider all the options and listen to the person’s opinions and, if possible, will talk to close family. Mental Health Act Assessments are usually carried out by:

   * an **approved mental health professional** (AMHP)
   * a doctor who's had special training (known as a section 12 approved doctor)
   * a registered medical practitioner (another doctor)

   [↑](#footnote-ref-7)
8. **SARCs (sexual assault referral centres)** are specialist medical and forensic services for anyone who has been raped or sexually assaulted. They are designed to be comfortable and multi-functional, providing private space for interviews and forensic examinations, and some may also offer sexual health and counselling services. Their services are free of charge and provided to women, men, young people and children. [↑](#footnote-ref-8)
9. **Independent Sexual Violence Advisers (ISVAs)** provide a range of specialist support to victims/survivors which vary case by case and are dependent on individual needs. Typically, ISVAs provide impartial information to victims/survivors regarding their options, from reporting to the police to accessing other relevant services.  [↑](#footnote-ref-9)
10. **Adverse Childhood Experiences**  is the term used to describe traumatic experiences before age 18 that can lead to negative, lifelong emotional and physical outcomes. [https://www.wavetrust.org/](https://www.wavetrust.org/what-are-adverse-childhood-experiences#:~:text=a%20better%20future.-,What%20are%20Adverse%20Childhood%20Experiences%20(ACEs)%3F,lifelong%20emotional%20and%20physical%20outcomes). [↑](#footnote-ref-10)
11. Allen, M. & Donkin, A. (2015) **The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects**. UCL Institute of Health Equity.

    <http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf> [↑](#footnote-ref-11)
12. Asmussen, Dr K. et al. (2020) **Adverse childhood experiences What we know, what we don’t know, and what should happen next**. Early Intervention Foundation February 2020.

    <https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next> [↑](#footnote-ref-12)
13. Brandon, M et al (2020) Complexity and challenge: a triennial analysis of SCRs 2014-2017

    Final report Department for Education March 2020, [↑](#footnote-ref-13)
14. Craig , EA . et al (2020) **Communicating Resilience among Adolescents with Adverse Childhood Experiences (ACEs) through Equine Assisted Psychotherapy (EAP). Western Journal of Communication**Volume 84, 2020 - Issue 4 Pages 400-418 | Published online: 17 Apr 2020 [↑](#footnote-ref-14)
15. Lester S, et al. (2019) **What helps to support people affected by Adverse Childhood Experiences? A Review of Evidence.** London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London. [↑](#footnote-ref-15)
16. **Operation Topaz –** a perpetrator disruption team enabling the Force to proactively protect the highest risk child sexual exploitation victims by developing opportunities to disrupt suspects. It works by building intelligence, supporting frontline officers and doing outreach work targeting the groups, institutions and locations where victimisation is most likely to be occurring. [↑](#footnote-ref-16)
17. A **care order** is given by a court. It allows a council to take a child into **care**. Under the Children Act 1989 a council can apply for a **care order** if it believes a child is suffering or at risk of suffering significant harm. The court decides if the child can be taken into **care**. [↑](#footnote-ref-17)
18. **Under Section 20** of the Children Act 1989, children may be accommodated by the local authority if they have no parent or are lost or abandoned or where their parents are not able to provide them with suitable accommodation and agree to the child being accommodated. A child who is accommodated under Section 20 becomes a Looked After Child. [↑](#footnote-ref-18)
19. **Adverse Childhood Experiences and the Lifelong Consequences of Trauma** Part One of Six. Trauma Toolbox for Primary Care

    This 6-part series was designed with the primary care practice in mind. American Academy of Paediatrics.

    <https://www.aap.org/en-us/documents/ttb_aces_consequences.pdf> [↑](#footnote-ref-19)
20. Nice, Dr T. Briggs. Prof S. (2020) Suicide in Children and Young People Crossing the Rubicon: From Suicidal Ideations to Suicidal Acts. Kent Safeguarding Children’s Board Major Report A Thematic Analysis

    <https://www.kscmp.org.uk/procedures/child-safeguarding-practice-reviews/published-local-child-safeguarding-reviews> [↑](#footnote-ref-20)
21. Local Government and Social Care Ombudsman: (December 2020) **Careless**: Helping to improve council services to children in care

    Focus report: learning l lessons from complaints

    <https://www.lgo.org.uk/information-centre/news/2020/dec/ombudsman-urges-councils-to-scrutinise-services-for-children-in-care> [↑](#footnote-ref-21)
22. Children and Young People’s Independent Sexual Violence Advisor (ChISVA) –A ChISVA is an independent worker who can provide practical and emotional support to children and young people aged 5 to 17 years, who have experienced rape, sexual abuse or sexual exploitation at any time during their life. The ChISVA service can also provide to support to individuals aged 18 to 25 years who have additional needs. [↑](#footnote-ref-22)
23. Department for Education July 2016 **Keep on Caring Supporting Young People from Care to Independence**

    <https://www.gov.uk/government/publications/keep-on-caring-supporting-young-people-from-care-to-independence> [↑](#footnote-ref-23)
24. Approved Mental Health Professionals (AMHPs) work on behalf of local authorities to carry out a variety of functions under the Mental Health Act (**MHA**). One of their key responsibilities is to make applications for the detention of individuals in hospital, ensuring the **MHA** and its Code of Practice are followed. [↑](#footnote-ref-24)
25. **Section 12 approved doctors** are those approved by the Secretary of State under section 12(2) Mental Health Act 1983 (MHA), where they are described ‘as having special experience in the diagnosis or treatment of mental disorder’. Whenever the MHA requires the recommendations of two doctors, one of them must be section 12 approved.  [↑](#footnote-ref-25)