July 2020

Serious Case Review in relation to Child CH

Response from Cumbria Safeguarding Children Partnership (CSCP)

In July 2018, Cumbria LSCB began a Serious Case Review (SCR) in relation to the services that were provided to Child CH and their family.

The full findings of the SCR are set out in the overview report which has been published alongside this response.

Individual agencies involved in the review have already taken forward the learning outlined in the report, and the LSCB and CSCP have also been implementing the learning identified prior to the publication of this report.

The table below sets out the main points of learning from the SCR and how the CSCP will continue to ensure practice improves across all services for Children in Cumbria. Any references to learning and actions for the LSCB in the report will continue to be taken forward by the CSCP.

The work to implement the recommendations and to monitor their impact on practice will become part of the long term work of the CSCP and member agencies. The implementation of these recommendations will be managed through the Board and the long-term implications will be tested through the Board's Performance Management and Quality Assurance (PMQA) framework to evidence the expected impacts and these will be reported in the Board's Annual Report.

Gill Rigg
Independent Chair – Cumbria Safeguarding Children Partnership
July 2020

CSCP RESPONSE

THEME 1: Managing Change

Finding CH1
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. There is a need to have detailed information on a child's needs when looking for a placement, information should also be sought from areas re any known concerns about a placement.
Lesson CH1.1
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.
Lesson CH1.2
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.
Recommendation 1
The learning from this review should be disseminated widely.
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.
CSCP Context / Actions already taken/ CSCP Action
The learning from this review will be disseminated widely CSCP will seek assurance on arrangements for placements for children. Single agency changes to practice have taken place in relation to finding placements.
How will we know

Assurance from single agencies regarding processes for placing children

THEME 2: Managing Risk

Finding CH2
The risks to Child CH were numerous and at different times the dominant risks varied. 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.
Lesson CH2.1
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.
Lesson CH2.2
The perceived risk can increase professional anxiety and be a barrier for access to services and placements.
Lesson CH2.3
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.
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.
CSCP Context / Actions already taken/ CSCP Action
The CSCP will disseminate the key messages and learning from this review widely The CSCP will seek assurance from agencies that information for CLA is shared with placements and inpatient facilities
How will we know
Multi-agency audits will show that professionals fully assess risks and these are responded to appropriately Assurance received from agencies around the process for placing children

THEME 3: Complex Systems across Areas

Finding CH3
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. CH lived in three different counties, had contact with three different health authorities, three different CAMHS providers, three different police forces, and she attended four different general hospitals. This kind of complexity can mean delay and challenge about responsibility which may impact on the child.
Lesson CH3.1
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.
Lesson CH3.2
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.
Lesson CH3.3
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.
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
Recommendation 3
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 6
That the CLSCB requests an update from the Cumbria Children's Trust Board regarding progress of the action plan regarding Child X.
LSCB Context / Actions already taken/ LSCB Action
The LSCB shared the learning from the review with the other LSCB areas where Child CH resided. The LSCB wrote to the Departments of Health and Education to share the reviews findings.

The LSCB received updates regarding the progress of the action plan in regards of Child X.

THEME 4: Responding to Exploitation and going Missing

Finding CH4
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
Lesson CH4.1
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' - processes across and within agencies should be streamlined to avoid repetition and increased bureaucracy
CSCP Context / Actions already taken/ CSCP Action
LGA Contextual Safeguarding Peer Review has taken place and reviewed the processes in relation to CSE and missing. Single and multi-agency audits of exploitation take place to review practice
How will we know
Multi-agency audit will show that assessments and safety plans are in place for children at risk of exploitation, these are shared and practice is trauma informed

THEME 5: The Child's Voice

Finding CH5
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. There were a number of professionals who Child CH was expected to engage with and it should be considered how sharing her personal information with so many people, multiple times, may have made her feel and therefore present.

Lesson CH5.1
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.
CSCP Context / Actions already taken/ CSCP Action
The CSCP will share the learning from this review in relation to the child's voice – promoting the need for those workers who remain consistently involved in a child's life through placement changes, to be sure that all of those being introduced or providing services in the new area are aware of the background history and current concerns.
How will we know
Audit will show the voice of the child is central to practice and children do not have to keep repeating their story

THEME 6: Planning

FindingCH6
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. 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. When Child CH was placed outside of Cumbria information should've been shared with the placing area to allow for more robust planning for Child CH.
Lesson CH6.1
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.
Lesson CH6.2
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?'
Lesson CH6.3

Robust planning for vulnerable children who are looked after is crucial. 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.
CSCP Context / Actions already taken/ CSCP Action
CSCP Seeking assurance from single agencies around the process for placements, including sharing of information with relevant agencies and areas. CSCP continue to promote the escalation protocol Children's Services have reviewed the process around planning meetings.
How will we know
Practitioners will report awareness of escalation protocol CSCP will receive assurances from agencies in relation to placements Audit will show that processes in relation to placements are followed and information is shared with relevant agencies

How we will disseminate and evidence the learning

Dissemination of the Learning	Specific Actions	Subgroup(s) or single agency	Deadline	Expected Impact and how it will be tested
The CSCP will ensure that the lessons identified in this SCR are publicised, included in learning materials and disseminated throughout the practitioners in the CSCP	Training materials will be reviewed to ensure the lessons are included. Policies and procedures (P&P) will be reviewed to ensure the lessons are included	Learning & Improvement Subgroup CSCP Board		Practitioners should use the lessons from this review in their everyday interactions with children, young people and their families The CSCP conducts regular surveys of staff and will include a question to ascertain how well the lessons from this review are known,
	The website will be updated to reflect the lessons from this review.	CSCP Support Office		
	A specific newsletter will be published to cover the lessons from this review and other recent SCR			

Dissemination of the Learning	Specific Actions	Subgroup(s) or single agency	Deadline	Expected Impact and how it will be tested
	The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published.	Learning & Improvement Subgroup		understood and being addressed in practice.
	Assurance will be sought from all agencies that the lessons from this SCR are being used – this will be done through the 2020 Safeguarding Audit (Section 11)	CSCP Board		