Serious Case Review

Child CH

REVIEW REPORT

Agreed by the CLSCB: 17 September 2019

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1 Introduction to the case and summary of the learning from this review

1.1 This Serious Case Review (SCR) is in respect of a 14-year-old child to be known as Child CH. She died in 2018 from hanging. The inquest has yet to be held, but the coroner is aware that this report is being published. At the time of her death Child CH was in the care of Cumbria County Council (CCC) and an inpatient at a mental health hospital in Lancashire.

1.2 The learning identified from this review is in relation to:

- Children who are placed or in hospital outside of their home area which require
- Risk assessment and planning to manage self harming behaviour, including ligaturing
- Practice and planning with children who are exposed to or at risk of exploitation
- Providing therapeutic input to a child who does not have a stable home

2 Process

2.1 The CLSCB recognised the potential to learn lessons from this review regarding the way that agencies work together to safeguard children. It was agreed that this SCR would be undertaken using the SILP methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time, avoiding hindsight bias. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the learning from the case within their agency. Then a large number of practitioners, managers and agency safeguarding leads come together for learning events[1]. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the events.[2]

2.2 It was agreed that the review would consider in detail the period from November 2017 until June 2018. This was when Child CH made allegations of historic sexual abuse, until the date of her death. Detailed family information will not be disclosed in this report[3], only the information that is relevant to the learning established during this review.

2.3 Early family engagement is required within the SILP model of review. The lead reviewer spoke to Child CH's mother and father as part of the review. Their views are included in the report where relevant.

3 Family structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Child CH
Mother of Child CH	Mother
Father of Child CH	Father

3.2 Any other relevant family members will be referred to by their relationship to Child CH, for example 'Mother's partner'.

3.3 Child CH was not aware of her father's identify until DNA testing was undertaken in 2017. At the time of her death Child CH had been having contact with Father and this was being promoted further in her care plan. He told the review that he had not been sure if he was Child CH's father prior to this, but that when it was confirmed he had tried to make Child CH feel welcome and part of the extended family. Father has his own difficulties and the contact was managed well to ensure that both Child CH's and Father's needs were met.

4 The background prior to the scoped period

4.1 There had been long-term concerns that Child CH may have experienced abuse and neglect while living at home. Social workers were involved with the family for most of Child CH's life. Child CH told her social worker that she had wanted to die from a young age. She reported a history of trying to suffocate and strangle herself with objects such as pillowcases and coat hangers, and writing suicide notes, while she was living at home. This was not known at the time.

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1 The Chair of the CLSCB agreed the SCR, the lead reviewer was appointed, the terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in March and April 2019. The lead reviewer is **Nicki Pettitt**, an independent social work manager and safeguarding consultant. She is an experienced chair and author of SCRs and a SILP associate reviewer. She is independent of CLSCB and its partner agencies.

2 The same group then came together again to study and debate the first draft of the SCR report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review[2].

3 Statutory Guidance expects full publication of SCR reports, unless there are serious reasons why this would not be appropriate.

4.2 Care proceedings commenced in May 2016 and Child CH was removed from her Mother's care, with significant harm being found due to long-term neglect and emotional abuse. After coming into care Child CH disclosed extensive alleged sexual abuse from multiple perpetrators from the age of 7 years. It is possible that she had not finished her disclosures before she died.

4.3 Child CH had three foster placements. There were concerns about whether the foster carers could keep Child CH safe. There were missing episodes, the increasing risk of sexual exploitation[4], self-harming and an overdose. It was at this time that Child CH began to disclose historic sexual abuse. Child CH was admitted to a children's home (Placement 1) close to her family home in July 2017. The placement was chosen to maintain her school place and friendships, and to enable managed contact with Mother.

4.4 Child Adolescent Mental Health Service (CAMHS) were involved from October 2016 until January 2017, starting when Child CH was in a foster placement. The GP who made the referral stated that Child CH had reported long term suicidal thoughts but had never had plans or intent to commit suicide. Child CH was assessed as having anxiety and low mood. She had CBT sessions with a locum therapist which focused on risk management. With Child CH's agreement she was then stepped down to CAMHS Tier 2 service 'My Time' for on-going counselling. There was a long waiting list and Child CH was in crisis before she was seen and her strengthening families' worker referred her back for support from Tier 3 CAMHS in May 2017. Weekly therapy began along with the prescription of medication[5] to address the issues of emotional instability, impulsivity and risky behaviours.

5 Key episodes

5.1 The time under review has been divided into three 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family. In this case the key episodes are determined by where Child CH was resident at time. This is because the services involved were largely determined by the location where Child CH was living/staying[6], as they were in different areas of the country.

5.2 As the episodes are key from a practice perspective rather than to the history of the child, they will not form a complete history, but will summarise the relevant activities that occurred, and are a brief outline of the information that informed the review.

Key episodes
1. Placement 1
2. Placement 2
3. Mental health hospital

Key episode 1: (Placement 1 from July 2017)

5.3 Placement 1 was a privately-owned children's home in Cumbria. It is a unit which is registered for up to four young people aged 11 – 17. At the time of her admission Child CH's

[4] Child Sexual Exploitation is 'a form of child sexual abuse where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.' Tackling Child Sexual Exploitation Progress Report. HM Government. 2017.

[5] Initially Atomoxetine then changed to Sertraline. Circadin also later prescribed.

[6] It is noted that for part of Key Episode 3 Child CH's placement remained Placement 2 although she was staying in a mental health hospital in Lancashire.

identified risks were self-harm, substance/alcohol misuse, and going missing. The plan was to stabilise her in Placement 1 and aim for a return to a foster placement, which is what Child CH wanted. It was believed that Child CH needed to be in residential care for a period in order to have a break from the intensity of family life.

5.4 While living in Placement 1 Child CH was reported missing on over 20 occasions. During her absences there were concerns that she was being exploited criminally and sexually. Child CH would often return from a missing episode under the influence of alcohol/drugs and showing signs of sexual abuse. She provided the names of individuals who she stated she had sex with, on one occasion admitting she had sex with an adult man to pay off a cannabis debt.

5.5 Processes were followed in regards to the missing episodes. Child CH largely cooperated with the Return Home Interviews (RHI) a commissioned service provided by Barnado's, and developed a good relationship with the CSE prevention project worker who later also provided one-to-one support work to Child CH.

5.6 When Child CH disclosed historic sexual abuse while in Placement 1, the project worker and social worker recognised the need for specialist therapeutic work and a referral was made to the NSPCC. The NSPCC allocated the case and were ready to meet with Child CH for a therapeutic intervention when the decision was made to move her out of Cumbria. It was not appropriate to start work with Child CH so close to a move, and the NSPCC believed that appropriate therapeutic interventions would be available following the move. The social worker and Barnardo's provided continuity of emotional support to Child CH at this time.

5.7 Child CH had attended hospital 11 times with mental health presentations including overdoses and deliberate ingestion of household substances with suicidal ideation between July and December 2017. On each occasion Child CH was seen by crisis services of Cumbria CAMHS prior to discharge to ensure the discharge was safe, to put a community safety plan in place, and to ensure that follow-up care was arranged. During each mental health assessment in hospital and each arranged community CAMHS appointment she was clear that she had no plans or intent to commit suicide. The voicing of her suicidal thoughts was understood as a means of communicating her distress and to enable her to receive care and support.

5.8 The allocated Strengthening Families Practitioner[7] had at least weekly contact with the care home during the specified period and had a role in liaising with health providers and CAMHS. Following possible sexual assault incidents while Child CH was missing, contact was appropriately made with the sexual health service.

5.9 Child CH was regularly discussed at the multiagency child exploitation meetings (MACE[8]) and had two risk assessment tool (RAT[9]) meetings. Cumbria police had eleven open on-going investigations at the time of Child CH's death. The delay in concluding the investigations was largely due to Child CH's difficulty in engaging or concerns about the impact of undertaking evidential interviews on her emotional state. There was on-going communication between Cumbria police, the social worker and the residential staff regarding whether the time was right for the investigation to be further pursued.

5.10 The locum CBT therapist that Child CH had seen a number of times both in 2016 and then in 2017 suddenly left the service in October 2017. Child CH was upset and disappointed, and

[7] The strengthening families service provided health support to children in care, and those on a child protection or child in need plan.
[8] Meetings are minuted by Children's Services, attended by partner agencies, chaired by Cumbria police in this part of the county.
[9] Multi-agency Risk Assessment Tool meetings regarding Child CH's risk of CSE.

she struggled to engage with a new CAMHS worker. She also stated that she did not see the point in engaging with a new therapist as she believed she would be moving soon. The CAMHS consultant psychiatrist saw Child CH in January and March 2018 and reconfirmed the previous diagnosis of PTSD, attachment difficulties, anxiety, and depressive symptoms.

5.11 Placement 1 informed the local authority in February 2018 that they could no longer care for Child CH. Child CH was aware of this and accepted that moving away from the risks in the local area would be helpful. In the weeks that followed Child CH was missing a number of times and attended the hospital intoxicated and made allegations of sexual assault. A strategy meeting was held to ensure all concerns were shared and considered. Those involved agreed that a therapeutic placement that could work with Child CH regarding her sexual abuse and risk of sexual exploitation would be desirable.

5.12 In the meantime funding was sought and a plan made for Child CH to spend time at a caravan with Placement 1 staff to keep her safe until funding was agreed. This was initially for a weekend, but as she went missing when she returned, further funding was provided for a longer stay. Much consideration was given to placements, and it was felt that Placement 2 was the best fit. It was hoped that it would provide stability and the opportunity for Child CH to build trusting relationships. When funding was confirmed Child CH was informed and she stated that she wanted to go as soon as possible. She moved the next day rather than implementing the planned move the social worker had hoped for, and this impacted on information sharing by Cumbria agencies with North Yorkshire agencies[10].

Key episode 2: (Placement 2 from March 2018)

5.13 Child CH's second residential placement was a privately-owned specialist unit in North Yorkshire. It provides specialist support to children and young people who have experienced or who are at risk of sexual exploitation and has on-site education. It was over two hours by car from Placement 1. The placement was jointly funded by the local authority and health service in Cumbria. Child CH's missing episodes and the associated on-going risk of CSE was the primary reason for her move of placement and for the choice of Placement 2. It was expected that Child CH would spend around 12 months there.

5.14 While there, Child CH was to engage in weekly sessions with the unit's psychologist. It was known that they were unable to provide Eye Movement Desensitization and Reprocessing (EMDR) treatment which had been recommended by the CAMHS worker in Cumbria when he was working with Child CH, as they were not qualified. It was planned that community CAMHS[11] in the area would support the placement, this had not been requested prior to the placement and did not happen prior to Child CH's admission to the mental health hospital. The social worker recorded that the placement psychologist was assessing Child CH, completing work around CSE, and working to stabilise her psychological needs. It was estimated that this would take around six months, but it was noted that Child CH was likely to need psychological input long into adulthood.

5.15 Child CH was seen at a number of acute hospitals in Yorkshire due to self-harm incidents and following Child CH's allegation that she had taken an overdose of stockpiled melatonin tablets (although this was believed to be untrue.) She was assessed by CAMHS crisis teams when she was admitted to hospital. (It is noted that she was not assessed on one occasion when she was not admitted). These hospital-based mental health professionals did not

[10] There a plan of introductions, but these could not start as it took around two weeks to get permission for the placement funding.

[11] The unit was in the geographical area for Tees Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Community CAMHS. However due to attendances at various hospitals the TEWVFT crisis CAMHS service and the crisis services at two other hospitals had contact with Child CH.

believe that Child CH was a risk to herself and she did not state to them that she intended to kill herself.

5.16 Nine weeks into the placement Child CH tied ligatures around her neck on two separate occasions within one 24-hour period[12]. Her social worker and staff from Placement 2 believed she was showing more serious suicidal intent at this time. She had had contact with Mother and was very distressed because Child CH believed that Mother had reconciled with a previous partner who had allegedly sexually abused Child CH. This was a significant betrayal for Child CH. Following the two ligature incidents she was taken to different hospitals near to Placement 2. At the first hospital the local CAMHS service were not informed of her attendance in their hospital department and Child CH was assessed as fit for discharge without having a mental health assessment. Staff from Placement 2 stated that they challenged this, but this was not evident on the hospital record. The hospital has told the review that the doctor believed that Child CH was being discharged to a safe and secure placement and would be seen the next day by community CAMHS. The hospital has recognised that the agreed pathway for young people was not followed by the doctor, who was a locum and was not aware of departmental policy.

5.17 Following the second incident the next day and an assessment at another acute hospital, Child CH did not return to Placement 2. Following an internal risk assessment the home believed that the risk of serious injury or fatality was too high to manage CH safely in the placement. They told the local authority that they could not offer the level of support and supervision that Child CH needed at this time, but that they were willing for her to return once she had received mental health support. The Psychiatrist who saw her on the second admission noted that her means of self-harm had changed from cutting and ingesting substances to using ligatures and that this was more likely to lead to a completed suicide.

5.18 Child CH spent 13 days as an inpatient in the general hospital with Placement 2 staff providing 24-hour support. The prolonged period in hospital was due to differing views and discussions about what sort of support was required, and difficulty in gaining an assessment for a Tier 4 bed for Child CH due to those differing views. While in hospital Child CH repeated that she had planned to kill herself and that she would try again. There were various CAMHS assessments stating that she would need 24-hour supervision at all times including breaching privacy, which was not thought to be possible in a care home environment, although it was acknowledged that she required a safe and stable placement to nurture her and provide therapeutic support. Those involved considered a care bed in a secure unit, but this was thought to be inappropriate for Child CH. The hospital stay was agreed following an assessment from a psychiatrist from the area where Placement 2 was situated, after an assessment by the psychiatrist in the general hospital and then an intervention by the CAMHS psychiatrist in Cumbria which did not lead to a bed being sought. This will issue be considered further below.

Key episode 3:

5.19 Child CH was an inpatient at a NHS specialist mental health hospital unit (also known as Tier 4 provision) in Lancashire from 29 May 2018. The hospital provides assessment and treatment for young people between 13 and 18 years. Placement 2 was initially retained for Child CH in the hope that she would return following assessment at the hospital. However notice was given four days before Child CH died as Placement 2 did not believe they could provide adequate supervision with Child CH's continued level of self-harm and use of ligatures while

[12] 'Three-quarters of people who kill themselves while on a psychiatric ward do so by hanging or strangulation. ' CQC 2015 Brief Guide: Ligature Points

in the hospital. A request was made to the CCC placements team for a new residential placement to be found for Child CH, and one was being considered in another unit owned by Placement 2's organisation. Child CH was informed about Placement 2 giving notice and the need to find a new placement in an unplanned way during a meeting at the hospital.

5.20 The admission to the hospital was for crisis support for Child CH. At the first CPA planning meeting after Child CH's move it was clearly stated that she would not have a formal psychological assessment or therapy as it was a crisis admission. She did have one to one support sessions however, including with a psychologist. Child CH continued to present with ligaturing behaviours in the hospital. Staff thought that Child CH used the ligatures as a way of slowing down her racing thoughts and as a way of communicating distress.

5.21 Staff from Placement 2 had visited Child CH at the hospital frequently, to provide continuity of care and support. Her social worker was a frequent visitor and CH met with her IRO in the unit. A community placement was being sought to include psychiatric and medication oversight and meaningful therapeutic work by CAMHS.

5.22 On the day that Child CH died there had been no concerns about her mental state or behaviour. She had left the unit twice previously during the day without concern or incident. She 'ran away' from staff and the other children during a very local escorted trip out of the hospital in the early evening. Lancashire Police were informed and staff members looked for Child CH in the local area. Cumbria EDT were informed by the hospital and Cumbria Police were informed by Lancashire Police. The view at the time was that Child CH may be making her way back to Cumbria.

5.23 Child CH was found in a woodland area around four hours after she went missing. Despite the best efforts of those involved, Child CH could not be resuscitated.

6 Analysis by theme and learning

6.1 From the information gained within the agency reports, from the discussions at the learning events, and from speaking to family members, several key themes have emerged and enable us to identify learning for the CLSCB and its partner agencies.

Theme
Managing change
Managing risk
Complex systems across areas
Response to exploitation and going missing
The child's voice
Planning

6.2 Each theme identifies learning, and each learning point is linked to a recommendation in either this report or within the agency reports. It will be stated if the learning is addressed elsewhere.

6.3 Managing change

6.3.1 During the period being considered Child CH lived in two different placements, had a 13 day stay on a paediatric ward in a general hospital, and was transferred to a Tier 4 Mental Health Unit. The transitions led to inevitable challenges including the need for information sharing, planning of moves, related changes of relationships when a child moves area, and

potential feelings of rejection and uncertainty for Child CH. Those responsible for her were keen to ensure that Child CH lived somewhere that gave her the best care, the opportunity to be safe, and that met her on-going therapeutic needs. The aim was for a home that would suit Child CH and where additional support could be provided from professionals outside of the home, such as CAMHS. The perfect place and external support for Child CH was not necessarily available however.

6.3.2 In Cumbria there is a team that is tasked with finding placements for children. They have acknowledged that they are on an improvement journey and that this case has highlighted issues for them and the system for finding placements. They stated that there is generally a lack of detailed information when they receive a referral, particularly when an emergency bed is required. A new form is being developed which will have to be completed entirely (with no gaps) and which is based around Signs of Safety. The team are also requesting that CSC managers clearly state why they are not accepting a proposed placement, to aid the search for an alternative. This is sometimes due to police intelligence or information known but not shared with the placements team. They are rarely made aware of (or seek) any local concerns about a placement in another area and recognise that this can pose a risk. It was confirmed that it is always a challenge to find a placement for a child who requires stability but is unstable, and as children do not tend to fit neatly into boxes finding a specialist placement can be very difficult

6.3.3 Those who were involved in agreeing the move from Placement 1 to Placement 2 checked the most recent OFSTED report for Placement 2 and while they recognised there were identified issues that required improvement in the unit, they still felt it was a good fit for Child CH. The social worker discussed a recent OFSTED inspection with managers of the unit and they believe she was aware of the plan for improvements. The Cumbria placements team do not generally speak to the local authority, CCG or LSCB in the area that the placement is situated but are considering doing this going forward. The social worker confirmed to the review that she considered other placements before deciding that Placement 2 was best for Child CH, although the case and plan for Child CH was not discussed with any agency in North Yorkshire[13]. She was reassured that Placement 2, while being a specialist unit for CSE, would also meet Child CH's mental health needs as therapeutic input was available via a psychologist. Other local professionals, such as York CAMHS, may also have assumed that psychological support was available on-site. The social worker believed that York CAMHS service would provide additional support to Child CH as Cumbria CAMHS were requesting this. This was not checked in advance however. In reality CAMHS did not see Child CH, other than when she was in hospital, and the psychologist at Placement 2 only saw Child CH twice in one to one sessions and twice more generally in the unit. This was because Child CH stated she did not wish to have individual sessions with the psychologist. It is acknowledged that the psychologist provided support to staff within the unit, and that they hoped Child CH would engage with her over time, but there was very limited direct contact between CH and the psychologist. The social worker recorded that Child CH was receiving this support weekly.

6.3.4 Placement 1 provided Child CH with residential care in her hometown. This allowed her a degree of normality because she could attend the local school, have contact with her family and friends, and remain part of her community. She also attended a local girl's group[14] which she engaged with no matter what else was going on for her. There were issues with how her therapeutic needs could be met, and with keeping her safe within the area

[13] the responsibility for the co-ordination and sharing of relevant information rests with the placing local authority.
[14] The group was for 12 weeks and worked with a targeted group of girls on safety, emotional wellbeing, friendship groups etc.

however. CAMHS involvement was positive for a period but ended because her allocated worker had left without the opportunity for an ending for Child CH, and she did not want to work with a new CAMHS worker. Despite this, Child CH began to disclose historic interfamilial sexual abuse and stated that she felt safe enough to talk about things she has not previously disclosed. A referral was made to the NSPCC to provide support regarding the allegations, but they had been unable to start this therapeutic work due to the need for Child CH to move. This meant that towards the end of Placement 1 Child CH was left with very little therapeutic support.

6.3.5 This was at the time when the risk to Child CH from going missing and from her self-harm increased and was potentially exacerbated by the uncertainty about a proposed placement move. Community CAMHS continued to state that it was not appropriate for Child CH to receive therapy at this time. This was due to the lack of a secure base, the fact that Child CH remained in the locality of her alleged past abusers, the probability that she was a current victim of CSE, and the likelihood of an imminent placement move.

6.3.6 Just prior to Key Episode 1 Child CH had found out who her birth father was. This had a profound impact on her. Contact with Mother was supposed to be supervised as it caused anxiety for Child CH, however she also went to Mother's on occasions when she was missing. There were incidents of self-harming by cutting or ingesting medications or household products. She used cannabis and other often unknown substances, and inhaled aerosols, which were generally accessed when she went missing. She stated at the time that misusing substances and self-harming helped her to cope with her difficult feelings and emotions. Her CAMHS worker and social worker discussed with her the impact this would have on her prescribed medication and her safety. There is evidence that Child CH engaged in sessions with staff in Placement 1 around the risks and dangers of substance misuse and that they explored alternative ways of managing her anxieties. Child CH showed a good understanding of the impact of substances but refused a referral for support from drug and alcohol services.

6.3.7 It was acknowledged that Child CH was unable to manage school and that the focus of any new placement should be on keeping Child CH safe from exploitation and working with her on this issue. The Cumbria Virtual School continued to monitor Child CH's situation and liaised with the social worker, who maintained her Personal Education Plan. When education was available within her placements and in hospital, Child CH often engaged with what was provided. Her educational potential was compromised however.

6.3.8 Twice within the time frame of this review Child CH had to accept the end of a placement. She had to manage uncertainty about her next home and had quick moves to new and unknown locations. With her history of distress at endings this was very difficult for Child CH to manage. At the time of her death she knew that she would not be returning to Placement 2, that she was due to be discharged from the hospital, and that there was no agreement yet about where she would go although those involved were considering options and working hard to find a suitable placement. Child CH was informed about Placement 2 giving notice during a meeting. This happened in an unplanned way and without the agreement of her social worker. Child CH was understandably upset and concerned. Although it is noted that she was provided with support following the meeting.

6.3.9 Placement moves meant that Child CH had to get to know a large number of residential staff. She attended and then left two schools and had different education provision within placements. She had changes of GP (and potentially school nursing or specialist nursing staff), had input from a number of different CAMHS workers (both community and crisis) and

saw numerous hospital staff within five different hospitals. She had to build potential therapeutic relationships with professionals linked to her placement moves, including psychologists at placement 2 and in the mental health unit. It was acknowledged that her relationship base was largely superficial. She had consistency of social worker and IRO however and efforts were made to provide links between her placements and for some staff to remain in contact with Child CH following her moves. Child CH struggled with these professional relationships however, always ultimately aware that professionals working with her went home at the end of their working day to their own lives and families. She had to live with a number of significant losses. Shortly before she died it was recorded at the hospital that Child CH had stated she wanted a placement where she would stay forever and not have to break relationships.

6.3.10 The reality of moving placement meant that Child CH was often cared for on a daily basis by those who did not know her well or have a good understanding of her history. Although managers or shift leaders tended to provide this knowledge, it is noted that she would often attend hospital with a residential worker who did not necessarily know her full background and could not always provide this knowledge or understand and communicate the patterns and risks when Child CH was admitted. It is the role of the CLA nurse to ensure that all those undertaking assessments or providing health care to children looked after by Cumbria have access to a child's history and professional involvement, and to coordinate health services for that child, even if they are placed outside of Cumbria. An up to date health plan should be in place and shared when a child moves. This was not effective in Child CH's case largely because of capacity issues in the Strengthening Families team who provide this role.

6.3.11 When she moved between placements her GP records followed her. It is noted that when she moved to Placement 2 that the GP she registered with near to the placement received her electronic record. It stated she was a child in care but had no other details, risks or vulnerabilities flagged. It was discussed at the learning event that it would be good practice for the Children Looked After (CLA) nurses to speak to the GP, or vice versa, in order to ensure that there is additional information shared and then flagged. GPs should always be aware that a child in care moving into their area and into a specialist placement is likely to have additional and complex needs beyond their looked after status, and that they cannot rely on the child disclosing this when seen. It is acknowledged that the CLA nurses in different areas have different responsibilities and expectations and it cannot be assumed that what happens in Cumbria or North Yorkshire also happens elsewhere. This can be difficult for a child when they move areas, and for their social worker who has to negotiate different systems.

6.3.12 The police in Cumbria did not share information with the police in North Yorkshire when Child CH moved. When she was admitted to the mental health hospital in Lancashire, no information was shared with Lancashire Police about Child CH's presence in their area. There is no clear expectation that this information is shared between police forces when a child moves even when they are well known, and it was acknowledged during the review that information sharing is best practice but not consistently applied[15]. There are improved systems for children in the criminal justice system, but less so for children where there are safeguarding concerns. It would have helped the police on the day that Child CH went missing if they had access to information, including an up to date photograph and case history which could have been emailed over directly by the hospital when they reported her missing. They also felt that it would be helpful if they had been informed of Child CH's

[15] North Yorkshire Police helpfully pointed out that even when information is shared with them, it is often inadequate. They believe that it should include the social worker's contact details and information on the risk factors.

admission to the mental health hospital prior to the incident, but acknowledged that it was to be a short stay and that her placement remained in North Yorkshire, and that it would be a challenge for the hospital to share information with the police regarding all in-patients.

Learning:

- *When a child moves placement or has to stay in hospital, particularly outside of area, this will have an impact on the child themselves but also on the awareness of the child by those providing services in the new area. There need to be systems in place, and timely robust practice, for information sharing and communication. This should include an updated health plan being shared by the CLA nurse.*
- *When a child in care is particularly vulnerable, there should be a plan for service delivery which takes this vulnerability into consideration. This should be communicated to partner agencies in the area where they are living by agencies in Cumbria.*

6.4 Managing risk

6.4.1 The risks to Child CH were numerous and changed over time. Initially the risks were from her family, and the risks they posed during contact remained a concern. When she was in care the risks for Child CH were predominantly due to her self-harm and emotional and mental health difficulties, going missing, substance misuse, and sexual and criminal exploitation. At different times the dominant risk varied. For example while she was in Placement 2 the concerns were for her mental health rather than due to specific safeguarding incidents.

6.4.2 While in Placement 1 the main risk to Child CH was thought to be from sexual exploitation while missing and using or seeking to access cannabis and other substances which increased her vulnerability and exacerbated her mental health issues. In Placement 2, where the opportunities to go missing and access to substances was limited, the main concern was Child CH's self-harming, particularly when she began to use ligatures[16]. This continued to be the case in the mental health hospital, where she tied a number of ligatures. As she had never attempted to use a fixed point when ligaturing,[17] it was believed by staff at the hospital, and reported by Child CH, that this was a form of self harm which she used to manage her distress and communicate her unhappiness to staff. In all three key episodes there was a pattern to Child CH's behaviour, with a build up to a disclosure followed by incidents of self-harming or ligaturing. CQC guidance published in June 2017 states that ligature assessments require an understanding of the service user /group, the environment, and the level of observation and supervision. They are focused on making the environment as safe as possible. Staff stated during the review that compared with other children in the mental health unit, Child CH's ligaturing actions was not thought to be severe, and she never used a fixed point within the hospital.

6.4.3 While she remained in her hometown Child CH was targeted by those who sought to exploit her vulnerabilities and unhappiness. Placement 1 gave notice because they did not believe they could keep Child CH safe. It was accepted that a placement out of the area would be the best option in the circumstances. Consideration was given to a secure placement at this point (and again during key episode 3) and it was discussed with a CSC Service Manager. However it was believed that Child CH required emotional not physical security from a

[16] A ligature is any item which can be used to make a loop or noose with the intention of limiting the supply of oxygen to an individual by hanging or asphyxiation.

[17] A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.

placement. Father told the review that he believed that a secure placement should have been tried.

6.4.4 There is a challenge in relation to securing an appropriate therapeutic placement for a child when there is no active therapeutic involvement to provide advice and support to the Local Authority about what provision would best meet the child's needs. This was the case at the move from Placement 1 to 2, as CAMHS were not actively involved at the time. Difficulties in securing a placement and deciding who should pay are other issues that will be considered further below. When Child CH was in the general hospital near to Placement 2 community CAMHS had not yet become involved so there was no CAMHS psychiatrist involved who knew Child CH and could provide a view on what she needed.

6.4.5 Those who knew Child CH believe that her behaviours were her way of managing the distress she was in. Her self-harming and drug-misuse were both described by Child CH as such on a number of occasions. Those involved did have some concerns prior to her move to an isolated rural placement including how she would manage her feelings with limited access to drugs or cigarettes prior to building therapeutic relationships. Placement 2 was a no-smoking placement, but there was a degree of flexibility shown in allowing limited smoking and the use of nicotine patches and support to help Child CH with giving up. When she was seen by crisis CAMHS at one of the hospitals near to Placement 2, Child CH said that smoking was a coping strategy for her and that being unable to smoke was making her feel suicidal. It is not clear if the plan for smoking at Placement 2 was reviewed following this, or if the placement were made aware of Child CH's feelings.

6.4.6 There was a plan for therapeutic input to be provided by the local community CAMHS service, which would involve medication review and oversight, an assessment regarding whether Child CH had an autistic spectrum disorder[18], and other therapeutic interventions to manage her post traumatic stress disorder. This did not happen as the appointment offered was missed. This is considered further below at 6.4.12.

6.4.7 While in Placement 2 Child CH continued to self-harm. This was thought to be a way of communicating her distress and due to an inability to regulate her emotions. When she was assessed following two ligature incidents in 24-hours, the psychiatrist stated that she would need 24/7 supervision but not a Tier 4 bed. They said that Child CH required a stable environment where she could build nurturing relationships rather than psychiatric care, which in the longer term would help her manage her distress and reduce the risk of self-harm or suicide. The same was the case when Child CH was in the Tier 4 hospital and it was identified that she needed to move as soon as possible. The issue was how to find a placement that could provide this. Placement 2 were clear that they were unable to provide 24/7 supervision of Child CH, as their understanding was that this required someone being with her at all times.

6.4.8 There were high expectations from non-health staff about CAMHS and/or other mental health staff being key in reducing the risk of self-harm or suicide to Child CH. It was anxiety provoking for them when there was little or limited CAMHS involvement. While Child CH was in Placement 1 the Social Worker expressed her concerns to her managers about the lack of mental health support for Child CH and requested that this issue be escalated with CAMHS. She recorded that '*the stress is building and building for Child CH and we are trying our best to support her without the help of professional mental health workers. I feel the need to escalate this as mental health support is a vital part of the team around Child CH that is*

[18] There were some suspicions that Child CH may have ASD, which was due to be assessed by CAMHS. the hospital were aware of this but thought the assessment could happen following her discharge, it is not clear why this was. It is known however that neuro developmental disorders such as autism share very similar features to attachments disorders.

missing, we need advice and guidance from mental health professionals in order to ensure we are doing everything we possibly can for this vulnerable young person.' Cumbria CAMHS argued that Child CH was not in a stable physical or emotional environment for CAMHS to provide the required therapy. They advised that they would focus on risk management and liaison with other services in forward planning for an appropriate therapeutic placement.

6.4.9 There appears to be a particular gap in services for children like Child CH, with attachment or post-traumatic stress disorders, with these children often falling between social care and health provision. (Hart and La Valle et al 2016.[19]) NICE[20] guidance on attachment in children and young people recommends that services should 'ensure that the stability or instability of the child or young person's placement does not determine whether psychological interventions or other services are offered'. However in practice CAMHS (and other therapeutic services, like those provided by the NSPCC in this case) often stipulate that a young person needs to be in a settled placement before any therapeutic work can commence. In Child CH's case, across the period of this review, there was concern about her ability to settle and the impact this would have on her being able to access the much-needed therapeutic intervention. On occasion it felt hopeless and a 'catch 22' situation for those involved.

6.4.10 Future in Mind[21], the report of the government's Children and Young People's Mental Health and Well-Being Task Force (2015) states that 'the provision of mental health support should not be based solely on clinical diagnosis but on the presenting needs of the child or young person and the level of professional or family concern.' The most vulnerable children who have had the most adverse childhood experiences will have varying degrees of emotional disturbance, which may or may not be identifiable through a specific mental health diagnosis. Future in Mind is clear that services need to be integrated to ensure that the responsibility is not with any single agency, be they CSC, health, education, or youth justice.

6.4.11 There were capacity issues within Cumbria CAMHS and they told the review that they struggled to provide the required intensity and continuity of support for complex cases like Child CH's at this time. There was also a reliance on agency staff. The therapist Child CH engaged with was temporary and they left without notice and this heightened Child CH's issues of abandonment. Capacity and demand is likely to be an issue for all CAMHS services as a recent NHS report states that the number of children who require support to address their mental health has increased from 9.7% in 1999 to 11.2% in 2017.[22] The Office for National Statistics reported in September 2018 that growing numbers of teenagers in England and Wales are killing themselves. Fifty-six girls and women aged between 15 and 19 killed themselves in 2017. This was the highest number since records began in 1981[23]. The suicide rate among that group, 3.5 per 100,000 people, was also the highest on record. (2.1 per 100,000 in 2010.)

6.4.12 The plan was for CAMHS support to transfer from Cumbria to North Yorkshire, with a request for them to provide oversight of Child CH's medication and support to her while she lived at the placement. There was a waiting list for Community CAMHS in North Yorkshire. They received a request from Cumbria at the time of her move, stating that Child CH was on medication and had PTSD. The request provided details about previous interventions and some background around crisis incidents, overdosing, frequent attendances at hospital,

[19] Improving Children's Social Care Services Results of a feasibility study Ivana La Valle, Di Hart, Lisa Holmes, Chloe Gill, Rebecca Brown, and Matt Barnard November 2016
[20] National Institute for Clinical Excellence
[21] Department of Health 2015
[22] Mental Health of Children and Young People in England – summary of key findings – trends, NHS November 2018
[23] The suicide rate among that group, 3.5 per 100,000 people, was also the highest on record, and well up on the rate of 2.1 per 100,000 in 2010.

missing from home episodes, and risk of CSE. It stated Child CH showed risky impulsive behaviours but there was no suicidal ideation. (There was no known history of ligatures at this time.) An initial assessment with a York community CAMHS psychiatrist and a clinical nurse specialist was planned for May 2018, after unsuccessful attempts to gain more information from Cumbria following the referral in March. Child CH was not brought to this appointment. Placement 2 states that they did not receive the letter that was sent. The 'Did Not Attend/Was Not Bought' (DNA/WNB) policy was not used by CAMHS and they did not make contact with the placement. Usual practice would be to look at the level of risk and then telephone and enquire why the child and family/carers didn't attend. Consideration could also be given to contacting the GP and the child's social worker. It would be usual practice for a copy of the letter to be sent to the social worker, who could have followed this up. This did not happen.

6.4.13 While she was in Placement 2 Child CH was seen by two different CAMHS crisis services attached to three different hospitals that she was taken to following self-harm incidents. The geographical area where the placement was based was between the three hospitals and ambulances could be directed from their control centre to take patients to any one of the hospitals. This led to the risk of admissions being seen as single episodes without a consistent and coordinated approach. Whilst a history was provided by Child CH herself and by the staff members accompanying her, each incident was more likely to be seen in isolation rather than with the oversight of a mental health professional who could get to know Child CH, consider her self-harming history and the escalation of behaviours over time, and make a plan for an effective intervention with a longer term outcome. The York crisis CAMHS service who had seen Child CH in hospital on occasion provided advice to Placement 2 about making a safe environment for Child CH by ensuring toxic substances such as cleaning products and sharps and other implements were locked away. They also provided advice following Child CH's alleged overdose from stockpiled medication.[24] The unit psychologist also provided support to the staff team regarding Child CH, and completed two safety plans. She had very little actual contact with the child herself, with Child CH refusing to attend one to one sessions.

6.4.14 In key episode 3 an enhanced risk assessment was formulated by the mental health hospital and the plan focused on Child CH's suicidal thoughts and the increase in her self-harming behaviour. It did not include the previous issues of going missing and CSE as these were not thought to be current risks. Because Child CH was not detained under the mental health act the well-known and used processes within the unit at the time were not relevant in her case. While there was no specific plan as to how any unauthorised leave of Child CH would be managed, there is a Trust policy for managing these situations which was implemented when Child CH went missing. Child CH had left the unit a number of times, but always with a staff member and with prior agreement. During the day that she died she had already been out with staff and other patients without incident.

6.4.15 Child CH appeared to enjoy the hospital as she had 24-hour care and waking night staff to support her needs, which had not been the case outside of a hospital setting. It was thought that she would continue to self-harm despite this support however, due to the abuse she had suffered in the past and the concerns she had about her future. It is also acknowledged that in Tier 4 beds (and indeed in care secure units) there is the potential for ligaturing to become a 'behavioural norm' due to the similar behaviours of other children in the unit. There was a constantly changing group of peers in the hospital, with many arriving in crisis. As Child CH's issues were chronic and long term, the negative impact of being in the hospital were

[24] Including trying a liquid version of the medication.

believed to outweigh the positives, and it was stated that she needed to move as soon as possible. At the third and final meeting held in the unit prior to Child CH's death there was a possible placement identified, but this hadn't progressed sufficiently to inform Child CH before she died.

6.4.16 CSC staff were anxious about the risks that needed to be managed to keep Child CH safe in a new placement, and they felt disempowered and disillusioned about the existence of a positive placement for Child CH. Hospital staff had advised that Child CH did not need an inpatient mental health placement, and that she should not remain on a Tier 4 ward as the potential harm outweighed the benefits. They agreed that Child CH could remain in the hospital until an appropriate placement was identified. The social work team said during the review that they did not feel listened to and struggled to understand how Child CH could be safe in a community placement given the level of self-harm and the possibility of accidental death. They were confused about the claim that Child CH did not require constant supervision and felt that they could not get a clear statement about what levels of supervision should be provided. The hospital staff believed they were clear. Placement 2 stated they could not manage Child CH with her level of self-harming, and CSC were concerned that all 'therapeutic' placements would feel the same.

6.4.17 It was the view of the hospital that Child CH required intensive therapeutic intervention but that it was not appropriate to provide it while she was an inpatient in the unit. It is the view of the hospital that to have commenced an intervention when Child CH needed to move on as soon as possible would have left her feeling rejected and would have potentially increased the risk. Child CH was stated to be 'very clear and insightful about wanting to form safe, stable and trusting relationships with professionals before talking about her experiences in too much depth or starting formal therapeutic work'.[25] The police officer who was assigned the missing person piece of work on the evening that Child CH died noted that the hospital had stated that Child CH had nowhere to be discharged to, and he was concerned about the impact on her health and development of the lack of a plan and effective on-going care.

6.4.18 There were issues identified in the Lancashire Police agency report regarding the day that Child CH went missing. They had not received any information when Child CH was admitted to the mental health hospital, so she was completely unknown to them. It was busy night and the local police had nine other people reported missing. As a number of children from the hospital unit had run off in an opposite direction to Child CH during the incident it took some time for staff to communicate to the police exactly who was missing and who had returned. Not long after it was established that it was only Child CH who remained missing. Although this was of concern it was noted by the hospital that when Child CH had gone missing in the past (in Cumbria) she had generally been at risk of exploitation and substance misuse and that she had never previously gone missing with the intent to self-harm. Her demeanour when she went missing, as reported by the unit, did not indicate that Child CH was currently suicidal or at immediate risk of this, although they shared that she had previously self-harmed and had recently been ligaturing. Child CH was classified as medium risk and it was assumed that she would try and make her way back to Cumbria and her hometown.

6.4.19 As there were no patrols available to attend the hospital, an officer on restrictive duties[26] undertook the required risk assessment, sought additional information, and spoke to the placement by telephone. There was no police capacity to attend the hospital and have conversations face to face that evening. Demand often outstrips resources on a Saturday

[25] The hospital Agency Report.
[26] Due to health issues the officer was only undertaking desk duties.

night in the area. Child CH's room was not searched until after her death when a note with some suicide ideation was found which could have changed the risk grading if it had been found when she first went missing. As Child CH had been seen on a road by an off-duty staff member an Immediate Response (IR) Sergeant went out to search for her in the area she had last been seen, which was more of a priority at that time than searching her room.

6.4.20 Lancashire Police were not aware that Child CH was in hospital in their area and they had no information on their systems regarding the previous involvement of police in other areas, the on-going investigations, and her history of going missing. The police agency report states that if a plan had been in place for Child CH on their system the risks and details from multi agency partners would have been accessible, which could have changed the risk grading and priority for the missing person investigation. A social worker from the Emergency Duty Team (EDT) in Cumbria sent an email to the Force Control Room while Child CH was missing stating that she was at high risk of CSE and that her Missing status should be raised to high risk. The email was forwarded to the officer making enquiries but was not accessed until after Child CH died. There was limited focus on her self-harming and increased use of ligatures in recent months and on the emotional impact of not knowing where she was going to be living or what was happening about the on-going criminal investigations.

6.4.21 Despite the learning about managing risk in the case, there are numerous examples of individual professionals spending time with Child CH and providing her with care, support and advice. The Social Worker worked with Child CH on practical strategies to manage her emotional health and support her needs, and residential workers largely worked to make Child CH feel safe and secure in her placements and she appears to have felt listened to. Consideration was regularly given to how Child CH would manage certain situations with the aim of reducing risks and the emotional impact on Child CH. For example Cumbria Police tried to ensure that Child CH saw the same officers regarding her allegations, strategies were put in place to help Child CH manage contact with her Mother, and her social worker ensured that Child CH's bedroom was set up to allow her to self soothe and help her manage her nightmares.

Learning:

- Different agencies and professionals have different thresholds regarding the perceived risk from self-harm, including using ligatures. This needs to be acknowledged. Risk assessments and plans need to be holistic, shared across disciplines, agencies and areas, and reviewed regularly.
- The perceived risk can increase professional anxiety and be a barrier for access to services and placements.
- Tier 4 mental health provision for young people brings additional risks. There should be open discussion and challenge within the setting and across agencies around this and regarding the risk of staff and young people being desensitised to behaviours and risks in these settings.

6.5 Complex systems across areas

6.5.1 This SCR shows what many others before it have found; that systems are complex and that both individual professionals and their agencies often struggle to negotiate an individual case through these systems. This is particularly difficult across different geographical areas. The 2016 Triennial Review of Serious Case Reviews states that understanding complex agency structures can prove difficult for both professionals and families. The CSC report completed for this review identified the pressure on staff of having to navigate the complex

health and social care arrangements across borders, and the professionals at the learning events agreed.

6.5.2 Opportunities were not taken prior to or immediately following the move to Placement 2 to make contact and consult with North Yorkshire County Council regarding the plan for Child CH to reside in their area. An exploration of the system in Cumbria has identified that they cannot be sure that the required notifications were sent as expected.[27] North Yorkshire told the review they received a partially completed notification around two months after Child CH was placed in their area[28]. This was not challenged at the time.

6.5.3 Child CH lived in three different counties, although she remained the responsibility of CCC as a child in care[29]. She had contact with three different health authorities (two in Placement 2), three different CAMHS providers (two in Placement 2) three different police forces, and she attended four different general hospitals (three while in Placement 2). For those professionals who worked with Child CH throughout the period being considered, this was a challenge. Whilst Child CH remained the responsibility of Cumbria Children's Social Care, the response to her health needs were determined by her placement address, and police involvement was determined by the area of the alleged offense or need for support. This kind of complexity can mean delay and challenge about responsibility which may impact on the child.

6.5.4 When Placement 2 was found, consideration was given to whether it would meet Child CH's needs. Agreement then followed regarding how the placement would be funded, although there was delay which had an impact on Child CH. She had to spend time in Placement 1's caravan at a seaside resort to keep her safe. She had limited preparation for the move as the social worker could not tell Child CH where she was going to move to until funding had been agreed.

6.5.5 The internal CSC process for accessing an external placement required a number of reports from the social worker, including the costs of the placement and reasons for the choice. It was described as 'paper-heavy' and required sign off at a number of levels of management due to the significant financial commitment. A national search was undertaken to find Placement 2 and the social worker was provided with six options. A meeting was held to consider the options, but Cumbria CAMHS did not attend and the social worker was concerned that their input was required to ensure the placement could provide the required intervention for Child CH's mental health needs. While the recent OFSTED report for Placement 2 was considered (it was satisfactory) there was no knowledge of previous concerns from partner agencies of the NYSCB about the placement. (See 6.5.6 below)

6.5.6 CAMHS support in North Yorkshire does not appear to have been sought robustly prior to or shortly after Child CH's move, and there was no confirmation that it would be provided, despite it being a key requirement for Child CH. Child CH had been open to Cumbria CAMHS and they had responsibility for transfer of her care but there had been no discussion in advance to see what the new area could offer alongside what the placement provides. The actual move happened quickly once financial agreement had been given, and this most likely had an impact on the planning and the provision of community CAMHS support to Child CH.

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[27] Regulations state that Local Authorities are required to consult and share information before placing children in distant placements. This includes notifying the Local Authority if they place a Looked After Child within their area and for this to be in good time to enable a thorough assessment of appropriateness. CCC have agreed to review their systems and practice for such notifications and consultations.

[28] The review was told that the placement informed NYCC of Child CH's placement and NYCC then requested a notification from Cumbria.

[29] CCC had responsibility for Child CH's care plan, and for ensuring that the local authority in the area where she was residing was informed of this plan.

6.5.7 Child CH self-harmed and entered crisis very quickly after commencing her placement, so the engagements with CAMHS became crisis led and involved two different crisis CAMHS services in three hospitals. This was due to the location of the placement being within travelling distance of 3 different A&E departments, with two different CAMHS crisis teams providing support. 111 and 999 services did not have access to a plan regarding what hospital Child CH should be taken to, and there is no evidence that a certain hospital was requested by the residential staff calling the ambulance. Yorkshire Ambulance Service have confirmed that they cannot hold individual plans for children. Their system only allows addresses to be flagged, not individuals within an address. This means that notes cannot be added to their system to ensure consistency for a child who requires hospital assistance. The ambulance service stated however that if the staff in Placement 2 asked for attendance at a specific hospital this would always be considered.

6.5.8 When a specialist placement is situated in an area and provides care and accommodation for children with complex needs from all over the country this can create a demand for local services that is challenging, particularly with the current demands in a time of austerity. The North Yorkshire LSCB (NYSCB) was involved in discussions with local partner agencies and the organisation responsible for Placement 2 around a year before Child CH's residence there. There were a number of concerns about the management of a group of children by Placement 2 and the impact this had on local services. OFSTED were also informed. It is possible that this history had an impact on the response to Child CH, including from the local CAMHS, who had been concerned the year before about whether staff in Placement 2 were sufficiently trained to manage the level of risk presented by the children placed there. The concerns were shared with the local authorities who had children placed there at the time the concerns emerged. As there had been no contact with NYCC prior to Child CH's placement the concerns about the placement were not shared with any professional in Cumbria prior to this case review. Placement 2 acknowledged during the review that there were issues in 2017, but stated that they were historic and that improvements were made. In April 2018 Ofsted found the placement to be 'Good'. The placement state these improvements have continued and that they have not received any further complaints from partner agencies. During this serious case review Cumbria Safeguarding Children Partnership (previously the CLSCB) was informed by the North Yorkshire Safeguarding Partnership that there are ongoing concerns about the units. It is a recommendation of this review that the learning is shared with NYSCB, and it was suggested by the lead reviewer that they should consider further engagement with Placement 2 and its wider organisation, and whether they wish to make a wider recommendation in respect of specialist units of this kind.

6.5.9 Child CH spent 13 days in the paediatric ward of a general hospital near to Placement 2 following the second ligature incident within 24 hours. The placement had felt unable to manage the risk of a further incident, said they could not provide 24 hour supervision of Child CH, and as a home for other children there was no way they could be totally sure that Child CH would not be able to gain access to things she could ligature with, such as shoe laces or headphones. There was debate about whether a stay in Tier 4 mental health provision was required, but as CSC were concerned it may not be agreed and other provision was also being sought as an alternative to a return to Placement 2. The social worker and her team manager had a good understanding of Child CH's emotional needs but required support and advice about what sort of placement would be best placed to meet her mental health needs, and to provide a view about the relevance of the impact of trauma on her mental health.

6.5.10 The CSC Service Manager contacted and met with the clinical director for Cumbria CAMHS asking for support in liaising with the CAMHS providers in North Yorkshire regarding accessing a Tier 4 bed or providing support to Placement 2. He advised that the NHS form 1 'Referral for Access Assessment into Inpatient Services for Children & Young People' needed to be completed and did it himself. The CAMHS psychiatrist who saw and assessed Child CH in the general hospital did not agree, stating that a Tier 4 bed was not a suitable option for Child CH who required a safe and nurturing environment not possible within a mental health hospital setting. This disagreement and confusion over who was responsible for the sourcing and providing of accommodation led to Child CH's extended stay on the paediatric ward of the general hospital. A second psychiatric assessment undertaken in the general hospital, which also considered information provided by the social worker then recommend a short stay in a Tier 4 bed and the mental health hospital in Lancashire was identified as a crisis admission.

6.5.11 Meanwhile, the York CAMHS team were informed that there was a possibility of an in-patient assessment at a local CAMHS unit. A pre-admission assessment took place and recorded concerns about the suitability of Placement 2 and noted that it 'seems to be a specialist placement to work with young people with CSE and doesn't seem to have any kind of experience in working with high risk behaviour'. It concluded however that Child CH was not likely to benefit from inpatient psychiatric care at that time and that she needs a "nurturing environment with carers who can build stable and caring relationships with her, rather than intensive psychiatric care' and that 'this is particularly around containing her risk when she is unable to manage her distress'. No particular placements were suggested.

Learning

- *When a child has to move placement there needs to be a commitment to finding a solution and ownership of the problem from all of the agencies involved, in a way that is as timely and uncomplicated as possible. In this case there were understandable but ultimately unhelpful decisions made that led to Child CH staying in a caravan, then a paediatric hospital bed, then a mental health hospital, with no clear idea about where she would be going next.*
- *When a child who is looked after needs to attend a hospital it is good practice that they attend the same hospital on every occasion when there is more than one hospital in a geographic area. The Residential Unit should request this when they contact 111/999.*
- *When a child needs a period of in-patient care in a mental health hospital, every effort should be made to ensure that the hospital is as close to the placement as possible.*

6.6 Responding to exploitation and going missing

6.6.1 In 2017 the Government published the Tackling Child Sexual Exploitation Progress Report. The report notes that reporting of CSE has risen significantly since 2012. Child CH was a victim of exploitation while living in Placement 1. It appears her stated need to get cannabis and other drugs to self-medicate made her particularly vulnerable to this exploitation. The concerns escalated in her last month in placement and led to the decision to move her away from her hometown. The Triennial Review of SCRs identified a number of risk factors that increase young people's vulnerability to CSE, and they all were evident in Child CH's case; "Experience of neglect, parental failure to protect, and time spent in care feature strongly, as do emotional and behavioural difficulties, school disruption, going missing from

home, school and care, substance misuse, low levels of self-esteem and seeking affection and approval often in risky places."[30]

6.6.2 A joint targeted inspection was conducted in 2016[31] in a small number of local authority areas and concluded that there had been progress when it came to the way that CSE was responded to. Procedures were in place in Cumbria and being used in the area where Child CH lived. The high number of missing episodes in Key Episode 1 led to meetings being held, although they were not always recorded fully. As Child CH was looked after there were other care-planning type meetings being held, and it appears the missing from home episodes and CSE were often discussed in these other forums. While this was a pragmatic response, it did not follow the CSE and Missing procedures. A large number of return home interviews (RHIs) were undertaken with Child CH at this time, but the information gained from these was not always considered in the plans made, partly because the Barnardos worker undertaking them did not always get invited to the relevant meetings. Despite this it appears that Child CH felt that the RHIs were beneficial and she had a good relationship with the worker who undertook them.

6.6.3 Placement 1 (and the previous foster carers) was in her hometown, the place where her past and current abusers lived. This meant that she continued to be at risk. While she was given a degree of independence suitable for a child of her age and was allowed to travel alone to school and her youth club, she would frequently go missing and her risk of CSE was very high. The plans made did not reduce the risk which escalated over time. There have been some improvements in the planning for children at risk of CSE in Cumbria since then. CSE work is now guided by a multi-agency plan where objectives for the specific CSE support and investigations are clear, recorded, and understood by all agencies and professionals. This would have been helpful in Child CH's case.

6.6.4 Going missing was not a significant issue when Child CH lived in Placement 2 however North Yorkshire Police were contacted twice stating that Child CH was missing. It is acknowledged that Child CH did not go far from the placement and on no occasion was it thought that she was at risk of exploitation while missing. North Yorkshire Police notified North Yorkshire County Council (NYCC) of the two missing from home episodes, following local protocol. The placement alerted Cumbria EDT and the social worker was made aware of the episodes, also receiving notifications from NYCC. There was no liaison by CCC with NYCC, as would be expected. An independent return home interview was not offered to Child CH, but her social worker discussed the episodes with her when she next spoke to Child CH.

6.6.5 The risk of exploitation reduced significantly when Child CH moved, although her CSE Risk Assessment Tool (RAT) risk assessment was not updated at that stage. It had been while she was still living in Cumbria however, with her CSE category changing appropriately. Child CH was category 3 when she left Cumbria, which is the highest category of risk for sexual exploitation and acknowledges that '*sexual exploitation is repeated and regular, often self-denied, at high risk of continuing exploitation and definitely engaging in direct physical / sexual contact relationships with one or multiple older adults where coercion or control is implicit'*. The Safety Plan that was in place included the need to keep Child CH distracted, the use of a threat of reducing her unsupervised/independent time, and preventative work on CSE, online safety, sexual health and relationships by her key worker at Placement 1 and the Barnardos worker. It lacked a contingency plan however and did not address her recent and emerging allegations of historic interfamilial sexual abuse.

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

[31] Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and HM Inspectorate of Probation (2016) 'Time to listen': a joined up response to child sexual exploitation' [London]: Ofsted

6.6.6 Tackling CSE requires timely sharing of information alongside a systematic, coordinated and multi-agency approach. This needs to happen on each individual case but also more generally in any area to ensure the bigger picture is considered. As a result of police intelligence analysis and the missing from home episodes Child CH was deemed a 'Divisional Vulnerability Target[32]' by Cumbria police during key episode 1, and she had a bespoke 'trigger plan' which was accessible to all officers who may come into contact with her. This decision was influenced by her perceived risk linked of CSE, along with suicidal ideation, regular missing episodes and drug use. This information would have been helpful to the police in both North Yorkshire and Lancashire.

6.6.7 Child CH was regularly discussed at the wider MACSE[33] (now MACE) meetings in Cumbria during key episode 1. At the time however there was no expectation that details shared were recorded on a child's social care file. This was due to concern that some of the information that was being discussed was 'intelligence'. This means that those working with Child CH were not always aware of crucial information that could have assisted with both the police investigation into Child CH's allegations and in ensuring targeted support for Child CH. The CSC report states that 'there is no evidence that the Central MACSE meetings offered any additional safety to Child CH during the review period. Given the number of disclosures that she was making and her links within the local community, effective work within this meeting could have assisted the mapping of what was happening for CH to help aid safety planning, including for other children.'

6.6.8 The impact on professionals of a child going missing and being at high risk of exploitation should not be underestimated. It makes planned work very difficult and leads to interventions that are often crisis driven. The amount of time spent by those working with Child CH, particularly her social worker, was immense. There were almost daily crises throughout the review period and Child CH was one of 20 children on the social workers caseload.

Learning:

- Those responsible for children who are exposed to or at risk of exploitation must ensure that in all cases:
  - assessments and safety plans are multi-agency, outcome focused, and appropriately shared when a child moves, including consulting with the new area on the appropriateness of a placement
  - practice is 'trauma informed'[34]
  - processes across and within agencies should be streamlined to avoid repetition and increased bureaucracy

6.7 The child's voice

6.7.1 The number of professionals involved with Child CH over the course of the review period was reflected in the large number of people who attended the learning events. The change of professionals and the introduction of new people was largely inevitable, and consideration needed to be given to the impact on Child CH of this. It is identified in the Barnado's report for this review that during key episode 1 the safety plan for Child CH 'identifies a number of professionals who Child CH will be expected to engage with but nothing about how sharing

[32] As a Divisional Target Child CH was discussed at the monthly Tasking and Co-ordination Group meetings, attended by the Divisional Commander and other Senior Leaders for this area of Cumbria.

[33] Multi-agency child sexual exploitation meetings.

[34] Trauma informed practice involves understanding, recognising, and responding to the effects of all types of trauma, within structures and with policies, procedures, and practice that encourage this. https://www.basw.co.uk/system/files/resources/trauma-informed-health-and-care-approach-report.pdf

her personal information with so many people, multiple times, may make her feel and therefore present.'

6.7.2 The two subsequent moves led to more professionals having to become involved in Child CH's life. She had the consistency of her social worker and IRO, but her direct carers, GP, CAMHS workers, physiological support, hospital professionals, police officers, CLA nurses and so on, all changed. The increasing complexity of Child CH's problems combined with these moves across geographical areas put unrealistic pressure on Child CH to make relationships, build positive attachments, and develop trust.

6.7.3 Moves demand proactive and robust sharing of information. Child CH required informed and coordinated services during and following her moves. Those who remained or were previously involved needed to be sure that all of those being introduced or providing services in the new area were aware of the background history and current concerns. This was not easy as finding out who to share information with in an entirely new area has its challenges, and on-going concerns about a child can have an impact on the time available to undertake this liaison.

6.7.4 Child CH made allegations over time, which also had an impact on her need to be spoken to and seen by a number of professionals. She had three medical examinations and two ABE[35] interviews. Her social worker spoke to her manager about this and they were acutely aware of the risk of re-traumatising her during any investigations. This showed a good awareness of Child CH's past trauma. Further ABE interviews were planned but were delayed due to concerns about her mental health. Balancing the risk and meeting Child CH's needs was not easy. The decisions made to protect Child CH from undertaking numerous interviews with the police regarding the abuse she was alleging added further distress to Child CH. While she was in the mental health hospital she tied a ligature which she related to distress caused by the police cancelling an interview regarding her allegations of historic sexual abuse.

6.7.5 A strategy meeting between Cumbria police and CSC was held while Child CH was in the mental health hospital, with the hope of planning the way forward on the outstanding investigations. There is no agreement at the time of this review about whether the mental health hospital was invited to the meeting. They state they were not asked to attend, but CSC claim that they were invited. It is clear however that they did not attend so did not provide advice about Child CH's emotional state and whether she could cope with further interviews. Her social worker updated her on the situation following the meeting and discussed the issue with the ward. Child CH had a strong wish to tell the police what had happened to her and to achieve justice, so it was difficult for her to understand why there was a delay. While it was deemed necessary and in her best interests, the perceived lack of progress would have exacerbated Child CH's distress.

6.7.6 Police in Cumbria allocated the same officer to the on-going historic sexual abuse investigations following Child CH's disclosures to ensure consistency for Child CH and to allow the police officer to understand the wider issues. They were unable to do the same for the investigations into the more recent sexual assaults that had happened while Child CH was missing however, although they attempted to ensure communication between the separate investigations. This was a challenge within the wider context, as this area of Cumbria has the highest reported crime levels within the Constabulary and resources are stretched. It was good practice to try to limit the number of officers involved.

[35] Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures. Ministry of Justice 2011.

6.7.7 Good practice was also noted in the area of Child CH being listened to by the professionals involved. Child CH was always encouraged to share her views and was given the opportunity to communicate with professionals on a very regular basis. She was a child who was well known to those who worked with her and who had a voice. She was a keen and active member of the Cumbria 'children in care council'. Her IRO told the review that she was always keen to chair her own reviews and was engaged with the process of devising and updating her care plans. Her opinions were asked for and listened to. He remembers that during the Initial Child Protection Conference prior to her coming into the care of the local authority, Child CH stated assertively that she needed to be on a child protection plan.

6.7.8 Consideration was almost always given to the impact on Child CH of the services available and provided. For example, staff on the acute hospital ward in Cumbria were concerned that their positive relationship with Child CH may led to her seeking continued admissions to the ward while she was in placement 1. This led to a plan to only allow admissions for medical treatment, with a quick discharge back home for the care required. While in placement 1 Child CH often refused intimate examinations and her decisions were respected along with her resistance to further sexual health support. Appropriate referrals were always made, but Child CH had the ultimate decision regarding whether she engaged or not. Child CH was offered advocacy regularly. She refused it, stating that she had enough people involved in her life.

6.7.9 It is acknowledged that there is contextual information regarding the shortage of staff in key roles in Cumbria that could have had an impact on Child CH and other children at the time. In this area of Cumbria a large number of staff are locum or temporary. This includes social workers, CAMHS workers including consultant psychiatrists, GPs, and hospital staff. The mental health hospital had undergone recent changes that had an impact on staff retention, and there were a number of relatively new and inexperienced staff at the time of Child CH's stay. There was an attempt to ensure consistency however with few bank or agency staff used. On the day that Child CH died there were sufficient staff on duty, all of whom were previously known to Child CH.

Learning:

- Child CH had the opportunity to speak to professionals on a daily basis and appeared to be able to voice her fears, frustrations and pain. However when a child has placement moves and changes of professionals involved with them, when they can't be reassured about where they will be living next, and when they can't have intensive therapeutic input due to moves and instability, they are likely to feel that their voice is not heard, or be unable to trust those caring for them.

6.8 Planning

6.8.1 As shown, planning in a case like Child CH's is time consuming and complex. There were no clear and agreed answers regarding what Child CH needed and no certainly about what could be provided. All children in care have regular reviews where their care and needs are considered. The reviews are chaired by an IRO (Independent Reviewing Officer.) CLA reviews in Cumbria follow national practice and consider if the decisions taken at the last review have been successfully implemented, and if not, why not. Consideration is given to the placement, contact, the child's educational needs, what leisure activities the child is engaging in, and the child's health. The IRO should seek to establish the child's wishes and feelings, and to ensure that the Care Plan has taken these into consideration. The IRO is responsible for setting any remedial timescales if actions have not been taken and there is a risk of drift in the delivery of the plan. While the CLA reviews should give professionals the opportunity to appraise the plan for a child and consider whether it is appropriate and

working for the child, they are not always held at the right time to do so, particularly when there are regular crises and unexpected changes of placement.

6.8.2 As well as chairing the reviews, it is also the role of the IRO to monitor the child's case on an ongoing basis. The IRO in this case knew Child CH and her history well, having also chaired the child protection conferences prior to her coming into care. The IRO recognised the complexity of Child CH's case and the pressures that the social worker faced. They were aware of the difficulties in accessing support and an appropriate placement for Child CH when she was in placement 1 and then in the general hospital in Yorkshire following the escalation in her self-harm and ligaturing, and when she was in the mental health hospital. An IRO can be helpful in expressing their independent view and formally escalating concerns for a child, and the IRO has reflected that they could have done so in this case, particularly when there was delay in finding a placement, and when the lack of stability impacted on the need for therapy and the criminal investigations.

6.8.3 There was a lack of escalation across services in Cumbria in this case. This appears to be due to a culture of acceptance locally and the knowledge that there were general (rather than case specific) capacity issues within Children's Social Care and CAMHS in Cumbria, which makes 'complaining' difficult. There was also an acknowledgement that there were no easy solutions for Child CH, and that those involved were working very hard to try and resolve the numerous difficulties.

6.8.4 The CSC agency report has provided good reflection on how planning can be improved when a case is in regular crisis. At times strategy meetings contained discussions about care planning and care planning meetings considered missing episodes and allegations made by Child CH. This was a pragmatic way of managing the fast-moving nature of the case. So much was happening that the response could be reactive rather than planned and measured. For example when Child CH made a disclosure of historical sexual abuse while living in Placement 1 there is a record of police visiting to speak to Child CH without a strategy meeting or recorded discussion with CSC. It is difficult to take a step back and make and review a plan when there are constantly changing factors to consider.

6.8.5 CSC have recommended that consideration is given to a more senior manager chairing multi-agency care planning meetings in complex and risky cases like this. If this had happened Child CH's longer-term recovery could have been considered alongside the management of day to day crises. The meeting ideally would have provided an objective strategic direction for the case. There are a number of points in the case where this type of meeting would have been helpful. For example, prior to Child CH moving to the mental health hospital in order to confirm what the aims and realistic expectations of the admission were. It is understandable that the move happened quickly as Child CH had spent a significant amount of time in a general hospital bed and there would have been pressure to transfer her, but the lack of an agreed and owned plan led to further uncertainty for Child CH and difficulty in finding a new placement when Placement 2 accepted they could not meet her needs.

6.8.6 Other meetings were held on occasion, but not always as often as procedurally expected. This was largely due to the number of meetings that would be required in a case like Child CH's. For example, during key episode 1 there were not always discharge meetings following a hospital stay. It has also been identified that the safety plans that were in place for Child CH were not shared with hospital staff, although they were regularly seeing Child CH when she attended A&E after an escalation in ingesting substances. Staff expressed frustration at

the repeated attendances and said they did not know what support was in place in the community.

6.8.7 When Child CH was in the hospital in key episode 3, a number of multi-agency meetings were held to plan a way forward. It was not easy to ensure the meaningful engagement of all those who needed to be involved however, due to the distances involved. For example York CAMHS professionals attempted to 'attend' the meetings by way of conference calls but their input was difficult to achieve due to technical sound quality issues.

6.8.8 Education was important to Child CH, but she struggled to maintain school while in Placement 1. Although she had stayed within her hometown partly in order to have consistency of education, Child CH left her school shortly after coming into care. A place was quickly found in another local school and a support plan was in place, however her attendance and engagement declined due to the emotional impact of the historic disclosures she was making. It was agreed that her emotional recovery needed to be prioritised over her education. The CSC agency report has reflected that communication between the school and Placement 1 could have been improved, as the school did not always know about recent events in Child CH's life. Child CH had skills and talents however that were encouraged in her placements and were said to be an escape for her when she was distressed. Child CH received education on site in Placement 2, and while there was no clear education plan, she also received on-site education in the mental health hospital.

6.8.9 Contact with Mother was often ad-hoc when Child CH was in Placement 1. This is partly because of the generally found difficulty in managing contact with an older child who had lived with her family until fairly recently and where the family are local to the placement. It was acknowledged and well known that contact with Mother could be risky for Child CH, as she appeared to have access to drugs at her mother's home, and on occasion would return under the influence of unknown substances. Her emotions would often be heightened following either direct or telephone contact with Mother. Child CH was regularly asked her views about contact. She initially did not want her Mother invited to CLA reviews and this was respected. When she later changed her mind Mother was invited but did not attend.

6.8.10 When Child CH was in placement 2 there was a clear plan for contact between Child CH and both of her parents. Child CH did not wish to see her Mother when she was in hospital, and this was again respected. Contact had recently been problematic. It is suspected that it was during telephone contact at Placement 2 that Child CH believed that her mother had resumed a relationship with someone Child CH had made allegations of sexual abuse against. This was followed by a serious ligaturing incident.

6.8.11 Child CH's physical and mental health both required particular focus in any plan. Her experience of sexual abuse and exploitation, her substance misuse and smoking, and her self-harming all required consideration. Improvements were needed in the way in which Child CH's access to alcohol and drugs whilst in Placement 1 was understood and managed. Child CH refused to engage in substance misuse services, but there was need for a substance misuse assessment which would have informed the care plan. While in the hospital a substance misuse questionnaire was completed with Child CH and she stated she would engage with Addaction. There is no evidence this was pursued on her behalf.

6.8.12 The Strengthening Families CLA nurse was involved when Child CH was placed in Cumbria and was in regular contact with and support to the placement. The role includes the need to liaise with and share information and the health care plan as soon as possible when a child moves to a placement in another area. This did not happen, although the CLA nurse in North Yorkshire was proactive and met with Child CH three times as part of their routine visits

to the placement every two months. An additional visit was made to complete a holistic health assessment. The sexual health team visit Placement 2 every two months on the alternate month to the CLA nurse. There is an expectation that Placement 2 inform the CLA team of all missing episodes, this did not happen for Child CH however. She was also not discussed at a local monthly Vulnerable, Exploited, Missing and Trafficked monthly meeting during her time at Placement 2 despite this being a clear requirement for children placed in the unit. The CLA health team in North Yorkshire have reflected on the need for them to be involved in placement planning work prior to a child being moved into the area. This may have assisted in the transfer of CAMHS services. This was not possible in Child CH's case however, as they were not informed in advance and the move happened very quickly. Staff in the mental health hospital did not inform the local CLA nurse as at the time this was not expected practice. They now have a responsibility to provide notification within 48 hours.

Learning:

- Information sharing and local involvement in a child's plan is essential both before and when a child who is looked after moves areas, and/or when there are frequent crises. If it is known that information has not been shared with an agency, it should be requested by them.
- Unmet needs and lack of progress with the most vulnerable children need to be escalated to senior managers within and across agencies. Agencies should aim for an organisational culture where a professional can say to a senior manager 'can I speak to you about this child?'
- Robust planning for vulnerable children who are looked after is crucial[36]. When there are numerous crises that impact on the ability to step back and consider the bigger picture, a more senior manager from CSC or a relevant partner agency should become involved and chair planning meetings.

7 Conclusion and recommendations

7.1 Child CH had a distressing and abusive childhood, and no secure attachment figure. This impacted significantly on her emotional wellbeing. She was in a position where she desperately required therapeutic input to enable her to obtain a secure settled placement, but this input could not happen due to the lack of such a placement. When Child CH died there was uncertainty about where her next placement would be.

7.2 The review found that Child CH died in spite of everything that was done to try and meet her needs and keep her safe. Even when professional practice was undertaken with diligence and in line with expected policies and procedures this is not always sufficient to meet the needs of a child in care with very complex needs and challenging behaviours. However it has been found that care planning for Child CH in the last months of her life was largely crisis and process driven, and that it was not always possible for those who were working with her to keep Child CH at the centre of their work. Children where there are complex risks and vulnerabilities need more than professionals working hard for and with them, they need a plan which is solution focused, owned, and held collectively by partner agencies.

7.3 Lessons have been identified about the way that agencies worked together in Child CH's case however and they have been identified in the agency reports and above. Also

[36] The North Yorkshire Safeguarding Partnership requested that this report clearly states that it was the responsibility of Cumbria to coordinate and manage the care plan. This is the case.

identified are weaknesses in the system in regards to; children who are placed outside of their home area, children who self-harm and engage in risky actions that could result in their death, and children who are hard to place due to the challenge of managing risks alongside providing a secure therapeutic home.

7.4 Good practice has also been identified in this case both in the agency reports and during discussions with the professionals involved in the case. They include:

- Child CH's school in Cumbria advocated a strengths-based approach, including music and other subjects she liked and was good at.
- A disclosure by Child CH to the Barnado's project worker regarding a male supplying her with drugs led to timely and appropriate reporting to the Police and the SW, and also included information pertaining to two 12-year-old boys who may also have been at risk.
- The Barnado's project worker knew Child CH well and worked hard to advocate on her behalf (with school for example) and to share her concerns about Child CH with other professionals.
- There were good links between CAMHS and A&E in the hospital in Child CH's hometown, and there was just one individual involved in all the assessments when Child CH was seen at the hospital.
- When Child CH stated clearly that she was unsafe in Placement 1, this was listened to and was a driving factor in moving her.
- Child CH asked to have the same worker supporting her with both elements of the Barnardo's work and was listened to.
- The Barnado's project worker went to visit Child CH in her new placement.
- A large number of professionals worked hard to try and keep Child CH safe. Numerous occasions were noted during the review where she had positive interactions with professionals.
- During the caravan stay 2018 the one to one support was beneficial and Child CH engaged well and had a good time.
- The CSE Risk Assessment was updated more often than procedurally required, recognising the escalating concerns for Child CH.
- Staff at Placement 1 were provided with support from an agency that works with children who have been sexually abused.
- Child CH had weekly one-to-one sessions with her key worker at Placement 1, reflecting on risk taking behaviour and developing strategies.
- The local hospital had alerts in place in relation to Child CH's legal status as a "Child Looked After" and then subsequently when deemed "at risk of child sexual exploitation".
- Child CH missed her dog when she came into care, so a plan was made for her to have contact with the dog.
- The social worker was involved throughout the period considered by the review. She showed sensitively and compassion to Child CH and provided consistency.
- CH had an up to date health plan as part of her placements. The North Yorkshire CLA nurse saw Child CH regularly in placement.
- Placement 2 notified the local police when Child CH arrived in placement including details of her missing from home episodes in Cumbria.

- Following the second ligature incident in 24 hours in Placement 2 the CAMHS team for the hospital who had seen her the night before were contacted by CAMHS in the area of the second hospital and asked why Child CH had not been assessed in A&E as she should have been.
- Placement 2 was retained and paid for so that staff could stay with Child CH whilst she was an inpatient at the general hospital and then following her admission to the mental health hospital, in the hope that she could be discharged there following mental health assessment and treatment.
- The GP practice in Yorkshire worked to ensure that Child CH received continuity of care during her registration period by being allocated a named GP to see her during her appointments. On the one occasion that Child CH failed to attend an appointment, the GP practice followed this up to ensure that she was seen at a later time.
- Child CH's head of year in her original secondary school in Cumbria worked hard to keep her in education.
- Child CH reportedly had a good relationship with her IRO who she liked and trusted. She was encouraged to attend and then chair her own reviews.

7.5 There has been a high degree of cooperation and engagement from agencies in Cumbria, North Yorkshire and Lancashire with the SCR process, which has been important in identifying the learning.

7.6 Two previous serious case reviews were undertaken in Cumbria where older children had taken their own lives. These were Child F in 2010 and Child J in 2013. The relevant findings from these reviews were about CAMHS in parts of Cumbria not being fit for purpose and a view from partner agencies that a referral to CAMHS did not guarantee a safer outcome for a young person at risk of suicide. At the time CAMHS reported long standing and deep-seated difficulties and referred to low levels of morale, high staff turnover, sickness absence, inadequate practice in relation to risk recognition and response, poor information sharing, and a lack of leadership and direction. While the situation has improved, the use of agency staff and on-going recruitment and retention challenges remain an issue and had an impact on Child CH.

7.7 In 2018 NHS England in the Cumbria area undertook a review regarding a child known as X. The case had some similarities to Child CH, particularly regarding:

- The national shortage of Tier 4 beds (and secure beds in the case of X)
- Joining up processes (and meetings)
- Responding rapidly to changing needs
- Moving towards a needs-led rather than service-led system for vulnerable children with complex needs
- The need for accountable system leadership
- The use of Tier 4 beds when it is acknowledged that it is not necessarily the best placement to meet a child's needs
- Planning meetings need to be focused and effective, with clear actions and responsibilities
- The need for community provision to support children without a diagnosable mental health issue, but with behavioural needs and who require significant preventative support
- The need for short-term 'safe place' accommodation to avoid stays on paediatric wards, and local long-term provision for children with complex behavioural, therapeutic and social care needs

- There is a need for improved oversight of children placed out of area, as the system has less influence on the delivery of services and potentially less intelligence about changing needs
- There are insufficient step-down services to support children being discharged from Tier 4 units

There is an action plan in place from the Child X review and this SCR has made a recommendation below that the CLSCB requests an update on the progress, particularly in regards to the recommendations about processes for managing the most challenging cases, escalation, tracking children placed out of area, improved communication about admissions and discharges, and sharing of information with the police. All of which are also relevant for Child CH's case.

7.8 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning in this case, and that changes have been made which will be outlined in the CLSCB's response to this SCR[37].

7.9 The agency reports have made recommendations which have largely been completed by the conclusion of the SCR. Some of the learning identified within this report will have been addressed by the single agency actions plans. For example: Placement 1 will be reviewing their processes for communication and information sharing with medical professionals in order to improve their understanding of the physical and mental health needs of the children they look after following a hospital admission. CAMHS in North Yorkshire are putting in place measures to ensure that all staff adhere to the 'was not brought' policy. CSC has recommended that the system for agreeing external placements is simplified. The mental health hospital has made changes to the process for completing enhanced risk assessments and additional training is being provided. They have also developed a clinical 'Measure of Self Harm' tool to profile severity, frequency and intention of an individual's self-harm incidents as a means of tracking change and ensuring detailed recording of incidents along with intervention guidance.

7.10 The purpose of providing additional recommendations is to ensure that the CLSCB and its partner agencies are confident that any areas identified as being of particular concern, and not included in the single agency plan, or which require an interagency action, a CLSCB action, or an action by another LSCB and its partner agencies, are addressed.

Recommendation 1:

The learning from this review should be disseminated widely.

Recommendation 2:

This report should be shared with the other LSCB's where Child CH lived during the timeframe considered by this review. A request should be made for feedback on any actions they propose to take in this matter.[38]

Recommendation 3:

[37] For example: Barnado's now have well established processes and ways of working that are embedded within a multi-agency plan for CSE support which are clear, recorded and understood by all agencies and professionals. And Cumbria Constabulary is in the process of implementing a formal transfer process to ensure improved information sharing between Police Forces regarding vulnerable children.

[38] This may include their view that specialist placements for exploitation as a model should be the subject of national review, which was shared with the CSCP just prior to publication.

The CLSCB to write to the Departments of Health and Education to state the need for the reform of systems nationally, which ensure that children are at the heart of service delivery, whatever their needs, diagnosis, placement, or home address. This issue should also be highlighted to the Independent Child Safeguarding Practice Review Panel**.**

Recommendation 4:

The CLSCB should request assurance from CCC and the CCG on the commissioning arrangements for placements for children who require stable and safe care, which provide management of risky behaviours alongside therapeutic input.

Recommendation 5:

The CLSCB should write to the Department of Education and OFSTED about the challenge in finding placements for children with significant risks and vulnerabilities, and the need for flexible bespoke packages of accommodation, care and support for these children that are based on the child's needs and are not provision led. They should be specifically asked to review the registration requirement for bespoke placements to ensure they can provide support in a timely way.

Recommendation 6:

That the CLSCB requests an update from the Cumbria Children's Trust Board regarding progress of the action plan regarding Child X.

Recommendation 7:

The CLSCB must assure itself that information about CLA, including up to date risk assessments, health and social care plans, an up to date photograph, and contact details for family and associates are **shared** with a placement or hospital when a child moves or is an inpatient, so it can be utilised by all partners if a child goes missing or requires emergency assistance.

Question for the CLSCB:

How can professionals be supported to ask themselves if they have the confidence to respectfully challenge other professionals if they believe that a child's needs are not being met by existing multi-agency plans?