Derby and Derbyshire Safeguarding Children Partnership

Child Safeguarding Practice Review

MDS20 and PDS20

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Final 17/07/2023

1. Introduction

1.1 This Child Safeguarding Practice Review (CSPR) has been commissioned by the Derby and Derbyshire Safeguarding Children Partnership (DDSCP) in accordance with Working Together to Safeguard Children 2018 and the Child Safeguarding Practice Review Panel: practice guidance (2019).

1.2 The review has considered the experience of two children from different families and different areas of Derbyshire. They will subsequently be referred to as young people, YP1 and YP2, in recognition of their age however they remain children as defined by the Children Act and the Derby and Derbyshire Child Protection Procedures.

1.3 YP1 was admitted to hospital after being found underweight and unkempt. They remained in hospital for two weeks before returning home to the care of their mother. YP1 had reportedly not left home for over a year.

1.4 YP2 was admitted to hospital with significant wounds relating to compromised skin integrity as a result of remaining in bed for a number of months. YP2 required extensive surgery and medical intervention and has remained in the care of the Local Authority since discharge from hospital.

1.5 School attendance, mental health and neglect are significant features in both cases.

1.6 The purpose of the joint review is to identify the learning from the individual circumstances of these young people and the systemic learning arising from their experiences that appear to have led to similar outcomes.

1.7 The aim of this joint review is to:

- bring together the themes to provide better systemic learning whilst ensuring that the individual features of each case are not lost
- identify improvement measures that should be taken to address where previous learning has not led to systemic practice improvement
- deliver a strategic approach to learning and improvement that provides the partnership with clear priorities informed by both the two reviews and previous learning
- provide evidence to embed learning and improvement in a way that local services for children and families are more reflective and achieve changes to practice that are consistent with the priorities arising from these reviews.

1.5 See **Appendix 1** for the full terms of reference (ToR)

2. Format of this Report

Part 3 describes the methodology for completing this CSPR
Part 4 summarises the learning themes that have emerged during this review
Part 5 outlines the review of each case
Part 6 highlights the joint themes
Part 7 presents the overall conclusions

Part 8 considers the action already taken
Part 9 makes further recommendations

3. Methodology

3.1 Sue Gregory has been commissioned by the DDSCP as the independent author for the CSPR.

3.2 The author had access to the Rapid Review completed in respect of YP2, information requested from agencies in respect of YP1 and was provided the Local Authorities report of the internal review of practice relating to YP1. Detailed chronologies have not been reviewed and the focus has been on extracting broad learning in respect of reducing risk to older children.

3.3 This review was undertaken during a period of COVID restrictions and therefore all 'meetings' and 'events' referred to in this report were virtual.

3.4 Practitioner events were held in respect of each young person to consider key questions developed in line with the ToR.

3.5 The author also had conversations with individual managers and practitioners either because they were not present at the events or to follow up on issues raised.

3.6 Both young people and their parents were invited to contribute to the review.

- YP1 felt unable to do so but their mother did have a telephone conversation with the author. The father did not respond.
- YP2 initially contributed in writing and then met with the author. The foster carer did contribute and was able to support YP2 to do so. To date it has not been appropriate for the author to have contact with YP2's mother. The father of YP2 has not responded.

3.7 A meeting was held with key managers from all organisations involved with YP1 and YP2 during which key points arising from all activity contributing to this review were considered.

4. Summary of key learning themes that emerged from the review

4.1 Personal and environmental factors can increase the vulnerability of anyone irrespective of age. Under 18years old are recognised as children under the provisions of the Children Act and are therefore recognised as vulnerable by the very fact of their age. It is important to remember that the provisions made in relevant legislation, guidance provided in Working Together and requirements as laid out in local multi agency procedures apply to all children under 18.

4.2 The risks of significant harm that individual children may face must be considered whether they are infants, younger children, or teenagers. Whilst it is recognised that the immediacy of the risks to older children **may** not always be as immediate as they might be for infants and younger children, they must still be considered, and also attention paid to potential medium and longer term risks.

4.3 Addressing the emotional wellbeing and mental health of all children can present needs and potential risks. Whilst it is necessary to consider the risks associated with self-harm and suicide there may be other risks presented to their physical health and wellbeing, such as those associated with:

- social isolation and absence of appropriate physical care/self-care.
- lack of exercise and appropriate diet (food and hydration)
- remaining in bed and seriousness of the implications of breaches in skin integrity
- being dependent on others for care and the capacity of parents to provide it

4.4 It is important to recognise the potential challenges of caring for a young person presenting with mental health issues and, therefore, to consider the parents/carers needs for support in developing strategies for meeting their child's needs. Consideration has to be given to the parents/carer's capacity, ability and willingness to provide for the child's needs and practitioners need to remain open to the potential of neglect and other forms of abuse as defined in Working Together and Multi Agency Procedures.

4.5 Parents/carers own mental health may have an impact on their responses and capacity to meet their child's needs and therefore should be explored and understood by those working with their children. Those working with parents with mental health issues should consider any potential impact on their ability to meet their child's needs irrespective of the age of the child.

4.6 Education is an important aspect of life for children and the significance of school attendance is reflected in it being one of the key performance indicators for schools. When dealing with poor attendance it is important to consider:

- What might be preventing the child attending school?
- What are the implications and potential risks of not attending school in addition to missing education?
- How might improvements in attendance be supported?
- How can education be provided when a child is unable to attend school including when there are accepted mental health issues?

4.7 The importance of building relationships between practitioners and the young person. This requires skilled communication and may take some time but without it the voice of the child will remain unheard. Consideration needs to be given to:

- How can practitioners be supported to be persistent when a young person refuses to see them or appears to not engage?
- How can managers be supported to ensure effective actions and decisions are made when it appears that the young person and/ or parent will not engage, and required change is not achieved?
- How do all practitioners ensure that they are hearing the voice of the child and not only that of the parent? This may include working with the child to seek consent for treatment (16 and 17 year olds) although this was not a specific learning point from practice considered in this review.

4.8 Assessments should be systemic and consider the child's needs and risks, the capacity and ability of the parent/carer to meet those needs and environmental factors.

4.9 The importance of effective communication between practitioners, within and between agencies to ensure that relevant knowledge is shared to inform appropriate decision making and to support timely escalation where appropriate.

- Particular attention should be paid at times of transition whether due to age of child, change of worker/service provider or reshaping of services.
- Communication should be maintained between referrer and service provider to ensure that all relevant information is made available including information that becomes available after the initial referral. It is also important that the referrer knows whether services have been provided and/or taken up.

5. Review of cases

YP1

5.1 Whilst this review considers activity between January 2019 and April 2020 there is background information in respect of YP1 that provides an important context in particular relating to interventions during 2018.

5.2 YP1 has always lived with his mother and older sibling. There is no record of father's role in the family nor of any contact with practitioners. The first record of concerns relating to YP1 are found in 2010 (7 years old) when school referred them to CAMHS citing 'behavioural difficulties and autistic tendencies' although there was no formal diagnosis.

5.3 In 2013, the last year in primary school, a school health questionnaire recorded YP1 to have a BMI (Body Mass Index) of 14.09. BMI is a calculation that uses height and weight to estimate how much body fat someone has. BMI percentiles show how a child's measurements compare to others with the same gender and age and help identify children who are gaining weight too slowly or quickly. At the age of 10 years YP1 was just under the 5th percentile indicating that he was slightly under the expected weight. Concerns were also noted about YP1's emotional wellbeing and self- esteem. At the same time mother reported that YP1 regularly stated that he wished he was dead. The school nurse was unable to contact mother to discuss these concerns further. The mother informed the author that she was happy with the support that YP1 received in primary school.

5.4 YP1 started secondary school education in 2014 and remained at the same school where staff seem to have been unaware of the issues identified in primary school. There are no concerns highlighted until academic year 9 (2017/18) when YP1's attitude towards learning and attendance started to deteriorate. An attendance record of 87% further declined to 29% in year 10 and was 0% in Year 11(September 2018 to July 2019) despite interventions through the school attendance service. In January 2018 they escalated their concerns about YP1's attendance record, school refusal and the resulting challenges that mother was experiencing by referring to Childrens Services. Derbyshire County Council (DCC) had re shaped their Early

Help and Attendance services to schools through the Rethink Early Help Offer from 2015. It should be noted that the school initially signed up for a three-year package of support from DCC and set up their own Early Help service in August 2018. The period of time subject to this review covers this transition period.

5.5 The referral was accepted and YP1 was allocated to a worker in the Multi Agency Team (MAT) with the task of completing an Early Help Assessment (EHA). The case remained open until September 2018 at which point responsibility was transferred to the schools Early Help service.

5.6 The MAT worker first visited the home in February 2018 when YP1 was seen in bed and observed to look 'thin'. Mother was advised to contact her GP re YP1's weight and offered a Parenting Support Programme which she declined but did disclose that she suffered from clinical depression. There is no evidence that mother's mental health was explored further or considered as part of the assessment, nor of the offer of parenting support being revisited. The EHA focussed on poor school attendance and YP1's self- esteem. There is no evidence of a systemic approach to the assessment i.e. no family history, consideration of environmental and contextual information or assessment of mother's capacity to meet the needs of YP1. There is no evidence of enquiries with agencies other than school which in effect did to focus on the evidence of concerns about YP1's weight and emotional wellbeing. Attempts were made to arrange a joint home visit with a colleague to discuss army careers and a subsequent referral was made to a sports mentor and while neither were taken up the author questions the thinking and decision making about the appropriateness of these services at that point for YP1. The EHA was signed off by a manager on 20th April with an agreement that the case should proceed as an Individual Focus Plan rather than a Team Around the Family (TAF). It should be noted that there was already a TAF in place at the school and it would seem to have been more appropriate to continue with this plan with the MAT worker becoming the lead professional. However, the MAT worker did suggest a TAF meeting and arranged it for 22nd May to be held at the school. The invite to the school nurse is the first indication of contact between the MAT worker and a health professional.

Comment: *The assessment was not robust and did not meet the standards required by DCC. It focussed on a single issue and did not address the information in respect of YP1's health and wellbeing, or mother's capacity/ability to meet their needs.*

5.7 At the first TAF meeting, it was noted that YP1 was engaging well with the school nurse and that mother should contact the GP to request a further home visit. Later in May mother was issued with a fine for YP1's persistent absence.

5.8 The school nurse visited the home following the first TAF meeting. YP1's weight is recorded as 6 stone 8lbs. The BMI of 13.97 which was lower than that recorded at age 10 years and well below the 5th percentile. This is considered underweight for a child of YP1's age and gender at this stage. The school nurse also noted concerns about YP1's poor dental hygiene, personal care, unbalanced diet, insufficient fluid intake, erratic sleep patterns, lack of motivation and social isolation. These concerns were escalated to the GP who made a follow up visit to the home. The GP did not think that the criteria for CAMHS service was met although did think

that YP1 was showing signs of depression. The school nurse visited the home again in August when YP1 was observed to look unkempt and the bedroom to be in a poor state with no sheets or pillowcases on the bed and dirty plates over the floor. There is no indication of action as a result of these findings.

Comment: *The concerns noted by the school nurse indicate potential neglect as defined in Working Together and the local procedures. There is no evidence that neglect was considered or that this information led to any change in the existing plan.*

5.9 Further TAF meetings were held at school in July and September which noted that YP1 remained absent from school and growing concern about YP1's emotional and physical health. While mother and grandmother attended these meetings there is no evidence of attempts to ensure that the child's voice was present or heard. The MAT worker was absent from the last meeting, and it is of concern that there was no discussion about the transfer of responsibility for the case from Local Authority Children's Services to the school as part of the changes to early help arrangements. The MAT worker did make a referral to the Emotional Wellbeing Service although this did not include the concerns about his weight or eating. The referral was accepted, and an Emotional Wellbeing worker visited the home but left when YP1 refused to come downstairs and subsequently closed the case. The case was closed to the MAT team with the school accepting responsibility. There is evidence that the MAT worker received regular supervision and that decisions including closure were signed off by the manager.

Comment: *The level of concerns in respect of the health and wellbeing of YP1, along with indicators of neglect, would indicate that the more appropriate decision would have been to escalate the case and not to transfer to the schools newly formed Early Help Service.*

5.10 YP1 was not seen again until November 2018 when visited by a school attendance worker. Again, YP1 refused to leave the bedroom. The room was observed to be very small and again in the same poor state as that previously seen. YP1 told the worker that they were happy to stay in bed all day and couldn't be bothered to eat. The attendance worker discussed their concerns with the school nurse and schools Early Help (EH) worker, and it was agreed that a meeting would be arranged. There is no evidence that any meeting took place. A home visit was carried out by the school nurse and EH worker, but no one answered the door. This was followed up by letters and in January mother told the EH worker in a telephone call that she was unhappy with the previous services and would not engage with them. A decision was made that the case be closed to Early Help and remain open to Attendance service.

Comment: *The lack of engagement by mother and that fact that there had been no change in YP1's circumstances should have triggered escalation of the case.*

5.11 Later the same month the school became aware that the family house was empty and their whereabouts unknown. A member of school staff referred the matter to the DCC Missing in Education Team and YP1's name was removed from the school register. In March a member of this team informed the school that the family

had been located at a new address in the area and, while school records were amended, there is no evidence of anyone visiting the address. As a consequence, there is no information as to the circumstances of the move, context of new environment or the safety and wellbeing of YP1.

***Comment**: A home visit should have been undertaken in light of the previous concerns and also that YP1 had not been seen by any practitioner for four months*

5.12 The GP visited the home on 5th August 2019, the first time any practitioner had seen YP1 for nine months. An immediate referral was made to the single point of contact for CAMHS citing poor interaction, self-neglect, and low BMI. This resulted in an urgent home visit by a Consultant Psychiatrist and Lead Nurse. They in turn referred to DCC Childrens Services and YP1 was admitted to hospital on 8/10/19. At the age of 16 years YP1 weighed 6st 8lbs (the same as recorded 18 months earlier) with a BMI of 13.7, was described as unkempt with dirt ingrained all over their body. YP1 disclosed that they had not left the house for over a year, although evidence is that the family moved during that time so they must have at that point, had not showered spent the time playing on an x box and ate little as didn't feel hungry. A subsequent Risk Strategy meeting concluded that the threshold for S47 of The Children Act had been met and that, following treatment in hospital, YP1 should return home subject to a robust plan.

***Comment**: The decision of this meeting was based on evidence that had first been observed at the health assessment some six years earlier and had remained the lived experience of YP1 throughout this period of time.*

YP2

5.13 YP2 has always lived with their mother. The father left home when YP2 was an infant and contact between them had been sporadic. The sudden ending of all contact in July 2019 is cited by the mother as a cause of the anxiety and depression that YP2 experienced. The family had not come to the attention of services other than universal health and schools until YP2's attendance started to deteriorate in Year 10 (86%). YP2 did not return to school after the summer holidays in 2019.

5.14 In September 2019 a member of school staff contacted YP2's mother to arrange a meeting in school to discuss YP2 refusal to attend. Mother reported that YP2 was suffering from low levels of anxiety and was finding some subjects too difficult resulting in not wanting to attend school. A modified timetable was offered as well as the support of an Attendance officer to arrange for YP2 to be collected and brought to school. Following the response from the school, YP2 attended on 2nd and 3rd of October when they were reported to present as smartly dressed, happy, chatty and comfortable with going around school alone. Although there were no apparent difficulties on these two days, YP2 never returned to school. A member of school staff visited the home on 6th October, and this was followed by a telephone call from the mother the following day reporting that YP2 was in bed after being distressed during the night and that she had made an appointment to take YP2 to see a GP.

***Comment**: The sudden 'failure' to attend school following the summer holidays, the mother's reports of mental health issues for YP2 as well as the apparent discrepancy*

between reported distress and presentation on the two days YP2 attended school should have triggered an EHA.

5.15 The mother accompanied YP2 to the GP appointment, within the week, during which she asked for a letter saying that YP2 was suffering from anxiety that she could give to school. The GP wrote the letter which the mother subsequently handed to school. The GP records indicate that the mother had consulted the practice on several occasions regarding YP2's anxiety, panic attacks and low moods and that she had been advised to contact the school nurse regarding counselling. In September YP2 had been prescribed medication, described as 'pill in the pocket' to be used when needed to help with symptoms of anxiety. The GP, who had also trained as a psychiatrist, thought that YP2 did not meet the criteria to access specialist CAMHs services and referred her to a local voluntary sector provider for counselling.

5.16 YP2, accompanied by the mother, attended an initial assessment session at the counselling service on 16/10/19 after which she attended all planned sessions (8) until January 2020. YP2 reports that they had a good relationship with the therapist. YP2 and the mother completed the "Childrens Anxiety and Depression" tool. The results of which indicated that mother may not have fully understood the extent of YP2's difficulties and, with their agreement, the therapist also worked with mother to help her understand and support her child.

5.17 The school Attendance officer made 6 telephone calls to mother during October but YP2 remained absent from school. The mother advised them that the GP had recommended that YP2 did not return until after the half term holidays and that they were now attending counselling sessions which she thought were having a positive effect. A member of school staff visited on the home on 11th November where YP2 was seen and spoken to. There were no observed concerns about YP2's wellbeing.

5.18 School maintained contact with the mother during November and offered a reduced timetable to support re-engagement with school. Whilst the mother initially said that YP2 would return to school in December she later sent an email stating that YP2's medication did not seem to be working and that she was concerned about their depression. The mother subsequently emailed the school to enquire about the possibility of out of school study and concern about the pressure being placed on YP2 to return to school. The mother had requested a second letter from the GP which was sent to the school to confirm that YP2 was suffering from anxiety and was having counselling.

5.19 The mother was unhappy when school staff explained to her in a telephone call that this was not sufficient to support Out of School tuition (OOST service provided by DCC) and stated that she would obtain another letter from the GP. This third letter was followed up by a telephone conversation between a member of school staff and the GP. The GP explained about the medication prescribed to YP2 and stated that there was no reason why they shouldn't attend school while accessing counselling. The mother complained to the school about the conversation with the GP and requested a meeting with the Headteacher.

5.20 YP 2 was taken to the GP practice on Christmas Eve when they were seen by a different GP. YP2 is described as presenting as tearful with worsening symptoms. The decision was made to make a referral to CAMHs, and a prescription was given for medication to help re- establish a sleep pattern. The level of urgency for the CAMHS referral was noted as "routine" and the referral was processed by the practice on 6th January 2020.

5.21 Communication continued between school and the mother including a statutory attendance panel meeting on 7/1/20 which was also attended by YP2. Shortly after this the school requesting a meeting to discuss Elective Home Education (EHE). Although the response from school was, they would not advocate EHE for YP2, the mother sent another email stating that was her wish, and a referral was made to DCC the same day. There is no evidence of YP2's view of this referral.

***Comment**: School continued to offer support to affect a return to school while the GP was responding to mothers' reports of YP's mental health and requests for letter to school to explain non-attendance. The mother's unhappiness about the direct contact between school staff and the GP along with her subsequent request for EHE could have triggered more respectful curiosity from practitioners. The author suggests that a multi-agency meeting involving the mother and YP2 should have been convened. A meeting would have also been an appropriate forum to inform the processing of the request for EHE. An EHA could have been triggered at any stage during this period which would have been an appropriate vehicle for sharing information, seeking to understand the underlying issues and what life was like for YP2, assessing the mother's capacity/ability to meet YP2's needs and thereby formulating a relevant plan.*

5.22 The CAMHs duty worker followed up the referral by a telephone call with YP2 and their mother. The content of the conversations confirmed the GP's view that the level of urgency was "routine". They were given contact details for the duty worker and urgent care team in the event of a deterioration in YP's mental health or an increase in risk. It would seem that 'risk' was associated with possible self-harm and suicidal thoughts and not wider harm. The referral was confirmed to the school by a CAMHs worker on 16/1/20 when it was explained that there was a waiting list of approximately 20 weeks.

5.23 The mother cancelled the appointment with the counselling service on 22/1/20 stating that YP2 was too ill to attend.

5.24 Not long after this there was another discussion between the mother and the GP who had made the CAMHs referral, during which she expressed her concern that the waiting time for CAMHs was too long as YP2 was now not leaving her bedroom. The GP discussed the situation with the practice safeguarding lead who suggested a referral to children's social care. The mother felt that the involvement of another agency would upset YP2 and "refused" the referral. The referral was not made as was not considered as concerning a risk of 'significant harm'.

***Comment**: There is no evidence that the counselling service already providing therapy were consulted/informed or whether the specialist CAMHs service were informed that this service was being provided. It was good practice for the GP to*

discuss with the safeguarding lead however it is suggested that the view that there was not a risk of significant harm may have been different if all information had been available through an EHA/plan. There is no evidence that this position was reviewed

5.25 YP2 attended an appointment at the counselling service on 29/1/20 although the mother had cancelled a home visit by the attendance worker stating that YP2 was too ill. YP2 talked to the therapist about an incident of self-harm the previous month and of having suicidal thoughts although not intending to act on them. The therapist was so concerned about the significant decline in the mental health of YP2 that she rang the GP practice to request an appointment for YP2 and the mother to attend that same afternoon. The therapist contacted the mother the next day who confirmed that they had attended the appointment with the GP and had another four weeks later.

5.26 The mother cancelled the next counselling session on 5/2/20 citing that YP2 was unwell, and it is recorded that YP2 "not brought" on the last appointment offered on 12/2/20. The therapist wrote to the GP on 8/2/20 noting a deterioration in YP2's mental health and expressing concern about the "risk to her mental health of self-isolating in the bedroom". Mother also contacted the GP in February to seek advice as YP2 was reported to be suffering with back pain.

Comment*: The therapist appropriately escalated their concerns in respect of YP2's presentation to the GP/ referrer. There is no evidence that this was then relayed to specialist CAMHS to inform the processing of the referral and the priority it was afforded. This would have been an opportunity to revisit the consultation with the safeguarding lead.*

5.27 On 21/2/20 the mother contacted the duty worker at CAMHS reporting that YP2 was remaining in bed, not leaving the house and was tearful during the night. She reported that YP2 may be self-harming as she had found blood on the sheets. The duty worker did not speak to YP2 but did agree to offer a 'priority' appointment within 6 weeks.

5.28 None of this information was relayed to the counselling service when Mother telephoned them on 4/3/20. The therapist spoke to YP2 who reported that there had been no further incidents of self-harm or suicidal thoughts. YP2 stated that although they wanted to return to counselling they did not want to do so at that time. It appears that the reasons for this were not explored further. YP2 was reminded of the details of a telephone help line service, that they had been given prior to the Christmas holidays, and how to access the counselling service in the future. YP2 reports that they attempted to call one of the helpline numbers at some point after this but that their mother took the phone off her.

5.29 The attendance worker visited the home on 11/3/20. The mother was asked if she was concerned about the risk of COVID19 at which she indicated that she did not want the worker to enter the house. YP2 was presented by the mother at an upstairs window and was seen to smile and wave. YP2 has stated that the mother made them put a clean top on to hide blood stains.

5.30 Two days later the mother again rang the CAMHs duty worker when, on the basis of information given by the mother, a judgement was made that YP2 did not meet the criteria for the *Urgent Care Team* and that the 'priority' appointment in place for 13/3/20 would continue. Despite the mother's apparent concerns, she cancelled this home visit stating that YP2 had a bad back, although she reported an improvement in YP2's condition and said that they were now leaving the bedroom. There was no contact with YP2 during the call. The appointment was rearranged for 26/3/20 although subsequently cancelled by CAMHs due to a blanket ban on home visits following the implementation of a national lockdown due to COVID19. A CAMHS clinician made 3 telephone calls to mother leaving messages asking her to contact them. There was no contact from mother until after YP2's admission to hospital.

***Comment**: There is absence of YP2's voice throughout this period with only the therapist having a telephone conversation with them. The therapist also provided YP2 with contact details for helpline services which is an example of good practice and provided YP2 an opportunity to have a voice. There is no evidence of feedback from CAMHS to the GP (as the referrer) of the inability to visit.*

5.31 YP2 reports that they had been developing wounds, as a consequence of remaining in bed, from as early as December 2019 and so was becoming increasingly physically unwell during early 2020. YP2 informed the author that their mother would make them shower and change before appointments with practitioners and when the grandmother visited at Christmas. YP2 believes that this resulted in the smell and potential sight of the wounds being hidden.

***Comment**: Wounds caused by long periods in bed, commonly known as pressure sores, are usually caused when a person is unable to physically move and are more common in older people or those with fragile skin.*

5.32 In late March the mother contacted the GP practice 3 times in 9 days: the first regarding a "sweat rash" on YP2 tummy which resulted in weeks course of antibiotics (YP2 states that mother made them take a photograph of a small area of their body to send the GP to illustrate the 'rash'); second to report that the medication was causing nausea and diarrhoea; thirdly to report that YP2 was now suffering from lower back pain and swollen ankles. Exercise, including daily walks was advised.

5.33 On 9/4/20 the mother again contacted the GP this time reporting that YP2 was having difficulty urinating, had dark coloured urine and a discharge. She also stated that YP2 was pale, tired, and not leaving the house. Advice was given over the phone as face to face consultations were limited due to COVID restrictions. YP2 was not spoken to on any of these occasions.

***Comment**: An EHA would have informed a multi-agency plan with an identified lead practitioner. This framework for communication and services may have identified patterns in mothers' communication with agencies that could have triggered greater concern; recognised that YP2 had not been seen or spoken to by a practitioner, apart from through an upstairs window, since early February in spite of increasing calls from the mother and concerns raised by the therapist; identified contingency*

plans if services were not accessed or delivered. It is recognised that managing services at a time of a pandemic and national lockdown is unprecedented in living memory however it is suggested that a clear multi agency plan would have assisted assessment of risk and decision making in respect of seeing YP2.

5.34 Six days later the mother dialled 999 and requested an ambulance. She reported that YP2 had been depressed and not allowed her to access the bedroom. The mother had managed to see her and discovered sores on her back and her underwear embedded in her skin. An EMAS crew responded within 7 minutes of the call and found YP2 in a very poor state. They had numerous wounds and found it difficult to stand. The clothing and bedroom were in poor condition. YP2 was taken to hospital and a safeguarding referral was made to DCC Childrens Services.

***Comment**: The information was relayed to the police some time later which meant that potential evidence from the bedroom/home may have been lost. It is unknown whether this action may have been considered earlier if YP2 had have been a younger child and/or whether the circumstances had been viewed through the 'lens' of safeguarding /child protection.*

5.35 The mother had herself been taking medication for depression and anxiety since 2007 when YP2 would have been 4 years old. A new GP took over her care from May 2019 and has continued to see her. This is a different GP, from the same practice, as that contacted by mother in respect of YP2. The mother complained of abdominal pains and was finding it hard to work at her job as a cleaner in a Care Home from which she had been signed off sick since March 2019. The GP referred the mother for a series of tests at the hospital, but it is unknown whether she attended, and the GP has no record of any results. The mother continued on antidepressants saying that she was anxious and had panic attacks. In August 2019 she informed the GP that her stepfather had died and that she was still awaiting an appointment for talking therapy. There is no mention of the loss of their grandfather in any information relating to YP2. Mother attended appointments with her GP each month. In November 2019 she reported chest pains and breathlessness and was referred to the hospital for tests. The GP also discussed weaning her off the antidepressant and it was agreed that the dosage should be reduced. In February mother told the GP that she had stress at home due to YP2's mental health and that she was thinking of home schooling. On 4/3/20 mother informed her GP that she was having difficulty coping at home due to YP2 not being at school and waking her a number of times in the night. The mother was given the contact number for an online service for parents of children with mental health issues.

***Comment**: There is no evidence of consideration of the impact of the mother's mental health on her capacity/ability to be the sole carer of YP2 at any point since 2007. She had her own active health needs during the time frame considered by this review, none of which appear to have been known to practitioners working with YP2. This may have been revealed and considered if an EHA had been completed.*

6. Joint themes from practitioner and managers meetings

6.1 The potential vulnerability and safeguarding needs of all children, irrespective of age, needs to be at the forefront of practitioner's minds when responding to issues such as, but not exclusively, school attendance and mental health. It is vital that all practitioners and managers remember that the Children Act and the Child Protection Procedures apply to all children and that 'Self Neglect' is a category of risk in 'Adults at Risk' procedures and not applicable to children.

6.2 It is recognised that further consideration needs to be given managing situations where there is a perceived "failure" of children and/or parents to engage with services and that practitioners/managers need to be creative and persistent in addressing identified issues.

6.3 The Rethink Early Help Offer was subject to significant discussion throughput the review. Whilst the extensive preparation, discussion and implementation plans are acknowledged it remains a significant cultural, as well as organisational, change in the way that EH services are delivered. As part of the extensive package intended to support schools, and children's services, in managing this change, DCC established a Transitions Team. It was noted that the team was not operational until after the change in service delivery due to the initial difficulties in appointing staff. Managers identified that new responsibilities for some school staff required new knowledge, skills, and a way of thinking about some issues as a consequence of which there is an ongoing need for more training and awareness raising. For some practitioners REHO brought new challenges e.g., managing relationships with families when trying to address welfare needs at the same time tackling attendance and implementing sanctions.

6.4 Managers describe the delivery of services as a "complex and bureaucratic" landscape. For example: There are two NHS Trusts providing specialist CAMHs services in Derbyshire, split by geography, with YP1 and 2 falling within the remit of different Trusts. A Specialist Community Advisor role has been established but managers were unclear how effectively they were used. There are numerous providers of emotional wellbeing and mental health services some of which school directly provide and some commissioned as part of the CAMHs pathway with some remaining outside of these arrangements as with that accessed by YP2. It was suggested that Rethink Early Help Offer had added to this complexity for some practitioners such as GP's who now have multiple routes into Early Help.

6.5 Whilst attendance is a key performance indicator for schools it is recognised that addressing non-attendance should have a wider focus than effecting a return to school. Practitioners with responsibility for attendance need to be aware of the risks of harm that may be hidden or contributed to by not being school. Similarly, all practitioners need to consider the wider risks when addressing identified mental health issues. The physical risks of staying in bed for prolonged periods of time were not considered in these cases. Managers suggested the need for bespoke training for Attendance staff.

6.6 'Stronger Families, Safer Children' provides a framework for the provision of children's services in Derbyshire. There are well established multi agency

procedures and there is a raft of national and local tools available to support practice.

6.7 Questions were considered about the ability to provide services in a timely manner due to waiting lists and protocols to access some provision. The waiting list for a 'routine' appointment with specialist CAMHs was 20 weeks at the point YP2 was referred and 27 weeks at time of the time of this review. Appointments screened as 'Priority' are offered within 6 weeks with access to the Urgent Care Teams being much quicker. This also has an impact on access to other services such Out of School Teaching (Oost) which currently requires support from a Consultant Psychiatrist or Consultant Paediatrician.

6.8 It was observed that while parents have the right to make positive choices to electively home educate their children, it is also evident that some children are removed in circumstances that concern the school. It is reflected that additional guidance could be provided locally to help schools liaise with the Local Authority where there are concerns about individual children becoming electively home educated. The intent would be to enable appropriate safeguards to be established and involve other agencies, such as health providers, where needed.

7. Conclusions

7.1 The provisions of the Children Act, associated statutory guidance and multi-agency Child Protection procedures apply to all children up to, and including, 17 years old. While older children may be regarded as better able to look after themselves, as well as being able to exercise some degree of self-determination, they may have particular vulnerabilities and face the risk of significant harm. Their safety and welfare remains the responsibility of their parents and carers unless they are unable or unwilling to do so. The duty remains with the Local Authority and other partners to provide services to promote their welfare (s17 Children Act) and to make or cause enquiries to be made when there is reason to think that they **may** be suffering abuse or neglect (s47 Children Act). It is clear from information made available to this review that needs of YP1 and YP2 were not met and that there was sufficient concern to trigger enquiries in accordance with s47 of the Children Act prior to their admissions to hospital. The perception that these two children were 'self-neglecting' may have distracted practitioners from considering abuse/neglect and the parents' capacity/ability to meet their needs.

7.2 Thirty children in their teenage years from thirteen families have been subject to review in Derby and Derbyshire between 2015 and the end of 2020. An audit of these thirteen reviews indicates that of these, 9 families (19 children) involved mental health concerns, 8 families (23 children) school attendance issues and that there was evidence of neglect in 7 families (21 children).

7.3 Concerns had been noted about the psychological and physical well being of YP1 over a period of 6 years. Although the concerns triggered an EHA in 2018, it is clear that this was insufficiently robust and that the decision to transfer responsibility to a newly formed EH service in school was inappropriate. The school continued to respond to the situation as an Attendance issue and, while the GP and School Nurse were seeing evidence that YP1 continued to be in a poor physical state, the primary

focus remained on their mental health. There was no evidence of the Graded Care Profile being used. The awareness of concerns in respect of YP2 emerged over a much shorter time with them not coming to the attention of services until September 2019 and escalated rapidly over seven months. School were primarily focused on attendance and attempts to get YP2 back into school while the GP responded to concerns in respect of mental health issues. There was only one conversation between school staff and the GP which was subsequently criticised by mother. The information available should have triggered an EHA which by that time was the responsibility of the school. This would have provided a focussed assessment of needs, and of mother's capacity to meet them, as well as a provide a framework for effective communication and information sharing between practitioners, mother and YP2.

7.4 Both mothers had known mental health issues which were insufficiently considered in respect of their impact on their capacity/ability to parent their child.

7.5 There is a marked absence of the voice of the child and consideration of their lived experience in both cases. YP1's claim that they preferred to stay in bed and that they weren't hungry so didn't eat much was too readily accepted while YP2's mother's account of her child's needs appears to have been accepted at face value. YP2 was effectively not seen in the home environment by any practitioner for over 5 months and was only seen by the GP's when mother took them for appointments at the surgery. While the therapist saw YP2 on their own on most occasions mother was always in the same building. No practitioner spoke to YP2 on the telephone apart from the therapist at the point mother notified them of ending the relationship. YP2 told this review that they feel that they had no voice.

7.6 Derbyshire has a robust framework of policies, procedures, and practice guidance with range of 'tools' available to support practitioners and managers in assessments, decision making and interventions. There is evidence that they were either not used or were insufficiently completed in both of these cases.

8. Actions

8.1 There has already been learning from this review. Practitioners and managers have actively participated and been able to reflect on their individual and organisations practice.
Some of the actions to date are related directly to the cases while others have happened as part of the implementation of REHO and ongoing practice development

8.2 The DCC Transition team is operational and a Vulnerable Childrens panel has been established to support schools in delivering their Early Help services.

8.3 YP2's school has strengthened the relationship between their Attendance officer and safeguarding lead. They have reframed their approach to tackling attendance issues to ensure that it is always seen through a lens of potential safeguarding concerns. Additional training has also been delivered.

8.4 Specialist CAMHs are currently reviewing the process for screening referrals and managing the waiting list. Consideration is being given as to how the Specialist

Community Advisor role can be better embedded in schools and used more effectively.

8.5 DCC has completed an internal review in respect of the practice related to their involvement with YP1

8.6 Schools have been reminded of the protocol for referral to school nursing service when attendance falls below 85%

9. Recommendations

9.1 It is recommended that Partnership:

- Ensures that all child protection training reminds practitioners that procedures and guidance apply to all children irrespective of age

- Include in multi-agency training: the risks related to prolonged periods in bed into existing child protection training. This to include specific reference to the significant risks arising from compromised skin integrity: the significance of weight and development for older children, as well as infants and young children, and the potential impact on long term well being

- Considers how practitioners/managers can be supported to reframe the concept of service users “failure to engage” to that of how can practitioners work persistently and creatively to engage children and their carers? And to ensure that the inability to establish an effective relationship could in itself be an indicator of risk

- Seeks assurance that the actions identified in section 8 are achievable and completed

- Works with schools to identify bespoke training packages/requirements for Attendance workers

- Seeks to strengthen the arrangements for assessing the welfare of children not in school. This to include:
    - guidance for staff involved in the attendance process (including those responsibility for health issues) that improves the awareness of welfare/safeguarding needs and ensures that the child’s voice is sought and heard throughout
    - guidance to improve the process for raising and assessing concerns when a child is withdrawn from school to electively home educate
    - reviewing the referral requirements for Out of School Tuition (OOST) to ensure timely referrals and that education can be provided for vulnerable children
    - using the Section 175/157 self -assessment process to obtain assurance from schools that measures have been implemented to improve awareness of welfare issues of children not in school

- Seeks assurance that all agencies understand the routes to an EHA and that such assessments are completed where required

- Seeks assurance that all practitioners are familiar with, and use where appropriate, the Graded Care Profile along with other tools that can be used when undertaking assessments

- Seeks assurance that the practice issues identified by the DCC internal review are addressed and that any lessons learnt are shared with relevant departments

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Appendix 1

Derby and Derbyshire Safeguarding Children Partnership
Terms of Reference

Terms of reference for Serious Case Review MDS20/PDS 20 (anonymisation code)

1 Introduction

This Child Safeguarding Practice Review is being commissioned by the Derby and Derbyshire safeguarding Children Partnership (DDSCP) in accordance with Working Together to Safeguard Children (2018) and the Child Safeguarding Practice Review Panel: practice guidance (2019). A multi-agency panel established by the DDSCP will conduct the review and report progress to the Partnership through its Chair. Membership will include representatives from key agencies with involvement.

The review will consider the lived experience of two young people (secondary school age) from two separate families. The two young people experienced serious neglect. The purpose of the joint review is to draw out learning arising from both their individual circumstances and systemic learning arising from their experiences that appear from analysis arising from the Rapid Reviews to lead to similar outcomes.

The joint review will

- bring together the themes of the cases to provide better system learning whilst ensuring the individual features of each case are not lost
- Identify improvement measures that should be taken to address where previous learning has not led to **systemic** practice improvement following previous case reviews
- Deliver a strategic approach to learning and improvement that provides the partnership with clear priorities informed by both the two reviews and previous learning
- Provide evidence to embed learning and improvement in a way that local services for children and families are more reflective and achieve changes to practice that are consistent with the priorities arising from the two reviews.

The review will consider the learning arising about the services provided to:

MDS20 - Subject Child YP1
PDS20 - Subject Child YP2

The review will:

- Explore all areas of potential learning about the way in which local professionals and agencies work together to safeguard children including seeking the views of professionals involved in the cases
- Determine the extent to which decisions and actions taken were child focussed and considered the children's lived experience
- Seek contributions to the review from appropriate family members and keep them informed of key aspects and progress
- Identify any actions required by the DDSCP to promote learning to support and improve systems and practice.

Methodology

The review will be completed in a proportionate way that enables the partnership to learn from the experiences of the family, practitioners involved in the case and relevant managers and promote a positive learning culture. The detail of the methodology will be linked to the key theme and explained below.

- Learning events will be held with front line practitioners involved in each of the cases and separately with practitioners from other schools and Education Welfare services
- At the learning events a series of exploratory questions linked to the themes below will draw out learning from these cases to improve how the partnership supports all schools and other services to carry out assessments of vulnerable pupils who are not attending schools
- Learning events will be held with managers involved in the cases and strategic managers as needed
- Parents and the young people themselves will be invited to participate in the review and be interviewed by the overview author
- Reports may be commissioned from agencies to provide specific additional information not included in the Rapid Review. The specific requests for information may be identified following the practitioners' meeting. There may be generic points for clarification and specific requests for individual agencies.

A child safeguarding practice review report will be completed to provide:

- A brief overview of what happened and the key circumstances of the lived experience for each young person in a way that does not identify them and is sufficient to understand the context for the learning and recommendations
- A critique of how agencies worked together and analysis of good practice and systemic areas for development
- Analysis of what would need to be done differently to prevent harm occurring to a child in similar circumstances; and
- What needs to happen to ensure that agencies learn from this case.

2 The key themes and questions that the review seeks to answer

These themes incorporate the areas identified by both rapid reviews and are presented thematically together as below:

a) What advice and clarity about indicators of concern for staff would alert them to consult with other agencies, if early signs of disguised compliance emerge, and promote professional curiosity?
b) Agencies continued to work at a low level potentially for too long and in both cases the reasons for drift and a lack of escalation need to be understood so that staff can identify concerns and know when to escalate them at an earlier stage.
c) Understanding how systemic improvements could be made to the access to and the assessment of the welfare of pupils whose school attendance is deteriorating and who become long term absent from school.
d) In one of the cases there is a need to understand what held back professional curiosity and in both cases strengthen arrangements for how staff, especially

school staff, are able to identify potential neglect of young people and assess the abilities of parents to respond appropriately.

e) Identifying what action should be taken to improve the effectiveness of arrangements to safeguard pupils who are the subject of applications to be electively home educated (especially where this appears to occur in response to challenges to families about school attendance).
f) Understanding how the voice of the child is used to inform referrals and evaluate whether further guidance should be issued to help clarify what action should be taken following repeated concerns from a parent followed by cancelled or failed appointments.
g) In one of the cases identifying action that could help strengthen arrangements that ensure the safety of children whilst they are on CAMHS waiting lists was a feature that is to be included
h) In one of the cases action was identified that arrangements and / or training needs are reviewed to ensure that partner agencies inform the police, in a timely manner, of any child abuse criminal offences that are suspected of having been committed.
i) In both cases the review will consider whether there is learning emerging from the analysis of the individual experiences of the young person and their parent in respect of their race, ethnicity, gender, age, religion or disability.
j) In one case there were concerns about the mental ill health of the parent and whether that had an impact on their ability to address the neglect of the young person's

Timeframe for the review

The review covers the time period of January 2019 to April 2020. Any significant incident relevant to the case but prior to the start of the period may be included in the analysis completed by each agency. The review is undertaken by one reviewer appointed by the *Review Panel*. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled and reporting on this to the *Review Panel* and the DDSCP.

Review Panel members*:*

- Derbyshire County Council including Children's Social Care and Education Welfare Services
- Derbyshire Police
- Named GP
- Designated Doctor
- Derby and Derbyshire ICB
- Hospitals – Chesterfield Royal Hospital including CAMHS
- Health Services – Derbyshire Healthcare Foundation Trust; Derbyshire Community Health Services Trust
- Education – Secondary School 1, Secondary School 2

3 Specific tasks of the Review Panel

- Identify and commission a reviewer to work with the review panel in accordance with guidance for concise and extended reviews.

- Plan with agencies involved in the review for the completion of key tasks as required
- Plan with the reviewer a learning event for practitioners and separately their managers (if directly involved in the case), to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the children and family members prior to the event.
- Receive and consider the draft overview report to ensure that the terms of reference have been met, the initial hypotheses addressed, and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the DDSCP for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

4 Tasks of the DDSCP

- Consider and agree any learning points to be incorporated into the final report or the action plan.
- Ensure the Review Panel complete the report and action plan.
- Confirm arrangements for the management of the multi-agency action plan by the Review Panel subgroup, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on DDSCP website.
- Agree dissemination to agencies, relevant services and professionals.