Salford
Safeguarding
Children Board

Serious Case Review Report

Child N

This report will be published in line with statutory guidance. In order to preserve anonymity as far as is possible, the author has:

- Used abbreviated letters to reflect each child and adult
- made limited reference to the gender of person, other than where not to do so would compromise the readers understanding of the report
- avoided the use of exact dates
- not used any details about local services which could lead to recognition of individuals

1. Introduction

1.1 This Serious Case Review (SCR) concerns services that provided a service to a young woman, Child N, who at the time of writing this report is now an adult. Child N requires 24 hour nursing care after sustaining a profound brain injury. Child N lives in a minimally conscious state; she cannot communicate, eat or drink without medical assistance and has a tracheotomy in place.

1.2 The Review predominantly considers the activities of agencies across two Local Authority areas; Local Authority 1, where Child N spent the majority of her adolescent and formative years, and Local Authority 2 where Child N lived from the age of 16 years and 11 months for three months until the incident which precipitated the convening of this Serious Case Review some three months later. Child N attended senior school in a third Local Authority area.

1.3 During her high school years, Child N lived with her mother MN, step-father SFN and three younger siblings. Information from the school and MN indicates that throughout Child N's school years, she was a child that was well supported by her family and had aspirations for her future.

1.4 Child N attended the same senior school for five years. She was an academically bright and capable pupil academically who also needed additional periods of emotional, social and behavioural support. Child N at times struggled to 'fit in' with her peers, and it is evident she felt the need to present herself as exciting and interesting at times. Those who knew Child N best at this time consider that this need sometimes led her to fabricate stories and events in order to canvass the attention of her peers. Child N was considered to react well to the additional support of a Learning Mentor and successfully completed her senior education.

1.5 In additional to the pastoral support from school based staff, Child N also regularly accessed a counselling service provided within the school by Relate. During these sessions, Child N predominantly discussed friendship, low level bullying issues, and latterly some references were made to relationship issues within her family.

1.6 MN recalls Child N's last two school years as a particularly difficult time. MN recalled that she spoke very regularly with the Learning Mentor who she considered provided very helpful support to Child N and herself. MN described times of feeling desperate in trying to understand Child N's behaviour and keep her focussed on achieving in education.

1.7 On reflection, MN considers that once Child N left school, family life was becoming unbearable, with a great deal of focus on keeping track of Child N. MN feels strongly when Local Authority 1 became involved with Child N, there was little understanding of their family or attempts to rebuild family life and that the support was wholly inadequate.

1.8 Child N was provided with a Supported Lodgings Placement aged 16 years and 9 months and stayed at this address for approximately two months. It is believed that Child N formed a relationship with a male she considered as her boyfriend, TT, shortly before moving into this housing arrangement. At 16 years and 11 months, Child N moved home to live with TT in Local Authority 2. TT was five years older than Child N and an adult.

1.9 Within one month of moving to live with TT, Child N registered with a local GP. In the ten weeks that followed, leading up to the critical incident, Child N visited the GP on four occasions. Whilst living with TT, Child N presented to the local hospital Accident and Emergency Department on two occasions prior to the critical incident, each occasion related to an overdose of drugs/medication, none of which was prescribed for Child N and one of which she described as a deliberate overdose attempt.

1.10 The critical incident occurred eight weeks after Child N had presented at hospital with an overdose of TT's prescribed insulin. Child N described this at the time as a 'stupid thing to do' but admitted that it had been with suicidal intent. On the date of the critical incident, an ambulance was called for Child N by TT at 9.51 am. Child N was described as unresponsive with her eyes rolled into the back of her head. The Ambulance arrived within eight minutes and undertook emergency procedures prior to transporting Child N to hospital. TT stated that Child N had fitted the previous evening; that she was put to bed after staggering about the house, but found to be

unresponsive the following morning. At the hospital Child N was found to be in a coma with an early prognosis that she was unlikely to survive, but if survival occurred, than she most likely would remain in a vegetative state. Twenty months on, Child N has never regained any consciousness.

2. Serious Case Review Process and Methodology

2.1 The case was first discussed at the Salford Safeguarding Children Case Review Subgroup (CRSG) in June 2013 following which discussion commenced with the Safeguarding Children Board in Local Authority 1 as to which Board should lead on considering the case. Negotiations then proceeded over which LSCB should lead on consideration of the referral for review. Legal advice was sought, and seven months later that a joint meeting took place with representatives from Area 1 and Area 2 Case Review Group. This meeting recommended that there should be a joint learning event to review the issues and involving practitioners and front line managers familiar with the case.

2.2 The Salford CRSG then recommended that a screening panel took place in Salford to better reflect the level of concerns raised by the information shared at the joint meeting. Members of the CRSG agreed that the alleged victim had been seriously harmed and that the circumstances of the case merited further consideration as to whether a Serious Case Review should be recommended. The screening panel took place in April 2014 and agreed that serious harm amounting to abuse and neglect had occurred to Child N and that concerns existed about the following issues:

- information sharing across and within Local Authority boundaries
- recognition and referral of causes for concern relating to incidents of domestic abuse, self-harm and possible exploitation in Child N's relationship with TT
- assessment and escalation of need
- listening to the voice of the child, including recognition of Child N as a child and not simply as a young adult who had the capacity to consent.

2.3 A decision was then taken on 10th April 2014 by the Interim Chair of the LSCB that a Serious Case Review would be undertaken.

2.4 The Salford Safeguarding Children Board made the decision to appoint three professionals to oversee the Review process, to work alongside a Review Panel made up of Senior Officers from the contributing agencies. The three professionals each had a nominated role as Panel Chair, Independent Author and Independent Facilitator. During the process of the Review, due to unforeseen circumstances, the Independent Author also adopted the role of Independent Facilitator.

2.5 The Review has followed the guidance set out in Working Together 2013, to ensure the following was achieved:

- a recognition of the complex circumstances in which professionals work together to safeguard children;
- to establish where possible precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- an openness to understanding practice from the viewpoint of the individuals and organisations involved at the time to avoid the over influence of hindsight bias

Careful consideration was given to the fact that information was to be collated from across three Local Safeguarding Board areas, and to this end a decision was made to collate data using two principal approaches. In the first instance, each agency that had worked with Child N or had particular information known to be relevant to the scope of the Review was asked to complete a Single Agency Analysis Report (SAAR). Following receipt of the majority of agency SAARs and all agency significant events timeline a Learning Event was undertaken with practitioners directly involved with the case. This approach was taken in order to promote single agency accountability whilst also placing an emphasis on the practitioner's perspectives of how services responded to Child N in order to reach a deeper understanding of what happened specific to this case and what can be learnt about from this to maximise the safeguarding of young people.

2.6 Through the SAARs, each contributing agency was asked to address the following questions:

- How well information was shared between agencies, within Local Authority 1, within Local Authority 2 and across the boundaries of the two areas

- How well risk assessments were carried out in respect of the circumstances of Child N
- Whether Child N was recognised as: a child with safeguarding concerns; a young person with vulnerabilities; a young person with mental capacity to make reasonable decisions about her welfare
- The impact of factors such as domestic abuse and sexual exploitation on Child N's welfare and safety
- How well the voice of Child N was heard and listened to
- Whether the local authorities gave appropriate consideration to Child N's homelessness and the potential for 'looked after child' status

It was agreed the outline timeframe for the Review would be 1st January 2012 to 27th April 2013. This timeframe was chosen to reflect the point from which Child N became significantly known to additional services.

2.7 Information has been provided to the Review from many services. This includes:

From Local Authority 1:
- Children's Social Care
- Early Help Service
- Positive Steps
- College
- Sexual Health Services
- Hospital 1

From Local Authority 2 this has included:
- NHS Clinical Commissioning Group (CCG)
- Hospital 2 NHS Foundation Trust (provider services)
- Children's Social Care
- Integrated Youth Service
- City West Housing

From Regional/national Services:
- Greater Manchester West Mental Health NHS Foundation Trust
- Greater Manchester Police
- North West Ambulance Service NHS Trust
- Relate Counselling Service

Additional:
- Senior School
- Pennine Care Foundation Trust - School Nursing

2.8 In addition to the above, the Panel identified a need to seek an objective expert medical opinion to review the medical interventions for Child N and comment upon whether the outcome of assessments were appropriate to her history and presenting behaviour. In order to reach confident judgements on specific aspects of medical care, specific comment was requested in the following areas:

- the robustness of a mental health assessment of Child N that took place 6-7 weeks prior to the critical incident
- given that the mental health assessment was conducted by an adult mental health practitioner (and Child N was 17 years old), was it likely that an assessment conducted by a child and adolescent mental health practitioner would have resulted in a different outcome
- the appropriateness of Child N's prescribed anti-depressant medication
- to what extent Child N was considered a child when reaching clinical judgements about services
- were safeguarding concerns identified and acted upon appropriately

2.9 The methodology adopted, in particular the opportunity to be an integral and direct part of a multi-agency review process, was new to many of the practitioners who attended the Learning Event. This event was considered to a powerful reflective event from which practitioners were genuinely consulted and invited to share their own learning.

2.10 The Review was committed to developing an understanding of Child N's life but sadly Child N was not medically fit to make a direct contribution. In order acquire some understanding of Child N's thought and feelings, the Independent Author accessed notifications made by Child N on face book and twitter. MN kindly provided the Independent Author with many photographs of Child N taken over her adolescent years.

2.11 The Independent Author met with MN who was provided a view about the services that she had access with. The Independent Author also met with TT to try to get a sense of Child N's day to day life prior to the critical incident.

3. Overview of what was known to Agencies

3.1 Seventeen months prior to the timeframe of this Review when Child N was 14 years, MN contacted Children's Social Care in Local Authority 1 and requested support. MN advised that Child N would frequently lie and that MN had sought privately funded counselling which had not helped. MN was advised to access a 'Surviving Teenagers Course' with no further action taken by the Department.

3.2 Ten months later, Child N was 15 years when she contacted the Out Of Hours social worker in Local Authority 1. Child N was upset and stated that everyone wanted her to leave the family home after she had told a lie about a boyfriend which had caused trouble at school. MN confirmed to the social worker that she had told Child N to make the call because she was stealing and lying. MN became upset stating that she had telephoned Children' Social Care several times but there was nothing anyone could do to help her. One week later, in response to the referral, MN was advised that the circumstances did not meet the threshold for a service by the Department but that she could self-refer to the Family Intervention Service.

3.3 Two weeks later, Child N alleged at a friend's house that MN had physically assaulted her. A joint police and Social Care Section 47 investigation was undertaken. Both Child N and MN wanted to work through an argument that had occurred. Following this, Children's Social Care made a referral to the Youth and Family Team, which stated that Child N was 'pushing the boundaries, drinking, lying, and arguing a lot'. The referral asked for support with parenting strategies and a Youth Worker was allocated. After three months the case was closed. The closure summary states the family had made no contact after letters and telephone calls; however, there was no record of any contacts made with the family or any other involved professional in the case notes. It cannot be substantiated that the family were ever contacted by the Youth and Family Team. During this period, Child N was seeing the Relate Counsellor through school.

3.4 When Child N was 15 years and 11 months, a pupil at school reported that Child N had confided in her that she had taken an overdose of paracetamol tablets. A senior Learning Mentor spoke with Child N who denied saying this to the pupil or that she

had taken the tablets. Child N did say that there had been an argument at home about Facebook because she had sent postings indicating that she was gay although this was not true. The school spoke with MN who advised that she had also discovered an email to Brook Advisory Centre which Child N initially said she had sent on behalf of a friend but later stated she thought she might be pregnant.

3.5 Shortly after Child N's sixteenth birthday, MN contacted the police. MN reported that that Child N had returned from school with a swollen face and that she was reporting this because in the past Child N had made allegations about MN physically harming her and she wanted it documenting. As a consequence, a police officer spoke with Child N who said the visible slight swelling was due to putting on make-up and rubbing it off. The chronology shows that Child N fought with another child in school that day.

3.6 In preparation for Child N's transition to college, the school had shared information with the college that Child N was a pupil who needed support. The college met with the school who shared that Child N had a history of fabricating stories and had stolen from home.

3.7 Shortly before the GCSE exam period, Child N told staff in school that she had discovered the existence of a paternal half sibling on Facebook by chance. Child N said she felt unsettled by this as she wanted to get to know the half sibling without establishing any contact with her birth father. The day following this disclosure there was a dispute at the family home which was attended by the police. The dispute did not involve Child N or any other child. Information was shared with Children's Social Care, the health visitor and school nurse. The school nurse shared the information with Child N's Learning Mentor.

3.8 Child N successfully finished her senior school. MN shared with the independent Author photographs of Child N taken on the day of her school leaving prom which show a vibrant young girl for whom leaving school was being celebrated as an important milestone by her family.

3.10 During the school holidays, aged 16 years and 8 months Child N was reported as missing to the police for the first time by SFN at 2.45pm. SFN reported that Child N

had been seen leaving the family home that day at 1pm with a bag of clothes and that earlier she had been challenged about smoking and checking her Facebook page. Child N returned home the following day safe and well, however, when a police officer went to speak with her, she refused to say who she had stayed with, only giving the general area.

3.11 Child N began college to study engineering after the school holiday. A Pastoral Mentor was assigned to establish a support plan with Child N, and it was agreed that Child N could access 1:1 weekly support and would also benefit from careers advice. A week into college at the first 1:1 session, Child N indicated that she was settling into college and had aspirations to go to university. At the second 1:1 session, Child N talked about her aim to join the army as an officer in the Engineering Corps and about her family life. The Mentor described Child N in her recording of the meeting as very gregarious and happy with her life just now. They agreed that keeping to a weekly timetable for sessions was not necessary but that Child N could access the Mentor whenever she needed the service.

3.12 During the first four/five weeks of college, all indications were that Child N had settled in well and managed the transition better than had been anticipated. She represented the college as a student ambassador, a position for which she was successfully interviewed, and was seen as having done this exceptionally well. Child N did express an interest in changing course to photography but as this was over-subscribed, agreed it best to remain where she was.

3.13 Five weeks into the term, Child N did not attend college without notification. Child N's Personal Tutor tried to make contact with Child N, and after failed attempts to do so, copied MN into an e-mail sent to Child N. MN subsequently contacted the Personal Tutor and advised her that Child N had run off after stealing money from her parent's company bank account. MN stated that she thought Child N was with a group of people from a specific place in Manchester who were into smoking cannabis. MN said that the family were very anxious about MN but from monitoring her Facebook activity they did not believe her to be at serious risk. MN explained that this had become a pattern of behaviour and they expected she would return home shortly.

3.14 One week later, Child N did re-attend college but left after the morning session before the Personal Tutor could get to see her. The following day, MN contacted the Personal Tutor to say that Child N had not been seen in over a week. The Mentor contacted MN and asked for any contact details for Child N. The following day, Child N met with the Mentor. The Mentor asked that she contacted MN which she agreed to do but stated that she had an appointment with Connexions the following day to discuss temporary accommodation. Child N agreed to continue with college and restated her desire to transfer to photography when possible.

3.15 That same day, Child N attended Positive Steps, the Connexions Service in Local Authority 1. Child N stated that she left the family home after an argument and had remained estranged staying with friends and boyfriends family for a week. Child N said she had no money or food and no one with whom she could permanently stay. It was established that Child N could stay with a friend that night and an arrangement was made for a food parcel to be delivered. Child N was advised to present at Housing Advice the following morning and to call back to Connexions after that to review the financial benefits entitlement. Also that day, Child N attended the local Centre for Sexual Health. After hearing Child N's circumstances, the Vulnerable Young Person's Support Worker contacted Positive Steps and was advised of the plan in place for Child N.

3.16 Child N went to Housing Advice as agreed and stated that she did not want to return as MN had 'thrown her out' and assaulted her, so she needed support with accommodation. MN was contacted and stated that there was an issue over money going missing and it was recorded that MN advised that Child N could not come home at that time. (*Note that MN told the Independent Author that this call came as she was en route to a trade fair some distance away, and that her family income relied heavily on attendance at the bi-annual trade fair. MN said she told the caller that she would be available on Monday as she believed that Child N was aware of the significance of that weekend).* A Supported Lodgings placement was arranged for Child N for the weekend. Child N then went back to Positive Steps and updated the service on what had happened. The Service tried to make an application for a Crisis Loan but Child N did not return to complete this process.

3.17 A meeting was arranged by Children's Social Care for the Monday morning which was attended by Child N and MN. It was agreed that Child N would return home that day with support to be put in place by the Families First Outreach Team. The Family First Team attended two meetings with Child N just over a week later. Firstly with college, where despite an e-mail stating that she was considering taking a year out of college, Child N agreed to continue with the engineering course with support to catch up on missed work. Secondly with Positive Steps Child N asked for support to complete a C.V. and finding part time work.

3.18 Sixteen days after returning home, MN contacted the police to report Child N missing. MN expressed concern that Child N was naïve for her age and might be at risk of crime or sexual exploitation. A police officer attended the home and spoke with FN and SFN who stated that Child N had previously been missing for a period of nine to ten days by staying with various friends and refusing to return home and that this had not been reported to the police as the family had known where Child N was. On this occasion however, they reported that Child N had taken clothes and emptied her school bag onto the bed leaving a packet of 32 paracetamol of which two had been used, and a bottle of 20 paracetamol of which only 6 remained. The police officer recorded that there was no evidence to suggest, or concerns being raised, that Child N had either taken the tablets or threatened to do so. The police officer completed a risk assessment which was determined as being low.

3.19 The day following the police report Child N attended the Centre for Sexual Health. Child N told the staff that she was homeless and would not disclose any address. The Nurse passed this information on to Positive Steps who contacted the Families First Team but was unable to get a reply. The Positive Steps Worker also left a message on Child N's mobile phone number to make contact.

3.20 Child N was found by police in a park four days after the missing report in the company of a young person who was three years younger, missing from care, and about whom there were concerns of risk of sexual exploitation. The police ascertained that both girls had been hanging about the Urbis area of Manchester which is a known hotspot for sexual exploitation. The information given to the Police Officers resulted in a multi-agency strategy meeting in respect of the accompanying child eleven days after the girls were found. This meeting was attended by the social

worker for the accompanying child and also the social worker that was allocated to Child N the day after being located. The social worker for Child N stated that she had spoken to Child N about taking the accompanying child into Manchester, and that Child N accepted it was not right and would not do this again. It was agreed from the meeting that Child N's social worker would need to speak with her again regarding going to the URBIS and potentially putting herself at risk.

3.21 Child N stated that if she was taken home she would run away again. Children's Social Care determined that Child N was a 'child in need' by definition of the Children Act and arranged for her to stay at a semi-independent accommodation whilst a supported lodgings placement was secured. Child N was allocated to a social worker. Child N advised that she intended to take a year out of college. The Positive Steps Team tried to counsel Child N into education, employment or voluntary work, but Child N struggled to commit to a particular plan. The service continued to support Child N. A Core Assessment was conducted by Children's Social Care which concluded that Child N should remain in supported lodgings until such a time as she was able to live independently as MN was not open to reconciliation. Child N was also located with a child missing from care the following day, a child who was at known risk of Child Sexual Exploitation and frequented the Urbis area in the City Centre.

3.22 The social worker contacted MN to arrange to collect Child N's belongings. Social work records indicate that MN said she wanted nothing to do with Child N. Child N was placed in Supported Lodgings aged 16 years and 9 months with a first time Supported Lodging Provider. During the time that Child N lived in the Supported Lodgings Placement she attended different Accident and Emergency departments at three different hospitals. The first occasion was in Local Authority Area 1 and was for treatment for a foreign body in the eye, the second occasion was the following day at a city centre hospital with an ankle injury, and the third occasion was in Local Authority Area 2 with a cut to an arm sustained on New Years Eve whilst intoxicated.

3.23 The Supported Lodgings Scheme had in place an agreement whereby young people were permitted to stay out up to three nights per week without permission being necessary. Seven weeks into the placement, Child N left the property after an

argument and the Provider alerted the social worker that she had refused to return. The following week, Child N advised the social worker that she was moving to live with TT in Local Authority area 2. Although the social worker warned Child N of the potential pitfalls of this plan, no further actions were taken by the social worker to establish any information about the person Child N was going to live with, to discourage this course of action, to ensure Child N was safe and supported after this conversation. Child N left the supported lodgings placement aged 16 years and 11 months and there was no further contact between Child N and the allocated social worker.

3.24 TT's home was the tenancy of his grandmother who had been in hospital for a substantial period of time. The day after Child N moved to this property an ambulance was called just before midnight, Child N was taken to hospital and presented with an accidental overdose of LSD. Child N informed medical staff that she had a diagnosis of bi-polar disorder and also that she thought she may be pregnant which was not confirmed after a test. TT attended the hospital with Child N, and she was reluctant to remain for assessment without him. It is noted that TT was escorted from the hospital by security although the reason for this is not recorded. The hospital undertook routine safeguarding screening with Child N who stated she was safe living with TT. Child N was offered a referral to a Substance Misuse Service but declined this.

3.25 Approximately three weeks later, Child N attended a GP new patient consultation with a Practice Nurse. The consultation provided was a thorough physical health check however her more general welfare circumstances were not established. The following day, Child N attended an out of hours GP service with back pain. Child N told the GP information that was not shared in the consultation the day previous, namely that she had been taking TT's antiemetic medication for three weeks because of vomiting.

3.26 Two days later Child N saw a GP at the surgery she had registered. This consultation discussed three issues, contraception, depression and a suspected urinary tract infection. Child N stated she had low mood, and was tearful at night. The GP record noted that Child N stated she had a *'previous medical history of bipolar'*. The GP

established that Child N had no thoughts of self-harm and began a course of anti-depressant medication - citalopram, a course of antibiotics and further urine analysis. The GP also made a referral to a primary care psychology service. An appointment was made for Child N with psychology service at the surgery, this was however cancelled when the practitioner was off sick and the appointment was not rearranged prior to the critical incident. Child N returned to the surgery the following week and saw a different GP. Child N explained that the urinary tract symptoms had not dissipated and that she was not feeling any benefit from the anti-depressant medication. Child N was advised to continue with both courses of medication.

3.27 Approximately one month after Child N moved to live with TT; TT received a visit from a Young Fathers Project Worker. TT was engaged with the service as he had a child to a previous partner who was subject to a Child Protection Plan. The Worker met with Child N during this visit and did not observe anything to cause concern. Child N had presented as chatty and supportive to TT. A second visit was made one month later. It is clear from the descriptions of the property that the home was being used by various young people and it presented as untidy and unclean. The worker was however reassured by a second observation of Child N and TT that there were no obvious signs of domestic abuse or unhealthy relationship dynamics.

3.28 One week after the second GP consultation an ambulance was called to the address of TT; it was reported that Child N had taken an overdose of TT's prescribed medication. Child N was just 17 years old. The ambulance crew made a referral to Children's Social Care in Local Authority Area 2. The ambulance service advised that Child N has tried to kill herself after an argument with her boyfriend and she stabbed herself with his insulin pen. The crew had noted that Child N had a large bite mark on her arm that she said had been caused by her boyfriend, along with evidence of old cuts to her forearms and when asked about this stated that she and her boyfriend cut each other.

3.29 Child N was taken to hospital and admitted to the Emergency Assessment Unit for treatment. TT attended the hospital. The Unit requested that the Mental Health Liaison Team (MHLT) assess Child N once she was deemed medically fit for assessment. Child N remained in hospital overnight and then left the hospital

without being formally discharged the following afternoon. The hospital contacted the police to report that Child N required an urgent mental health assessment, and that having spoken to her by telephone she was at the home of TT but refusing to return.

3.30 A Police Officer attended the address; Child N agreed to return to hospital and was accompanied by the Officer. It was noted that the address was the tenancy of TT's grandmother who was in hospital but appeared to be being used by all of his friends. Child N chatted to the Officer and said that she had been in a relationship with TT for nine weeks and that she had taken the overdose following an argument about money. The argument resulted in TT refusing to take his Insulin medication and attempting to leave the house. Child N stated that she had tried to stop him and a struggle ensued during which TT had bitten her on her upper left arm, Child N punched TT on the back, and he then slapped her face before leaving. When Child N realised that what she had said to the Officer would lead to TT being arrested for assaulting her, she refused to provide a statement of complaint to the Police or allow her injuries to be photographed. Child N did, however, allow the officer to see the bite mark, which was described as a 3 cm bruise to her arm. Child N told the Officer that this was the first time that 'anything like this' had happened between them and she did not want anything else like it to happen again. Child N was adamant that she wished to stay in a relationship with TT and continue to live at his grandmother's address as she 'had nowhere else to stay'. Child N described TT as suffering from schizophrenia, depression and bi polar and a person who also smoked cannabis on a regular basis. The Officer completed a child concern risk assessment which was graded as medium risk and a crime report was created. The Police incident log recorded this incident as both a domestic incident and a concern for a person under 17 years. Following a discussion with the Multi-agency Safeguarding Hub, the Police made a referral to Children's Social Care in Area 2.

3.31 During the assessment by the MHLT, Child N reported two previous incidents of self-harm in the past two years both following arguments with her mother, firstly an overdose of paracetamol and ibuprofen, and secondly an attempt to hang herself. Child N reported that neither incident resulted in medical intervention. Child N further stated that she had a previous history of deliberate self-harm via self-

laceration as a means of managing her emotions. With regard to the presenting issue, Child N stated that she had suicidal intent 'at the time' but on reflection stated that it was a 'stupid' thing to do. The assessment concluded that Child N had good insight into her mood and mental state. Child N disclosed some questionable lifestyle choices with regard to aspects of her relationship with TT but it was concluded that she had capacity and is fully aware of the consequences of their actions. The MHLT agreed that Child N could be discharged to the care of the GP, with advice to attend follow up planned appointments at the surgery and for the Emergency Duty social work Team to liaise with the previous social worker team with a view to transferring support now she has moved.

3.32 The Emergency Duty Team in Local Authority 2 had been in liaison with the hospital throughout the incident. Liaison with the Emergency Duty Team in Local Authority 1 revealed that Child N remained an open case. The overdose and alleged assault was discussed at the Multi-Agency Safeguarding Hub in Area 2 once usual business hours resumed. The referral from the Ambulance service to the Emergency Duty Team was the first occasion that Children's Social Care in Local Authority 2 knew that Child N was residing in their area. Local Authority 2 advised Local Authority 1 that they needed to make a formal referral. Despite Child N remaining an open case, Local Authority 1 took no action in relation to the information that Child N had taken an overdose and was a suspected victim of assault. No contact was made with Child N and no transfer arrangements to Local Authority 2 were put into motion. The case was closed one month after the incident with no consultation with other agencies and no attempts to establish Child N's current welfare. Local Authority 2 closed the contact without establishing that Child N's needs had been pursued and met.

3.33 TT was arrested by the Police on suspicion of assault. TT conducted a no comment interview in relation to the suspected assault. Whilst TT was in Police custody, Child N was visited again by a police officer to establish if she would make a statement of complaint which she refused to do. TT was released later that day after the Duty Inspector decided that the case did not meet the threshold for referral to the Crown Prosecution Service for a charging decision to be made. No further police action was subsequently taken.

3.34 Following discharge from hospital, Child N was contacted by the GP practice and asked to attend a GP appointment. Child N saw the GP she had seen at her second GP appointment at this GP surgery. The citalopram dosage was doubled and an analgesic was given for back pain with 100 tablets prescribed. The GP record does not indicate that the attempted overdose and attendance at hospital was discussed. Later that evening, an ambulance was called for Child N by TT because of chest pains. Child N was taken to hospital and discharged.

3.35 Ten days after hospital discharge, Child N was visited by a member of staff from the Vulnerable Young Person's Team (VYPT) following a referral from the hospital at the last admission. The remit of this team is to provide public health, social and emotional advice and/or interventions to young people up to the age of 19 years who may not be accessing mainstream services. A health assessment was conducted which agreed that Child N would be referred to a counselling service for young people. A referral was made to this service however; the VYPT Nurse was advised that the waiting list was 8-10 weeks for an initial meeting.

3.36 Three weeks after the hospital discharge, Child N attended the GP surgery and saw a third GP. Child N was accompanied by a male friend; this is likely to have been TT. Child N explained that she was low in mood and crying herself to sleep every night, that she had thoughts of self-harm but no plans. The GP asked Child N about her social history, and Child N described TT as her 'carer'. The GP noted that a previous psychology appointment had been cancelled by the service and made the decision to refer Child N to the adult mental health team. In response to this referral, a Community Mental Health Nurse tried to telephone the GP but as the GP was on holiday requested a return call once the GP had returned. A letter was sent to the GP by the Adult Mental Health Services advising that a full mental health assessment had been undertaken by the MHLT after Child N presented with an overdose and that an appointment would be offered if the GP felt that Child N's circumstances had changed in which case the GP should re-refer.

3.37 Child N attended a further GP appointment six weeks after hospital discharge. On this occasion, Child N saw a different GP to any she had seen previously. A citalopram prescription was re-issued and it was noted that Child N had a forth coming

physiotherapy appointment to review her back pain. A further visit by the VYPT Nurse two days later noted that Child N remained concerned about her mood and it was agreed that a referral would be made for counselling to an alternative provider. Child N did not attend the scheduled physiotherapy appointment.

3.38 The Housing Provider who had responsibility for the property that TT was living in was contacted by the police and neighbours expressing concern about people staying at and visiting the address. The Housing provider had no knowledge that the tenant had been in hospital for several months or that TT was living at the address. A joint visit was undertaken by a representative of the Housing Provider and the police. The property was in an unsatisfactory condition and TT was advised that this would need to be rectified with a further check being made in a few days. TT advised that she would like to take over the tenancy and was advised that this was highly unlikely. The Housing Provider followed this visit by trying to establish contact with the grandmother's social worker and TT's parents.

3.39 Three days later the critical incident occurred, Child N was 17 years and 2 moths old. The ambulance was called on a Saturday morning. The information that was subsequently gathered by the police established that TT had attended at the hospital shortly after Child N's arrival. TT told hospital staff that he had found a packet of pain killing tablets were missing from his bedroom and he suspected that Child N had ingested 15 tablets. He stated that Child N had 'fitted' the previous evening so he had put her to bed where they both slept. TT stated that he woke the following morning to find Child N fitting, foaming at the mouth, drenched in urine and had vomited. TT called an ambulance and asked a friend to help carry Child N downstairs. On this occasion, the ambulance crew did not raise a safeguarding concern.

3.40 During the subsequent police investigation, it was established that TT's address had been used as a haven for disaffected young people. A police search was conducted and two young females were discovered at the address, both were believed to be under the influence of alcohol and drugs and one reported as missing from home. Drug taking, both illegal and prescribed drugs was described as common place and it was discovered that another vulnerable young person had been taken to hospital with an overdose four months earlier having taken drugs and alcohol supplied and

prescribed to TT. This matter was referred to the Crown Prosecution Service for consideration of criminal charges to be brought against TT in respect of supplying or possession of controlled drugs. A decision was made that there was insufficient evidence to charge him with either offence.

4. Analysis

The examination of single and multi-agency working leading up to the precipitating incident of this Serious Case Review has identified several aspects of single and multi-agency learning. Where an issue of single agency practice is identified as an issue of concern and the relevant single agency has made a recommendation to address this, the recommendation is referenced in bold typeset. The table of single agency recommendations is referenced at the end of the report.

4.1 From the information known to agencies and supplemented by the contribution of MN, it is clear that Child N experienced a turbulent adolescence which at times overwhelmed her family's ability to cope. Child N had no relationship with her birth father following a separation with her mother before she was born. MN described how her next partner was aggressive and how she, Child N and her second child experienced fearful occasions when he would harass them at their home after their separation. MN recalled that Child N became very protective of her and struggled, feeling somewhat misplaced when after some years alone she met Child N's step-father. MN recalled how around this time, and still in primary school, Child N stole something from a shop and MN tried to deter her from doing this again by taking her to a police station to underline the seriousness of what she had done.

4.2 As Child N entered adolescent years, MN described aspects of her behaviour that caused her to become exasperated. MN described how Child N fabricated stories to make herself 'interesting' to her peers, stole money – small amounts at first leading up to amounts of £50, pushed boundaries from an early age with make-up, cigarettes and alcohol and would then swear it was not her when they both knew it was. MN said that the school were extremely supportive and that she worked closely with the Leaning Mentor to keep Child N on a safe pathway. To this end, MN considered, and the information from agencies would suggest, that once Child N lost

the structured environment of school her risk taking behaviour became much more erratic.

4.3 Child N was extremely well supported by her senior school, who worked in a close partnership with MN on both educational and welfare issues. During her school years, Child N frequently accessed a counselling service provided by Relate which was commissioned by the school. The information from Relate shows that Child N used the service during each school year and generally talked about friendships, bullying and her family life. Child N did talk in one session about a family dispute; this information should have been shared with other agencies. The SAAR report from Relate states that 'it *was safe to believe that the police would have referred the case to Social Services for assessment in the event that a risk of harm was identified*'. The recognition and response to domestic abuse has been a progressive issue in child protection over the past 20 years. In 2008, witnessing domestic abuse for children became a specific category of significant harm as defined by the Children Act 1989. The extent of the problem is now overwhelming agencies, and there is a danger of practitioners becoming de-sensitised to the issue by perhaps seeing as a norm of behaviour in working with families at a high threshold of need. Successive Child Protection Enquiries and Serious Case Reviews have driven home the point that no agency should assume the actions of another, and should always share information that could be suggestive of risk to a child. In this case, although the police did share the information with Children's Social Care and health, the information was provided to the school several weeks later by the school nurse. Significantly, the information told to the counsellor was the only information that confirmed that Child N knew of the incident and that it had an impact on her. Sharing this information at an earlier stage could have provided an opportunity to discuss the impact on Child N with MN.

SCR Recommendation to Relate: *To ensure all counselling staff have a complete understanding of the need to share information that could have safeguarding implications for children and never to assume that responsibility has been adopted elsewhere within the safeguarding systems.*

4.4 The senior school had a good understanding of Child N and recognised an emotional vulnerability which they shared with the college she was planning to attend. The

college attended a meeting with the school to establish the areas of vulnerability in order to plan for her support needs. When Child N began college two things became significantly different to the support she had benefited from in school. Firstly, that the school had worked in partnership with MN and secondly that the Mentor, pleased with Child N's initial settling in period, was reassured that the structure of support could be removed at very early stages. The college have recognised through the SAAR that at the point attendance deteriorated for Child N, they could have been more questioning and contacted agencies to advocate on behalf of Child N and seek their assistance in keeping Child N in college. For parents, the transition from school to college is significant, not least because far more emphasis is placed on the young person to share information and there is far less direct contact from the staff. The loss of a well-established partnership with the school would in itself have had an impact on MN's ability to work through the difficulties of Child N without a network of support.

4.5 MN stated that she had frequently contacted Children's Social Care in Local Authority 1 and two contacts are recorded in their records to this effect, seeking help with the management of Child N. When a Youth Worker was allocated to the family after a Section 47 investigation, the case was closed with no contact having been established. Significantly the case closure details no specific attempts either by telephone or letter at contacting the family or other agencies such as school if this could not be achieved.

See Area 1 Early Help Service Recommendations 1,2,3,4

4.6 The next substantial contact with Children's Social Care occurred after Child N had been reported missing for a second time by the police. On this occasion, Child N returned home with the addition of a service from Families First Team. MN recalled this meeting and considered that as a family they were made promises about support that did not materialise. The records show that a worker from Families First supported Child N to attend two appointments, made one visit to the family home to see both Child N and MN, and had approximately ten telephone contacts with MN. Ultimately, just over two weeks later, Child N became missing again. MN is honest in stating that at this point she was overwhelmed by the stress that Child N's behaviour was having on family life, and that the three younger children were now suffering

because their parents were constantly distracted by Child N. MN described being at the end of her tether, and considered that she had tried many different strategies to support Child N but to no effect. On this basis MN did not oppose Child N when she said she would not return home and hoped that over time their relationship would repair.

4.7 When Child N presented as homeless to Local Authority 1, she was provided with temporary accommodation and then introduced to a supported lodgings placement. At this point, Child N and her family were adrift, she had stopped attending college was therefore NEET (not in employment, education or training). Children's Social Care undertook a Core Assessment which stated that Child N needed supported accommodation until she was ready to live independently. Although Child N had had difficulties throughout adolescent, in the space of only six weeks she had gone from being a young girl with some noted degree of vulnerability, but who was considered to be happy and prospering in college, to a young girl who became highly vulnerable with no support network, no structure and no economic means. The Core Assessment that was completed in respect of Child N had significant limitations and it is difficult to see how the assessment sat within the overall approach to the case, it did not address Child N as a child of her wider family and failed to reach an understanding of the family functioning from which social work intervention could have addressed what was needed for Child N to live with her family again. Specifically the assessment focussed on homelessness as being the presenting issue of concern. In 2009, an appeal upheld in the House of Lords (G vs Southwark) changed previous case law and as such became a landmark ruling when considering the circumstances of children presenting as homeless. Effectively the ruling affirmed that if a child meets the criteria for accommodation in Section 20 Children Act 1989, that the accommodation should be provided under that provision and Local Authorities may not choose to provide accommodation for lone children under other powers unless the child themselves have been appropriately advised of their entitlements and being capable of making an informed choice, refuses such provision. It is clear that Child N was assessed at that time as having no person prepared to exercise parental responsibility and as such a duty had arisen and the Local Authority was not entitled to side step that duty by simply providing accommodation under

another process. Giving due regard to the implications of this judgment, Child N was entitled to support under Section 20 of the Children Act 1989 but she was never advised of this entitlement. There is no indication throughout all the information that was known about Child N that Children's Social Care ever considered the possibility of using Section 20 of the Children Act to alleviate Child N's circumstances, or that any other agency challenged their decisions not to do so.

See Area 1 Children's Social Care Recommendation 3

4.8 The impact of not recognising Child N to be entitled to receive services under Section 20 of the Children Act 1989 was compounded by the fact that although she was determined as having a Child in Need status, no usual Child In Need Processes were followed. No multi-agency meeting was ever convened and no Child In Need Plan was drawn up for Child N. In addition, there is no indication of any social work interventions at this stage other than assisting with the move to a supported lodgings placement. Had Child N become formally looked after under Section 20, a number of processes would have occurred which would have enhanced her welfare. This includes the appointment of an Independent Reviewing Officer, the requirement to have a looked after children care plan and a greater emphasis on understanding the circumstances that led to her becoming looked after which may have assisted any potential for reconciliation with her family. The absence of adhering to established multi-agency procedures resulted in each agency working with Child N in isolation and missed opportunities to share information about Child N's whole circumstances.

4.9 The effect of the move to supported lodgings without any multi-agency process in place was that Child N was left to do her own thing at 16 years and 9 months and find her own way through an early transition to independence. Effectively she went from a situation where a parent was struggling to exert control and boundaries to one where there was very little. The supported lodgings scheme was a provision that was managed in the main through one worker. Access to information kept on Providers suggests that the recruitment of Providers was focussed on the physical provision of accommodation as opposed to the availability of emotional support and guidance. Although it was stated that all Providers had checks completed as part of the assessment, no police check was on file for one of the Providers in Child N's case.

The assessment to become a Provider was a very limited document and focussed on the health and safety aspect of the accommodation. Child N was the first placement that the Providers experienced. It was agreed from the outset with the social worker that Child N was permitted to stay out overnight three times per week with no expectations of dependencies in place to oversee this arrangement. The Supported Lodgings Providers have provided information for this Review which states that they had no issues with Child N's behaviour other than untidiness and a tendency to leave rotting food in her bedroom and wardrobe, but they were concerned about her increasing tendency to stay away with TT. In an effort to get to know TT they allowed him to stay for tea and even stay overnight on a couple of occasions. A substantial sum of money went missing about two weeks before Child N left the placement which they believe was taken by Child N. Although there was telephone contact between Child N's social worker and the Providers, the social worker did not visit the placement after Child N moved there. Since the beginning of the Review, no further Supported Lodgings placements have been made in Local Authority 1. The Local Authority intends to revise the procedures for assessing, approving and reviewing Supported Lodgings Providers.

See Area 1 Children's Social Care Recommendation 4

4.10 MN stated that she had hoped that the social worker would help facilitate a resumption of the relationship between Child N and herself once the heat of the situation had calmed down. MN said that the day that Child N left there had been a disagreement about social media. MN had gone shopping and rang Child N to ask about an item of clothing she was buying her, Child N said at this point not to bother as she was leaving. MN said she was frantic, they had just enjoyed a weekend in London and she hoped that this was a turning point. MN recalls that she rang the Families First Team to tell them what was happening and had wanted someone to go out to see Child N but this did not happen. MN said she felt very let down by a service that had promised a responsive service when Child N had returned home. MN said that once the social worker became involved, she felt judged as a mother who was withdrawing from her daughter without any appreciation as to what the family had gone through and the fact that she had four children to consider.

4.11 It seems that TT had been known to Child N for some time. They had met each other whilst hanging around the Urbis Centre in Manchester. MN said that Child N started frequenting that area whilst she was in her last year at school. MN noticed certain changes in Child N's demeanour; she became anti-establishment, and voiced her belief that rules had no place in Society. The police SAAR notes that the Urbis area of Manchester is an area that was frequented by Child N, the associate who was missing from care when found with Child N, and TT. It has been known to the Police for a number of years that this and the area surrounding are locations which attracts a large number of young people, some of which have been identified as being vulnerable from across the whole of the Greater Manchester area. Statistics for 2014 show that 25% of all known returned missing from home children in Greater Manchester have told the Police that they have been to these areas whilst missing. As a result there is presently ongoing police and multi-agency activity which is being supported by local charities in these areas on most evenings and they are subject of enhanced regular police patrols. Further partner led multi-agency initiatives are being planned as part of a long term review of vulnerability in the centre of Manchester.

See Greater Manchester Police Recommendation 1

4. 12 Child N was at risk of child sexual exploitation although thus was not identified as a risk in the core assessment. Her circumstances were suggestive of a number of risk factors; that she was using illegal substances, that she had associations with other young people known to be at risk, that she had little adult controls on her whereabouts and that she was isolated with minimal support. Child N may well have felt trapped by her circumstances, she had stated to the police when discussing the bite mark to her arm that she wanted to stay with TT and had 'nowhere else to go'. The Review Panel was advised that older children presenting as homeless is a growing area of concern in both Local Authority 1 and Local Authority 2. Concern was expressed about the adequacy and availability of supported accommodation options, and there was a sense that each new presentation to intake services presented a challenge to resolve. In Local Authority 2 between March 2014 and January 2015, there have been 29 assessments on older children who have presented as homeless. This represents an increase from the previous year and

increasingly children are presenting at a point of crisis. A similar picture is painted in Local Authority 1 and for this reason a recommendation is made to the Boards to achieve a greater understanding of the whole vulnerability issues for older children who need accessible support and accommodation.

See SCR Recommendation 5.5.5

4.13 Child N was able to make the decision to move to live with TT without challenge. When Child N told the social worker what she was doing, there is little evidence that the social worker made any realistic attempts to dissuade her. No consideration was given to informing MN and whilst it could be argued that there was no legal requirement to do so and Child N may not have wanted this, there are occasions when determination about a child's best interest should override a child wishes, and where concern for welfare means that all possible sources of support are reconsidered. Child N was still the subject of a Child in Need plan and this significant change did not alert the convening of a child in need meeting nor was Local Authority 2 alerted to the fact that a Child In Need was moving into their area as would be expected in accordance with the North West Children in Need moving across Local Authority Boundaries 2013 guidance. The social work approach to the management of Child N as a Child in Need in Local Authority 1 is passive at best and disinterested at worst. One can only form the impression that Child N was simply perceived and responded to as having an accommodation problem which was met first through Supported Lodgings and then by TT rather than as a vulnerable child whose circumstances were extremely precarious. Given that Child N had met TT at a known CSE hotspot, he was older and offering her a home, the social worker for Child N should have been alerted to dig deeper, in particular with sceptical approach to whether Child N was being coerced, groomed or simply felt she had no better alternative before her. The approach of the social worker also raises questions about the management oversight of the case through case work supervision and assessment counter signatory. The need to improve systems and practice in respect of Children in Need has been identified by Local Authority 1 during this Review, and this has also been identified by another recent Serious Case Review in that area.

4.14 After Child N left the Supported Lodgings placement the social worker made no attempts to contact her. Such a lack of interest in a vulnerable 16 year old who was

actually a Child in Need to the Authority raises fundamental concerns about the case holding social worker, and it does feel as though Child N's circumstances were 'processed' rather than seeing the child and her life. No checks were made as to the suitability of the arrangement, no forward safety planning took place and contact became lost with Child N from Children's Social Care in Local Authority 1. Had Child N had received genuine social work intervention, there was every likelihood that she could have been supported to remain in college and regain a relationship, even if not to live, with her family. Child N received a very poor social work service which may well have contributed to her ongoing choices.

4.15 Given what is now known, it is likely that Child N had started to use illegal substances in her last school year and this increased to a greater need/dependency from the summer holidays onwards. Moving to TT gave Child N greater access to illegal substances and an environment to use without the knowledge or challenge of a responsible adult. TT is known to have longstanding physical and mental health issues and from moving to live with TT her increased access to health services suggested a similar pattern was emerging. The first hospital presentation for Child N was the day after she moved. Child N was 16 years; she advised that she had been living with her boyfriend who she had known for two weeks and had accidentally overdosed on LSD. During the assessment, Child N was asked three routine safeguarding questions which are:

- Do you look after anyone at home
- How often do you drink 6 units or more of alcohol
- Have you ever been hurt of felt frightened by anybody you know

The answers to the above questions raised no concern and once medically fit Child N was discharged to TT's address. The questions are generically applied to help assess vulnerability, in Child N's situation however, the information she gave outside of the questions should have raised greater concern about her vulnerability. There is a danger of relying too greatly on prescribed processes which are general when a greater reliance should be placed on bespoke situations. It would have been proportionate to refer a concern for welfare for a 16 year old who presents with a drug overdose but refuses a referral to a drug service, states she is living with a

boyfriend she had known for only two weeks and reported a non-medicated bi polar diagnosis.

4.16 The Review Panel and Practitioners meetings have spent considerable time in trying to understand how Child N spiralled into increased vulnerabilities in particular given the attempts by various medical services to reduce them. Having already stated that Child N became lost to Children's Social Care Services at the point she moved, she did become increasingly visible to medical services for both physical and emotional health issues. Child N's health screening when she registered with a GP was thorough from a heath perspective, yet although she was still only 16 years old, her domestic circumstances were not considered. The presentation at hospital and the initial Heath consultation both beg the question as to whether Child N was being perceived by professionals as a child. On both occasions, she was still 16 years, yet she appeared to be viewed as a young adult whose circumstances were private with no right to question. Child N is described as a child who was very articulate by those who knew her best; however, they also stated that her verbal articulation masked an emotional immaturity. This suggests that Child N presented as older than her years, but functioned at younger than her years.

4.17 When Child N first attended a GP appointment at the surgery where she registered, she was prescribed an anti-depressant medication, citalopram, initially being given a two week supply, and also referred to a primary care psychology service. Both courses of actions are more recommended for adult patients, again suggesting that Child N's child status was not a dominant factor in the consultation. Current National Institute for Clinical Excellence (NICE) Guidance 28 advises that for those under 18 years, citalopram should not be used as a new therapy, and favours an alternative drug of fluoxetine. The guidance goes on to state that citalopram should only be used when:

- That child and their parents/carers have been fully involved in discussions about the likely benefits and risks and have been provided with written information
- The child's depression is sufficiently severe and/or causing serious symptoms to justify a trial of another anti-depressant
- There is clear evidence that there has been a fair trial of fluoxetine and psychological therapy

- There has been a re-assessment of the likely causes of the depression and of treatment resistance
- There has been advice from a senior child and adolescent psychiatrist – usually a consultant
- The child and/or someone with parental responsibility for the child has signed an appropriate and valid consent form.

Both citalopram and fluoxetine are drugs that selectively inhibit the re-uptake of serotonin in the body, and they are termed SSRIs (selective serotonin re-uptake inhibitors) however, through clinical trials, only fluoxetine has been shown to be effective in treating depressive illness in adolescents, whilst citalopram have actually shown an increase in harmful outcomes.

A GP attending the Learning Event from the GP practice was confident that citalopram was an appropriate prescription, however, the opinion of the NHS Commissioning Group SAAR and the independent psychiatric opinion commissioned for this review was at odds with that perspective. The Independent Psychiatrist provided an opinion that the prescription of anti-depressants was not appropriate when Child N was also presenting with physical symptoms that could have affected her mood and therefore should have been treated before considering medication.

See NHS Salford CCG Recommendation 1

4.18 The referral to primary care psychology services did not proceed because the worker was unavailable, nor was it re-established prior to the critical incident. Given Child N's age however, a more appropriate route for referral would have been the Child and Adolescent Mental Health Service. This Service is designed to meet the needs of adolescents and would have been in a better position to consider Child N's whole circumstances and offer challenge about her support needs to Children's Social Care.

4.19 Child N did have a mental health assessment when she stated she had deliberately overdosed on TT's insulin medication and showed some signs of physical injury. This was approximately eight weeks before the critical incident. The hospital acted robustly by contacting the police to seek Child N's return to the hospital when she left without assessment and this was achieved by the intervention of the police. Greater Manchester West Mental Health Services have responsibility for the MHLT that undertook the mental health assessment. During the Review the Trust found the

assessment to be very comprehensive and this is supported by the view of the Independent Psychiatrist. The Independent Psychiatrist comments however that even a robust assessment in Accident and Emergency is of limited efficacy in terms of both mental state examination and risk assessment without adequate community follow up and that given Child N's reported previous significant attempts of self-harm and the evidence of early relationship difficulties, very close monitoring and intensive follow up arrangements in the community setting should have been established. The Independent Psychiatrist concludes that the robust mental health assessment could not stand alone as a comprehensive assessment of Child N's needs and that an urgent referral to the CAMHS service should have been made with a multi-agency approach and Care Planning Approach.

See *NHS Salford CCG Recommendation 2*

4.20 The risk management plan put in place by the MHLT included a referral to the Vulnerable Young Person's team and a discharge to the care of the GP. The Team could have referred Child N to a CAMHS Team EMERGE who work specifically with 16 and 17 year olds and follow up assessments within seven days on an Accident and Emergency attendance, but it is stated that they were not aware of this specific service. The attempt by the GP to refer to the Community Mental Health Team was never resolved through discussion between the two services, and given that this was four weeks before the critical incident this was a missed opportunity to discuss in depth the needs of Child N and how they could be best met.

4.21 The police SAAR considers that the police activity in returning Child N to hospital and initiating an investigation of assault to Child N provided an opportunity to take a firmer protective stance. Whilst vulnerability in two areas was recognised, that being a concern about a young person under 17 years and a domestic incident, and the triage of this incident went through standard police processes, the process failed to consider what was known about TT's history or the total safeguarding history in relation to both Child N and TT available from police systems. This happened because the concern about a young person under 17 took precedence, as was standard police procedure at the time, which meant that risk assessment procedures in relation to domestic abuse was not completed. Had this incident occurred four weeks later, the police response to the domestic incident coding would have

reflected the fact that the Home office definition of a domestic violence incident was changed so that young people aged 16 and 17 years would be included and the definition was changed in order to capture coercive control. The police SAAR concludes that the oversight of the Public Protection Unit did not comply with police procedure for two reasons, that the totality of the risk assessment was not adequate because it did not consider all available information and secondly that no supervisor review was completed before the incident was signed off. In short, although faith was placed in the fact that a referral was made to Children's Social Care, information available to the police that suggested the presence of particular risk factors for TT was not considered or analysed. Had a complete risk assessment been undertaken, then this could have led to the convening of a Strategy Meeting where information would have been shared and analysed across agencies.

See GMP Recommendations 2, 3

4.22 The Vulnerable Young Persons Team made two visits to Child N after her hospital discharge. The team was however working in isolation from other services who either were or should have been working with Child N. The service had no contact with the GP and two referrals for counselling services at the same time as the GP surgery was seeking a further mental health assessment. On the first visit, Child N stated that she did not want her social worker to be contacted and the Nurse respected this although understood from hospital records that Local Authority 1 had been informed. There is no specific comment in the records about Child N's living conditions, although the police and Housing Provider found them to be unsatisfactory only days after the second visit.

See Salford Royal Foundation Trust Recommendation 1

4.23 No agency or professional grasped the need to work together for Child N and ensured that this happened. There can be no doubt that Child N's circumstances were deteriorating, and despite having had direct contact with the hospital, GP, Vulnerable Nurse Team, and her circumstances becoming known to Children's Social Care in Local Authority 1 and 2 no firm intervention was taken to assess and plan for Child N's needs.

4.24 Agencies were asked to consider whether and how well the voice of Child N was heard. Without Child N's contribution, it is difficult to know what she wanted from

her life and whether that changed over time or whether she considered herself to be trapped into certain decisions for some reasons not known. Generally agencies felt that in individual issues, Child N's voice was present in their decisions and actions, but there are some significant omissions. Child N was not advised that she was entitled to services under Section 20 of the Children Act 1989 and what this might have meant for her, she was therefore denied this opportunity. When Child N was discharged from hospital after the stated overdose she wanted to see a counsellor but a service could not be accessed for her in a timely way. On occasions, Child N was permitted to make life changing decisions without any guidance such as leaving college and moving to live with TT. We should not forget that sometimes children need a professional to care enough to say no and not support their choices. One of the things that MN described as very important to Child N was a long standing desire to join the armed forces. MN described how she wanted to avoid labelling Child N through earlier potential medical processes because she did not want any barriers to stop Child N achieving her goal.

4.25 Child N's last presentation at hospital was in a critical state; it was anticipated that Child N would not survive. Although there are a number of factors in relation to this incident that give cause for concern about what happened to Child N prior to being taken to hospital, at the time the hospital did not appear to have any cause for concern and focussed on Child N's acute medical needs. The hospital contacted Children's Social Care in order to trace Child N's parent. On the third day of Child N being in hospital, SFN contacted the police to report concerns about what had happened to Child N, and a police investigation ensued. The investigation is ongoing and once this is concluded, it is intended the police will submit a further report to the Serious Case Review Panel and consideration will be given as to whether there is additional learning and if so, the Overview report will be amended to reflect this.

5. **Findings**

5.1 The Review of how services were provided to Child N and her family has resulted in some very salutary realisations for agencies who would have wanted to do better and this is reflected in many of the SAAR reports. There are a number of critical points where services should have been more responsive to the needs of the family

and Child N and other points where deviation from established procedures and guidance had a profoundly negative effect on Child N's welfare.

5.2 This Review highlights a critical pathway of missed opportunities to provide better and more protective services to Child N which could have made a difference to the ongoing life choices that she made. The critical opportunities can be summarised as followed:

- Early help services should have created a multi-agency approach from which the needs of Child N and the whole family could have been considered;
- The Families First Team should have taken a more interventionist approach and ensured that Child N was better supported through the transition to college, and identified the indicators of substance abuse;
- Consideration should have been given to Child N's entitlement to become a looked after child at the point it was determined she could not live with her family;
- Determined social work intervention should have worked with Child N and MN to repair relationships to enable Child N to remain a member of her family;
- Given that Child N was determined as Child in Need by Children's Social Care in Local Authority 1, multi-agency Child in Need Processes should have been initiated and, if she was determined to move to Local Authority 2 this should have been as part of a support plan that established how her safety and welfare needs would be met;
- Child N's circumstances should have triggered greater consideration of risk of sexual exploitation from the point she was known to frequent hotspots for CSE activity, stated she was moving to live with an older male that she had met there and presented as a victim of domestic abuse shortly after moving to live with him;
- Child N's substance misuse and refusal to accept support services should have triggered cause for concern to her welfare;
- Child N should have received clinical treatment for depression in accordance with NICE guidelines;
- Following the stated overdose, both Local Authority 1 and Local Authority 2 should have been dogged in ensuring she was receiving appropriate support;

- Following the stated overdose, Child N should have had follow up community treatment and further assessment from a child and adolescent mental health service.

5.3 It is important to note the particularly positive experiences and good practice that Child N experienced. This includes:

- A senior school that understood her as a person and worked in partnership with her parent to good effect;
- Nursing staff that acted robustly when she took hospital discharge without consent in order to ensure here needs were assessed.

5.4 The Learning Event was attended by ten different organisations that had worked with Child N in the year leading up to the critical incident; some did not know of each other's existence and no one person knew the whole history of what had happened to Child N in that year. What is remarkable though is that at no point did any one agency initiate or question why there was no multi-agency plan for Child N despite the fact that this was clearly needed from the summer she left school. Practitioners undoubtedly understood the need for this and the benefits of doing so, but still there is a tendency to work alone, or at best, in contact with one other organisation. All agencies report a continual mismatch between resources and demand which has an impact upon competing priorities for time. Knowing this to be true, the Learning Event in relation to this case focussed on how resources could be used both efficiently and effectively when a multi-agency approach is taken and why this is necessary to optimise outcomes for children. The event also helped practitioners to consider that challenge and support are not exclusive concepts in multi-agency working and that all agencies need and should welcome challenge as part of maintaining best practice. Many Practitioners found the day to be extremely valuable, commenting that although they receive supervision, time pressure dictates that the accountability aspect takes precedence over any opportunities for reflective case management. Some of the lessons that practitioners stated that they took from the event are highlighted below:

- To be persistent and have tenacity
- Whole systems working is vital "no man is an island"

- Share information with all agencies no matter what organisation it is and promoting the organisation I work for and what information I can share
- To consider more thoroughly consequences of inaction
- To not presume people know information, better hear it twice than not at all
- Heightened awareness of need to listen, respond, build relationships, signpost and advocate for children
- Today I will take away thinking of someone under 18 as a child

5.5 The following paragraphs describe the key points of learning from this Review from which audits against current services and actions should be formulated:

5.5.1 ***The provision of early help services must take a pro-active approach to working with children and families and to preventing adolescent children becoming harder to help through unstructured interventions***

Child N attended her senior school for five years, during this time a good working partnership was developed with MN. Given that it was the remit of Families First to work with families to prevent family breakdown, the team was not successful in working with Child N and her family. It is disappointing that there is no concrete evidence of any attempts to work with the family at the point of emergency when Child N returned home.

The Biennial Analysis of Serious Case Review 2005 -2007, considered 10 Serous Case Review of young people aged 11-17 years. The report noted that the older children subject to reviews were well known to agencies and had profiles characterised by risk taking behaviour, substance misuse and sexual exploitation. The struggles of the young people were examined as a case study, which identified the key issues as follows:

- That early preventative intervention can prevent later entrenched problems;
- That when children's behaviour becomes a way of speaking, they need to be heard;
- The need for a holistic assessment which incorporates an understanding of the child and family functioning;
- The need to mobilise specialist services and ensure that they are coordinated;

- The need to ensure that information was shared across agencies, with plans better coordinated and reviewed.

There is a danger that support services that fall below statutory children's services are too ready to place emphasis on the parent to steer the service as a way of gate keeping or 'leaving well alone' after a crisis has passed over. However, long term sustainable change can only be achieved through a programme of planned intervention which should be led by the service.

5.5.2 ***That agencies working with children who are at risk of becoming NEET take affirmative action, and work together to prevent this occurring***

Generally speaking, the education, training or work opportunities that disaffected children receive is possibly the most crucial aspect of engagement. From a purely practical basis, children attending and engaged in education or work are less likely to turn to other forms of stimulus, and education will provide life chances that give young people aspirations for their own future. Child N was able to leave college too easily without any other form of education or employment to go to. Whilst the college knew that she had been missing from home, they never knew that she left home. At this point three agencies were involved with Child N, Families First, Positive Steps, and the college. A multi-agency approach that sought to work with Child N and MN should have been deployed to maintain her occupied position. Increased unstructured time allowed Child N to develop an unhealthy and anti-social lifestyle. The SAAR from the college of Area 1 made stretching recommendations for the college to implement their learning form this review, to initiate and maintain contacts with external agencies involved with pupils, and to continue attempts at re-engagement once a pupil has left the college without forward provision.

5.5.3 ***That to protect vulnerable adolescents, Local Authorities must exercise their duties in accordance with Section 20 the Children Act 1989 and in compliance with the 'Southwark' ruling***

Local Authority 1 could not explain why this was not exercised for Child N, but were clear that the duty was known. During the Learning Event, practitioners spoke of a perceived and latent pressure not to accommodate older children. It was agreed

however that completing good quality assessments and risk assessments was the pathway to ensuring sound decisions were made for children, and to enabling a practitioners to advocate for a child with confidence. At a time when Local Authorities have significant budget pressures, it is vital that practitioner's assessments of need focus on identifying that need are not fundamentally influenced by the pressure to rationalise resources. Other agencies also agreed it was their role to challenge on behalf of children if they consider their welfare needs remained unmet.

5.5.4 ***Where safeguarding agencies receive information that suggests a child could be at risk of child sexual exploitation, robust and affirmative multi-agency responses must be initiated to ensure all information is shared to maximise protection and options of services.***

Supporting children at risk of sexual exploitation, requires acute awareness of indicators on behalf of families and professionals, robust multi-agency systems that support information sharing, a tenacious approach from professionals to provide pathways of services for children and disruption of activity of offenders. This case is a salutary reminder of how quickly a child's vulnerability can heighten, and just how devastating the outcomes can be. Time is of the essence, agencies need to be able to respond quickly and firmly to protect children.

5.5.5 ***The LSCBs need to be satisfied that there is a range of provisions suitable to meet the needs of children who present with homeless and support needs***

There is a danger that assessments of older children's circumstances will be overly influenced by the professional awareness of limited resources. The Review must serve as a constant reminder of the true extent of vulnerability of older children even when their personal presentation does not necessarily indicate this. Homelessness is a symptom of a difficulty experienced by a child, it requires the meeting of a very basic need for shelter, which should not detract agencies form understanding the holistic needs of a child and providing the support needed to navigate the transition to adulthood.

5.5.6 ***Any child who is an open case to Children's Social Care should have a multi-agency plan and team around the child, and that all open cases of 16-18 years olds are audited against this standard***

Every child who is an open case to Children's Social Care under current threshold arrangements if likely to be either a Child In Need, subject to a Child Protection Plan or Looked After. In all of these circumstances, the child should have a multi-agency plan. Management oversight and case work practitioners must ensure that the plan is active, relevant and commonly understood by agencies working with that child. Similarly all agencies must take responsibility for multi-agency working, and where it is expected that a social worker would be the Lead Professional to challenge in instances where this does not happen.

5.5.7 ***No Children's Social Care Service should close a case or sign off a contact until they can be satisfied that all outstanding needs have been considered***

This statement seems so obvious that it should not need stating, Child N's needs however were known by two Children's Services, one to whom she was an open case and to whom she was a resident child, yet neither ensured an appropriate safety plan was in place following her first stated overdose.

See Salford Children's Social Care Recommendation 1, Area 1 Children's Social Care Recommendation 1

5.5.8 ***That a clear pathway of mental health services for 16-18 year olds is created and disseminated to all agencies that work with this age group***

This case has shown that there has been real misunderstanding amongst medical professionals about the services and treatment available and most suited to the 16-18 age group. There is no reason to believe that the misunderstandings in this case would not happen again without substantial activity to educate practitioners and clarify the established pathways of care.

5.5.9 ***That NICE guidelines on anti-depressant medication for children is re-affirmed across all GP surgeries and acute mental health services***

The issue of appropriate anti-depressant treatment for adolescents is a matter that has divided practitioners during this Review. The NICE Guidance is however unequivocal and should be reinforced for all GPs and other mental health professionals as appropriateness of the medication was not identified by the mental health assessment.

5.5.10 ***That the Board ensure every opportunity is taken through procedure, strategy and line management structures to re-enforce the message that all young people must be treated as a child in accordance with the Children Act 1989 until they attain the age of 18 years***

At the very heart of this Review has been the extent to which Child N was seen as a child. The years between 16 and 18 years present many dilemmas for professionals working with this age group. At 16 a child can marry with parental consent, can apply for state benefits in their own right and to all intents and purposes are seen as capable of making their own decisions. Under the Children Act 1989, a child is a child until they have passed 18 years, and concerns and questions about vulnerability should be responded to from this perspective. Child N was perceived as capable by most professional she met, but her choices and vulnerabilities belied the fact that she was a child growing up faster that she was emotionally able to cope with.

Appendix 1: Recommendations

Area 1 & Area 2 LSCBs

1. The provision of early help services must take a pro-active approach to working with children and families and to preventing adolescent children becoming harder to help through unstructured interventions.

2. That agencies working with children who are at risk of becoming NEET take affirmative action, and work together to prevent this occurring.

3. That to protect vulnerable adolescents, Local Authorities must exercise their duties in accordance with Section 20 the Children Act 1989 and in compliance with the 'Southwark' ruling.

4. Where safeguarding agencies receive information that suggests a child could be at risk of child sexual exploitation, robust and affirmative multi-agency responses must be initiated to ensure all information is shared to maximise protection and options of services.

5. The LSCBs need to be satisfied that there is a range of provisions suitable to meet the needs of children who present with homeless and support needs.

6. Any child who is an open case to Children's Social Care should have a multi-agency plan and team around the child, and that all open cases of 16-18 years olds are audited against this standard.

7. No Children's Social Care Service should close a case or sign off a contact until they can be satisfied that all outstanding needs have been considered.

8. That a clear pathway of mental health services for 16-18 year olds is created and disseminated to all agencies that work with this age group.

9. That NICE guidelines on anti-depressant medication for young people is re-affirmed across all GP surgeries and acute mental health services

10. That the Board ensure every opportunity is taken through procedure, strategy and line management structures to re-enforce the message that all young people must

be treated as a child in accordance with the Children Act 1989 until they attain the age of 18 years

LA1 Children's Social Care

1. When a Child in Need moves out of the borough, the Greater Manchester Child in Need transfer process must be followed prior to case closure.

2. Children's Social Care should always take account of significant history and impact on children when responding to Domestic Abuse notifications received from police.

3. 16-17 year olds presenting as homeless should always be considered in relation to the primary duty under Section 20 accommodation, pending a further assessment.

4. Supported Lodgings arrangements for 16-17 year olds who are deemed Child in Need should be subject to regular management oversight and review.

5. The voice of the child should still be heard when dealing with 16-17 year olds.

LA1 Early Help Service

1. All staff follows Step down procedures and allocation procedures.

2. Record keeping policy adherence needs to be monitored closely and regularly audited.

3. A clear engagement policy is required for early help.

4. Cases cannot be closed until management oversight has been completed.

5. Take good practice of recording referral information into the multi agency HUB.

LA1 Positive Steps

1. More emphasis could have been put upon checking and recording the emotional state of a client who is in such challenging circumstances

2. When it is identified that a vulnerable young person leaves the local authority area and becomes the responsibility of a new local authority, we should be actively ensuring that information is sent to the new LA so that the young person can immediately be supported rather than waiting for them to present at an agency

3. Liaison with other supporting agencies has been effective and we need to ensure that staff, especially new members of staff, are fully aware of the range of agencies available and how to make effective referrals to them

4. CAPIR completed with vulnerable clients; Positive Steps guidelines are made explicit to staff.

LA1 College

1. Review the process for gathering transition information from schools and ensure that references to other agencies alluded to in such information are contacted as a matter of course

2. Review procedures for information sharing and notification with other agencies.

3. Develop better understanding of the term "vulnerable young person" and expectations of service delivery.

4. Establish a procedure which ensures that attempts are made to maintain contact with vulnerable young people when they have left the organisation in order to provide a channel for re-engagement, even when communications is only possible by another agency.

LA1 Sexual Health Services

1. A review of the process for addressing the issue of homelessness in relation to young people aged 16 – 18yrs both within the Trust and across partner agencies.

LA1 Hospital 1

1. To improve documentation when action is taken to safeguard children

LA2 NHS Clinical Commissioning Group

1. Local guidance to be issued to GPs reinforcing the NICE Guidelines CG 28 'Depression in children in young people: "Identification and management in primary community and secondary care" and cascade via the GP Safeguarding Leads Forum meetings

2. Guidance to be distributed about the pathways for assessment of 16-18 year olds who present at A & E with mental health issues or self-harm

3. GP Safeguarding Children training to include;
    a. -The voice of the child in general practice consultations
    b. -record keeping following an SCR

4. Standards for GP Patient Registration

5. Increased awareness of these issues through SCR Training events within both local authority areas

LA2 Hospital 2 NHS Foundation Trust

1. The VYPT are to strengthen current information sharing processes, both within SRFT and other relevant agencies to include across boundaries.

2. The VYPT to further develop processes to formulate a chronology of attendances to the ED dept. This is to enable the practitioner to gain an oversight of individual cases to ensure a comprehensive assessment can be undertaken. For young people who meet the criteria for referral to the VYPT.

3. In order for all SRFT staff to access the safeguarding children's team consideration is to be given to extend the hours of service to include out of hours.

4. For SRFT ED registration documentation to accurately complete all demographic details to include, GP, school, religion and the ethnicity of patients attending the ED on every attendance.

LA2 Children's Social Care

1. Where young people move across boundaries the responsibility is for the Local Authority from which the child has left to supply all relevant information both verbally and in terms of documentation. However, consideration should be given to

a process for escalating where there is a lack of compliance with the regionally agreed procedures.

2. Ensure that arrangements for management oversight of assessments are robust.

3. Ensure that screening processes cross-reference significant adults and any related child protection concerns.

LA2 Integrated Youth Service

1. The Young Fathers Project should inform Salford's After Care Team if it comes into contact with any young people aged under 18, who are looked after/or present as being looked after, by a borough other than Salford, and appear to living permanently in Salford.

City West Housing

1. A review to be undertaken internally of City West Housing Trust s' procedure (Vulnerability Matrix) and procedures, whereby a new household member is identified as residing at the property and how we can risk assess and provide support and intervention to those customers.

2. 'Privileged Position' Housings' position in Safeguarding.

Greater Manchester West Mental Health NHS Foundation Trust

1. All members of staff in the Salford Mental Health Liaison Team must be made aware that when patients present at A&E who are age 16/17 years old they should consider in their assessment whether referral to the CAMHS EMERGE for 7 day follow up

2. That wherever possible and when clinically indicated in order to inform risk assessments and the management of; the Salford Mental Health Liaison Team should complete a risk assessment on patients that are referred by the acute hospital trust prior to medical clearance.

3. That following a referral when attempts are made to contact a GP by the CMHT this is followed up.

Greater Manchester Police

1. A fully documented policing plan to address vulnerability and CSE in the city centre is to be implemented.

2. Mandatory refresher training package to all specialist public protection staff (Triage function)

3. Mandatory refresher training package to all PPIU supervisors (Roles and responsibilities)

4. Design and deliver a training package to all front line staff and supervisors. (Safeguarding / Vulnerability / CSE)

5. Victims / offenders / Crimes to be flagged for CSE.

North West Ambulance Service NHS Trust

1. Develop guidance for EMD's in relation to identifying children during domestic abuse incidents (and other incidents) who may be vulnerable requiring a safeguarding child referral.

2. Review the Safe Transportation of Children Policy and Procedure and the Rapid Response Vehicle Handbook to ensure the safety of children is paramount and staff responsibilities are clear.

3. Provide a training document to highlight vulnerabilities of children aged 16-17 (including self-harm).

Relate Counselling Service

1. In this new experience for Relate GMN, to provide training for our YP counsellors, about learning about SAAR and any implications for our work.

2. To meet with the Senior School to share any joint learning

3. **SCR Recommendation to Relate:** To ensure all counselling staff have a complete understanding of the need to share information that could have safeguarding

implications for children and never to assume that responsibility has been adopted elsewhere within the safeguarding systems.

Senior School

1. With heightened awareness in the light of the SCR, ensure that we sign-post and offer high-quality Care, Guidance and Support to all pupils, not least the most vulnerable

Pennine Care Foundation Trust – School Nursing

1. To review the process of transition of health records for 16- 18 year old to enable access to records. Review roles and responsibilities in Oldham for 16- 18 year old school nursing provision

2. To review the provision of school nursing across the region for 16-18 year olds