WOLVERHAMPTON SAFEGUARDING TOGETHER

Table Top Review for Child S

1. Introduction

1.1 Discussion at the One Panel in April 2020 concluded that the case of Child S does not meet the definition of a serious child safeguarding case, or the criteria for a CSPR. However, in the case of Child S the Panel felt that the case highlighted improvements that were needed to safeguard and promote the welfare of children and agreed to carry out a Table Top Review (TTR).

Scope of the TTR

1.2 A multi-agency group was established to carry out the TTR. This included a representative from each of the Safeguarding Partners (Council, Police and CCG) along with any other agencies involved with the family and any relevant subject matter experts.

1.3 A few agencies have been involved with Child S and the family for a considerable amount of time and it would not be possible to review each intervention during the whole timeframe.

1.4 The group were required to work within agreed timescales to:

- Collate and scrutinise information provided by agencies
- Provide local context
- Provide challenge to quality of reports and the analysis of professional practice
- Identify single agency and multi-agency learning and support the development of single agency action plans
- Ensure proper lines of accountability are followed to ensure those responsible for not meeting professional standards are held to account
- Ensure the report has met the agreed Terms of Reference, is succinct and focused on improving local safeguarding arrangements
- Make recommendations to WST
- Formulation of a Learning Lessons Briefing for sign off by One Panel using an agreed format

2. <u>Methodology</u>

- **Individual agency chronology**
- **Scoping documents completed by lead agencies**
- **Round table discussions (virtually)**

- **Discussions with family members**

2.1 A lead reviewer was appointed to lead the review. Agencies were asked to complete the scoping documents and attend the meetings to discuss the children and identify learnings. The meeting attendees had access to the key agency scoping documents and multiple meetings took place with practitioners involved with the family, where the children were discussed.

2.2 The predisposing risks and vulnerabilities that were known at the time were considered, to understand the case. This was followed by the consideration of the preventative and protective actions taken, to understand the interventions.

2.4 Drafts of this report were shared with those involved as well as with the One Panel and WST's Scrutiny Group to ensure collaboration and ownership and provide scrutiny and challenge. The recommendations were written by the Lead Reviewer and the review team.

2.3 This report has been written in the anticipation that it will be scrutinised by the One Panel and used to formulate key learning for the agencies involved.

3. Scoping Period

1st January 2019 to 19th February 2020.

4. Narrative

4.1 The eldest child in the family Child S was admitted to Hospital in May 2019 following a significant psychotic episode. This and previous episodes had unresponsive to medication in the community and had been getting worse with a significant increase in aggressive behaviour at home and school. This episode had been lasting for a significant amount of time.

4.2 A Root Cause Analysis (RCA) to understand the reasons for admission for this young person (part of the process designed by NHSE) identified that there had been several safeguarding issues, and it was not understood whether these had been fully investigated and assessed nor whether interventions had been effective. These included:

- Child S seeing her biological Dad attack her mum with a machete. Her younger brother has displayed harmful sexualised behaviour and using aggressive sexualised language.
- Her Mother's partner is reported to be a habitual cannabis resulting in a significant smell of cannabis always being present within the home. Child S making allegations of rape which could not be proven due to her psychotic episodes.
- She had also made allegations of being touched inappropriately and being raped by 100s of men.

5. Enquiry discussion

5.1 Professionals shared their understanding of Child S's journey and spoke about the many actions that were taken by each agency to assess and try to meet her needs.

5.2 **Key events**

- 2013 - Referral to social care relating to an alleged serious Domestic Abuse in which Child S's Mom was assaulted.
- 2013 – Child S presented to CAMHS for visual and auditory hallucinations. Mental Health had been deteriorating over the proceeding 5 years and her level of aggression has increased. She has been on Olanzapine since 2013.
- July 2013 - An EHCP was written for Child S in which she was assessed as having complex needs.
- 2014 – Child S first became known to Disabled Children and Young People's Team due to a referral for short breaks
- Child S began receiving regular services from CAMH's in 2015
- 2015 - First safeguarding referral received in relation to supervision within the home (NFA)
- 2017 – Child S disclosed sexual abuse (NFA)
- Oct 18 - an Assessments concluded that Child S's current education provision were not able to meet her social, emotional, and mental health needs and recommended a review of her EHCP and educational provision as soon as possible
- 2018 - Professionals were unable to identify an educational provision that could meet her needs.
- 2019 – Child S's behaviours escalated and the possibility of a psychotic diagnoses was first considered
- May 19 Child S was first assessed under the Mental Health Act and a period of hospitalisation for assessment was required

5.3 Most agencies reported a plethora of multi-agency meetings that were well attended with good communication between partners. Before the scoping period there were periods in which communication was not good enough.

5.4 Agencies were clearly appropriately concerned about Child S's deteriorating mental health condition and at times there were concerns by Health and Education professionals as to how much her home life and experiences within the home were exacerbating her difficulties.

- Generally good communication between social care and the school
- Good communication between social care and the hospital
- Relevant partners involved in EHCP Planning
- Child S was discussed at weekly complex cases meeting
- Child S was listened to, and allegations of abuse were investigated as far as was possible (there were some limitations to this)
- Child S's strengths were identified in assessments by professionals

5.5 It quickly became apparent that Child S may have been affected by multiple impairments and mental health challenges that were comprised not just of emotional and behavioural issues, but also learning and other cognitive disorders.

5.6 Despite the good work outlined above, instances where practice could have been better were identified within the conversation.

5.7 An earlier full family assessment including a thorough parenting assessment may have unearthed environmental issues that were impacting on Child S's health

- There is hypothesis that sexual abuse may have featured at some point within this family. Both Child S and her brother have behaviours that relate to either reporting abuse or presenting with harmful sexual behaviour.
- The sexual abuse allegations relating to Child S's father made by another family member were never fully explored in a social work assessment. He had left the home, but social care record's do not conclude the matter in any way
- The role of Mum's new partner in relation to care of the children was not fully understood
- Little was known about Child S's brother's needs at an early enough point

5.8 There were concerns that allegations made by Child S would not be followed up and fully investigated by the Police as her mental health needs could result in her accounts always being deemed to be unreliable.

5.9 Change in medication seemed to have been a trigger for her mental health deterioration but health professionals felt investigating her medications was unlikely to have any explanatory power. The only medication that seems to have had an effect is not one that would usually be used with a child who is living within the community.

5.10 Over the long term it was felt that support had been intermittent and more sustained involvement by professionals may have been more helpful. This was punctuated by staff turnover and changes in practitioners both in health and social care

5.11 Although Child S had a meaningful EHCP plan there was real difficulty in finding a provision that could meet her needs.

6. Analysis

6.1 All children and young people should be able to access the right support at the right time when they experience a mental health problem. Unfortunately, all too often, children and young people have a poor experience of care, or they struggle to get timely and appropriate help that meets their needs. (CQC 2017)

6.2 It is known that Child S experienced her first symptoms of mental health difficulties before her teenage years, and she began receiving support from CAMHS when she was 11 years old following practitioners identifying this need.

Despite the efforts of health, education and social care services, interventions appear to have been ineffective in preventing the onset of complex mental health difficulties.

6.3 Sadly, Child S was detained under the Mental Health Act and admitted to hospital in May 2019. Child S then received different medication and support. She made positive progress and began to do well. Child S was discharged in March 2021. Her mental health remains stable, and she is compliant with medication.

6.4 It is fair to say that a whole family assessment that worked that thoroughly understood the lived experience of the children and properly assessed Mum and her partners ability to meet those needs may have been beneficial from the onset of social care's involvement. At the time DCYP were involved it was thought that Child S's needs centred around her learning difficulties rather than there being any family and environmental concerns.

6.5 At this time there were no concerns raised during home visits, no signs of drug use or smell of cannabis and all children appeared clean and appropriately dressed during visits. It would therefore have been considered to be oppressive practice to complete a safeguarding assessment at this time.

6.6 It should however be noted that Social Care may have missed an opportunity in 2013 to undertake a comprehensive assessment, and concerns relating to Child S's dad should have been fully explored.

6.7 In 2019 when Child S was 14 her needs began to increase, and her behaviours became more difficult. It was at this point that she had her first psychiatric assessment during which the possibility of long-standing psychotic illness and other possible diagnosis were discussed.

6.8 The review found that finding the right provision for Child S was difficult and despite best efforts a placement that could meet her educational and health care needs was not identified in a timely way.

6.9 It is known that for those children and young people who need more intensive and specialist care, there are significant challenges in accessing services. There are long waiting lists for many of the services that provide specialist mental health care, and the imbalance between demand and capacity in for specialist educational provisions and inpatient care means that children and young people cannot always find an appropriate bed in an inpatient ward close to home. This clearly was a factor in the care of Child S and had an appropriate placement been found it may have had an impact on preventing the escalation of her needs.

6.10 It should be noted that this may not necessarily have been the case and Child S may have needed the medical interventions including her current medication to become stable.

6.11 There has been a long-standing, well-known debate about the ontological status of mental disorders. For Child S, her mental health condition could be a result of the trauma she experienced in 2013. That said, the timeline suggests her mental health difficulties had begun prior to this incident. Professionals have to accept

that there are unknowns relating to her early childhood experience that might have been understood better with a more comprehensive social work assessment in 2013.

6.12 It should also be accepted that such an assessment may not have unearthed any further information to indicate early trauma within the family home. The cause of her mental health difficulties could be biological. It is not the purpose of this review to attempt to decipher which of these factors was most prevalent in Child S's case.

6.13 The Review found that despite the very sad information disclosed in the meeting most agencies acted appropriately in their care of Child S.

6.14 A few areas for improvement were agreed and these largely mirrored those identified in the root cause analysis undertaken by Health agencies. Some of these recommendations have already been addressed within agencies as outlined below.

6.15 A Child Assessment Team has since been created and safeguarding assessments have significantly improved since this time.

6.16 Joint Health and Social Care Commissioning is being progressed with the aim of improving the availability of sufficient placements to meet the needs of children with SEND

7. Recommendations

7.1 Social Care should ensure there is always a thorough full family assessment that incorporates the risks from the historical perspective with what was going on in the household at the time.

7.2 The Children with Disabilities Team should undertake more, whole family assessments

7.3 Appropriate Education Health Care Plan and provisions need to be identified in a timely manner

7.4 Staff turnover cannot be avoided but all partners should try to ensure consistency of professionals for children with complex health needs

7.5 A more consistent approach to joined up working between agencies from the onset of Mental Health difficulties for children should be adopted