Essex Safeguarding Children Board

Child Safeguarding Practice Review

CHILD P

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1 INTRODUCTION

1.1 This case review was commissioned following the death of Child P who took her own life in September 2019 five days before her fourteenth birthday. Child P had lived with her maternal grandparents following the illness and death of her mother in 2015.

1.2 At the time of her death Child P was known to child mental health services[1] and Essex Children's Social Care as well as universal services. Services were being coordinated via a Child in Need plan.

1.3 Essex Safeguarding Children Board carried out a Rapid Review of the involvement of organisations within Essex and concluded that due to the number of professionals involved in Child P's life, a multi-agency review should be carried out led by an independent consultant.

The Review Process

1.4 The independent reviewer[2] worked with the review team comprising senior professionals from the organisations who had been involved with Child P and her family.

1.5 The terms of reference[3] were agreed and stipulated that the period of the review would be from the date that Child P's mother died to the date of Child P's death. This timeframe was designed to ensure that professional responses to the impact of loss and bereavement on Child P's emotional wellbeing was considered during the review process.

1.6 Agency chronologies were received from:

- Acute Hospital Trust
- CCG on behalf of the GP Surgery
- East of England Ambulance Service NHS Trust
- Essex Child and Family Wellbeing Service
- Essex Community Rehabilitation Company
- Essex County Council, Adults Social Care
- Essex County Council, Children's Social Care
- Essex County Council, Education including Child P's school
- Essex Police
- Local Bereavement Project

[1] In Essex child mental health services are known as the Emotional Wellbeing and Mental Health Service (EWMHS). EWMHS is provided by the North East London NHS Foundation Trust.
[2] See Appendix One for a short biography.
[3] See Appendix Two

- Local Borough Councils x 2
- Local Community Health Services
- National Probation Service
- North East London NHS Foundation Trust (EWMHS)

1.7 Child P's maternal grandmother, father and a close family friend were invited to contribute to the review, and all were willing to do so. The lead reviewer spoke to them and is very grateful for their insights and comments and willingness to share information, despite the extremely upsetting circumstances. Their contribution has provided the review with a greater understanding of Child P's life and what agencies need to consider when seeking to improve future practice.

1.8 The review also included discussions with practitioners who had been involved with the family. Child P's death has caused much distress to those who knew her, and these discussions have shown a willingness to reflect openly and honestly on what happened and how to improve our safeguarding system.

1.9 A final draft report was agreed by the review team and shared with practitioners and family members to check for accuracy and discuss the initial learning.

1.10 This final report was accepted by Essex Safeguarding Children Board but publication was delayed due to further discussions with Child P's school, her father and friend of the family. Minor amendments made following these discussions. Sadly, Child P's grandmother died before the report could be shared with her.

2 FAMILY BACKGROUND

2.1 Child P is described by her family as a wonderful girl who was much loved, but throughout her life experienced multiple losses which had an impact on her emotional wellbeing.

2.2 Child P was an only child and her parents separated and divorced when she was small resulting in disputes about her contact with her father. A court order initially directed contact should be supervised. Outside her immediate family Child P's most significant relationship was with a friend of her mother's (known throughout this report as the family friend), spending time most weekends with the friend and her son.

2.3 Child P's mother was diagnosed with cancer when Child P was seven years old. Her mother subsequently married again (a same sex partnership), and Child P is reported to have enjoyed a relationship with her stepsister.

2.4 Around this time, her mother divorced her wife resulting in Child P losing contact with her stepsister. Her grandmother described to the review numerous further losses including the death of her godparents and the death of her dog in a road traffic accident. When her mother's illness was diagnosed as terminal, Child P moved in with her grandmother and remained there after her mother's death with regular overnight stays with the close family friend.

2.5 Since the separation of her parents, Child P's contact with her father had been minimal but around the time of her mother's death he moved back into the area sharing a house with a female friend. A Residence Order had previously been granted in favour of Child P's maternal grandmother and mother. After her mother's death the court agreed that Child P would remain with Grandmother and Father could have unsupervised contact with the gradual introduction of overnight stays.

2.6 Both grandparents experienced poor health and received support from Adult Social Care for themselves and in respect of their learning-disabled son who lives in supported accommodation.

3 CASE SUMMARY

3.1 Both before and after the death of her mother, Child P was supported by a bereavement project for young people linked to the hospice who cared for her mother during her illness. Child P engaged well with the project and when the contact stopped in October 2015 the evaluation of the impact of the service, completed by her grandmother, was positive. From the project's perspective, she had managed the death of her mother well with the support of her family and friend's network. At this stage, any concerns in the wider professional community about Child P's emotional wellbeing related to the repeated losses she had experienced.

3.2 In February 2016, Cafcass (who had been involved with Child P regarding contact arrangements with her father), received a contact from Grandmother concerned about father's alcohol use and aggressive behaviour.[4] Cafcass made a referral to Children's Social Care. No record of this referral has been located on the notes although there is a request for information from Cafcass at that time. This is significant as it would have been useful background information when subsequently assessing and understanding Child P's feelings about her father.

3.3 When Child P was age eleven and in her final year of primary school, she was found by her grandmother to have been sending older men extremely explicit messages in

[4] Father has since informed the review that grandmother had been informed by a third party that he was "on his way to kill her" and the allegation was totally false.

which she posed as someone older[5]. The family friend has told the review that she was very concerned about the graphic detail contained within the messages; detail that should not have been known by a child her age.

3.4 Child P was referred to Children's Social Care which could have resulted in a multi-agency strategy discussion to consider the meaning of this behaviour and potential risks to Child P. There is no evidence that this approach was considered, and instead a referral was made to The Children's Society and the child mental health service (EWMHS). Child P declined the help of The Children's Society, but it seems they were sufficiently concerned to alert the police. The police subsequently contacted Children's Social Care asking for a Child Sexual Exploitation risk assessment to be carried out. This assessment was completed by a family solutions worker[6] who identified Child P as "standard risk[7]" and over the next six months undertook sessions with Child P focusing on loss and bereavement, relationships and one session on internet safety. Help from Family Solutions ceased in June 2017.

3.5 The EWMHS contact at this time included a discussion with Grandmother in December 2016 and classification of the referral as non-urgent. This resulted in a full assessment 12 weeks later. The case was then closed to EWMHS as there had been no mental ill health identified and neither Child P nor Grandmother appeared to want to work on their relationship: the GP was informed. Learning relating to this episode is explored further in Finding Three.

3.6 During this period Child P had no contact with her father. Following an assault on a female friend he moved out of the area and his friend moved in with Child P and her grandparents. This friend has been described as having considerable influence over Child P. Father was convicted for this offence and the pre-sentence report noted that he had no contact with Child P as she was living with the victim of his assault. He was sentenced to 12 weeks custody suspended for eighteen months with a Rehabilitation Activity Requirement and a thinking skills programme. As a result of this sentence, he was allocated an offender manager in the Community Rehabilitation Company. The content of discussions with his offender manager focused on his desire to resume contact with Child P and ways this could be achieved. He shared two letters from Child P which the offender manager described as "sad" with her talking about her inability to form attachments.

3.7 There was no direct communication between the offender manager and Children's Services to discuss whether a referral was needed or any discussions with others who may have known Child P such as the school. More inter agency discussions may have provided an opportunity for a joined-up approach between professionals in managing

[5] Known as "cat fishing"

[6] Family solutions is a service for families in Essex who may be experiencing a combination of difficulties that affect their children.

[7] There is nothing in the records provided to the review to indicate what this decision was based on.

plans for any contact. Child P's father was referred by his offender manager to an organisation working with offenders' families and he started working with a family support worker. Again, there is no record of any communication with other agencies and work with him was not carried out within the context of an understanding of Child P's needs at the time.

3.8 Child P's father did not complete the requirements of the suspended sentence order because he committed another (nonviolent) offence and was sentenced to 12 weeks in custody. On release he had some contact with a probation officer and his statutory supervision expired in January 2018. The role of the Probation Service within the multi-agency network is discussed further in Finding Two.

3.9 In January 2018 Child P was again referred to EWMHS, this time by the GP. The GP's concern was Child P's level of anxiety, low self-esteem and the possibility that she needed anti-depressants.

3.10 As EWMHS did not assess that an urgent appointment was needed, Child P was seen by EWMHS in April 2018 when she was assessed as high risk and a therapist allocated. There continued to be concerns about Child P's mental wellbeing during 2018 and although she was willing to see the EWMHS psychiatrist, Child P did not wish to engage in therapy with the allocated therapist. The concerns during this time which were known to the family friend, EWMHS and school were that Child P had been drawing marks on herself to look like cuts since 2016 and posting these on Instagram. By 2018 these were real cuts.

3.11 Also, during 2018, Father's friend died. At the time of her death, she was living with Child P and her grandparents. Around this time Grandmother self-referred to Family Solutions but when contacted by them a month later declined their help. The family friend has told this review that this was because Grandmother had been suffering from cancer at that time.

3.12 By October 2018 EWMHS were sufficiently concerned about Child P to refer to Children's Social Care and to the bereavement project, as by this stage Grandmother had received a diagnosis of cancer with a poor prognosis. The bereavement project did contact Grandmother, Child P and her school but did not feel that specific bereavement work was appropriate at that time. This was because Child P was not aware of her grandmother's diagnosis of a terminal illness. They agreed to keep in touch with the professional network to offer this help at the right time.

3.13 The assessment and intervention team in Children's Social Care completed a child and family assessment. This assessment focused on Child P's mental health and current family circumstances, including the issue of where she was going to live; there is no reference to previous concerns about her sexually inappropriate activity online as would have been expected practice.

3.14 In parallel to the child and family assessment, Adult Social Care were assessing Grandmother and Grandfather's care and support needs due to their health problems and became aware of several tensions in family relationships – notably between Grandfather and the rest of the family.

3.15 During 2019 there continued to be stressors within the family including a deterioration in Grandfather's health, alongside Grandmother's cancer treatment and Adult Social Care worked with the family to provide a creative and appropriate package of care. Child P's grandmother told the social worker from Adult Social Care about the challenges in caring for Child P and it is positive that there was liaison between Adult and Children's Social Care with a social worker from Adult Social Care attending a Child in Need meeting in April 2019. The family friend was not invited even though Child P was staying with her although Child P's father had resumed contact with the family and did attend.

3.16 The Child in Need Plan was initially meant to be short term, focused on improving Child P's emotional and mental wellbeing and ensuring a stability in the light of Grandmother's illness. The original aim was that this stability would be achieved by Child P moving to live permanently with the family friend who had been close to her mother. Child P's family believed strongly this was the best possible option, and after Child P was taken to hospital reporting suicidal thoughts she moved in with this friend. From the perspective of Children's Social Care this was to be a private fostering arrangement.

3.17 There were delays in completing the private fostering assessment as the family friend needed to receive financial support and practical help with housing. She wished to be assessed as a local authority foster carer and consequently was not prepared to sign the required documents. As far as she understood, none of the options being put forward (which included the possibility of applying for a Special Guardianship Order) gave her the financial security and practical help that she needed given Child P's mental health issues. The response by Children's Social Care at this time is discussed further in Finding Four.

3.18 Whilst private fostering was being discussed it became clear that longer term help was needed from Children's Social Care and in May 2019, Child P was allocated to a social worker in the family support and protection team. The family friend remained concerned about the lack of support from Children's Social Care and wrote a letter of complaint. She remained disappointed that she did not receive a reply.

3.19 The school were aware that the family friend was struggling on several fronts and attended a MARAC[8] meeting in July 2019 which had taken place due to concerns about domestic abuse from an ex-partner. Child P's presence in the home was

[8] Multi Agency Risk Assessment Conference – a meeting held in situations of high risk domestic violence/abuse to share information and agree a safety plan.

recorded in the minutes but she was not included in the action plan. It seems that there was an assumption that the allocated social worker would be aware of the issues discussed and this could be considered in ongoing assessments and plans. This was not the case.

3.20 All reports show that Child P was happy whilst living with the family friend, but because of the impasse regarding her legal status and provision of practical support, alternative possibilities began to be explored. A referral was made for a Family Group Conference, but the family did not feel that this was a helpful way forward at this time as they believed that the solution lay in Child P living with the family friend.

3.21 The situation changed when in July 2019, the family friend found sexually explicit images that Child P had made on a phone that she had lent Child P. Child P was not aware that the images had been stored in the Cloud and were accessible to others even though they had been deleted from the device. The images and texts wrongly implicated others in a sexual assault on Child P. The family friend also found evidence that Child P had created several on-line personas and had used these to frighten a close school friend. These messages included inciting the school friend to attempt suicide. In addition, bags of pills and a suicide note were found amongst Child P's belongings.

3.22 The family friend recalls talking to a police officer and social worker who also spoke to Child P at school. At this point it had not been established that Child P's allegation of sexual assault was false, and Child P was not aware of the wider concerns about her internet use, including inciting her friend to take her own life. In the family friend's opinion, there were sufficient concerns to suggest that Child P should not be at home (for example she had taken a knife and could not be restrained) and should be in a safe place for her own safety and the safety of others. The social worker was not in agreement with this view and re-iterated to the family friend that Child P should be looked after within her family.

3.23 Social workers recall the mood at the time as being one of shock and a feeling that this had "come out of nowhere". The immediate concern was for Child P's mental health as well as considering whether she was a risk to others, as it was known that Child P had arranged to go on holiday abroad with a school friend and their family.

3.24 A strategy meeting was held between Children's Social Care, Police, Child P's school and the school nurse (EWMHS were aware of the meeting, but it seems were not formally invited). A police record of the meeting indicates that:

- There was some confusion about the best way of managing any potential risks because Child P was going away on holiday with a family with children. The social work view was that it seemed the main risk was to the school friend to whom the messages had been sent, rather than children in the family with whom she was going on holiday. The social worker suggested that the police

should make a safeguarding referral if they were worried, and the family could then be approached. Responsibility for informing the family of any concerns sat with Grandmother.

- Concern that Child P was not aware of concerns about texts indicating that she encouraged the attempted suicide of her friend and who should inform her of this. It was agreed that the social worker and school would inform her the next day and that she would be supported by the school. (NB this does not seem to have happened and Father has informed the review that he put a stop to it because he was concerned that it was not a good time to inform her just before she was due to go on holiday). Police noted concerns about Child P's mental health and that they wanted this assessed before a formal interview.
- Social workers believed that Grandmother could take responsibility for safeguarding Child P, but the police believed that she would need help to do this.

3.25 Concerns about Child P's mental health resulted in EWMHS receiving messages from several different people all worried about her. Around this time a new therapist was allocated to Child P in acknowledgement that she had not wanted to engage with the previous practitioner. The signs were that Child P liked her new therapist and was willing to start to attend sessions with them.

3.26 Specifically, following the strategy meeting the police contacted EWMHS to ask for an urgent assessment to ascertain whether Child P was fit for questioning. It was agreed that the police would go ahead and talk to her and call EWMHS or the Crisis team if Child P's mental health deteriorated as a result. The interview was then delayed as Child P was away on holiday.

3.27 Whilst Child P was on holiday there was a change of social worker as her previous social worker had left the department. Her new social worker met with Child P's father (who had moved in with Child P and her grandparents) and he spoke about his plan for Child P to live with him full time. The social worker recalls him speaking openly about his previous drug use, the times he had tried to secure contact and the recent police enquiries. At this point Child P did not know that the police were taking action and it was agreed that Father and Grandmother would sit down and explain this to Child P when she returned from holiday.

3.28 Meanwhile Child P's school had been discussing with senior local authority colleagues how to best manage a situation where Child P and the pupil to whom she had sent the texts were in the same school. It was already apparent that there would be extreme difficulties for Child P amongst her peer group. Child P's family suggested a change of school and the school's solution was that this could be achieved by a managed move with Child P remaining on the roll of her current school and close communication between the two schools. This was agreed to be one possible option.

3.29 In the early hours of 13th August 2019, Child P was seen in A & E due to a deterioration in her mental health and asked to speak with someone from the mental health crisis team. Child P talked about concerns about changing school, moving in with her father and that they were having to work on their relationship as this had been strained. An urgent EWMHS review was requested, and a safety plan agreed with Child P's grandmother.

3.30 Also on 13th August, there was a Child in Need meeting (which Child P did not attend). There was discussion about where Child P should live and her schooling. The school stated it would not be appropriate to exclude Child P, as they had a duty to consider her needs alongside the safety of others in the school. Child P's family said that they had told Child P she would be moving in with her father.

3.31 Later that day, Child P met her new social worker who recalls a chatty young person who spoke about how upset she was that her relationship with her school friend had ended because of the online activity. During that visit, the social worker remembers Child P having a "kiss and a cuddle" with her father. The social worker also reported to the strategy meeting the next day that Child P had said that she did not want to live with her father and wanted to stay and care for her grandmother: it was the view of the social worker that she knew her grandmother had a terminal illness. She said she would run away and hurt herself if she was made to live with her father. From the social worker's perspective, the focus of the work at this stage was:

- Rebuild Child P's relationship with her father.
- Build her relationship with her grandmother.
- Sort out her schooling.
- Support her mental health.

3.32 The final strategy meeting took place on 14th August 2019, and it was attended by the school and EWMHS as well as Children's Social Care. Information was received from the police. It was noted that Child P did not want to live with her father and would "run away and kill herself" if she was made to do so. The possibility of a change of school was also discussed and it was noted that Child P was now viewed by the police as a suspect rather than a victim and the plan was to get a video statement from the victim before interviewing Child P.

3.33 Following the meeting the school carefully considered options for Child P and although there were grounds to permanently exclude her, they did not pursue this option due to concerns about her mental health. Their intention was to pursue the possibility of a managed move and agree a multi-agency risk management plan at the forthcoming Child in Need meeting.

3.34 The child mental health crisis team contacted Grandmother to follow up on the A&E attendance. During the conversation Grandmother was clear that she was very unwell

and could not look after Child P. The best alternative options were either that she lived with her father or went into foster care.

3.35 The social worker saw Child P again on 20th August 2019 and remembers feeling that her father would not be able to support her with her mental health, but she did wonder whether a referral to D-Bit[9] for some work on reunification might help. At this point Child P seems to feel that Children Social Care understood her concerns about her father as she told EWMHS at a planning meeting the next day that she thought they were listening to her. It is positive that at this meeting Child P agreed to weekly therapy contact with her new therapist as she recognised the need to address some of the issues with the loss of her mother.

3.36 The final Child in Need meeting took place three days before Child P's death and this review has had the opportunity to review a recording of the meeting. This recording has informed the description below.

3.37 Several factors came together at this point that cumulatively caused Child P considerable distress:

1. There was a misunderstanding within EWMHS about the time of the meeting which resulted in workers from EWMHS arriving at the school at 12noon rather than the agreed 2pm time. It has been difficult to work out exactly how this came about but all records show that the agreed time had always been 2pm. The outcome of this confusion was that EWMHS could not attend at 2pm and their direct input into the meeting and expert opinion in relation to Child P's mental health was lost.
2. There was a short conversation between EWMHS, Grandmother, Father and Child P at 12noon and the family understood EWMHS to be suggesting that Child P should move into foster care and be placed in a "special needs" (Pupil Referral) Unit. The mention of foster care is in line with the recent conversation with Grandmother, but the school plan appears to be a misunderstanding on the part of EWMHS. Father has explained to the review that the family position was that Child P should live with him.
3. The Child in Need meeting was chaired by a duty social worker as Child P's social worker and her manager were on holiday. It had been felt that it was important for the meeting to go ahead to agree schooling before the start of the autumn term. The chair had been briefed but this was a very complex set of circumstances to navigate. The management of this meeting and Child in Need meetings in general is explored further in Finding Five.

[9] A team in Essex working to reunify children with their parents.

3.38 Although saying little for the first part of the meeting, Child P became increasingly distressed at talk of her moving in with her father, making the point that she did not feel that she was being listened to and that "If they say that I have to live with dad then I am not going to live". Child P made it clear that her preferred alternative would be foster care, but the chair of the meeting made it clear that this would not be approved by senior managers within Children's Social Care. Child P commented "I am just a problem". The clear message to Child P during the meeting was that the best way forward was to work on the relationship with her father despite her distress at this prospect. The issue of a school move was explained as a positive step, but the impression is that school was less of a concern to Child P than the issue of where she would live. She commented "I can get through school, but I cannot get through me".

3.39 There was no direct discussion of the pending police enquires within the meeting although Child P alluded to this saying "I was angry because of everything I have done".

3.40 It is not possible to say with any degree of certainty what was going through Child P's mind at this point but there were many factors that would have been hard for her to process.

1. Uncertainty about where she would be living and extreme distress at the prospect of living with her father.
2. Potential loss of her maternal grandmother.
3. Loss of the secure relationship with staff at her school.
4. Loss of peer group and concern about how they would be viewing her in the light of the recent accusations.
5. Awareness that the police were carrying out a formal witness interview with the friend who had made accusations about Child P's internet activity. Child P would also have been aware of the previous police involvement when she was age eleven and, although this had not been discussed in recent assessments it is possible she would have worried about the implications for the current situation.
6. Her view of herself as someone that nobody could help and manage.

3.41 Three days after the meeting Child P took her own life.

4 SUMMARY OF FINDINGS

4.1 Whenever a young person takes their own life there is likely to be a range of emotions including disbelief, shock, anger, distress, and a need to understand why this could have happened. It has been evident from conversations that have taken place during this review that the death of Child P has affected many people very deeply, most

significantly her family and friends who continue to experience the devastating impact of her loss. Professionals who knew her have also been affected and have shown a willingness to reflect openly and honestly about their role and think about what lessons can be learnt to improve practice in the future. This willingness to reflect and learn is a positive aspect of the safeguarding system in Essex.

4.2 In 2018, Safeguarding Partners in Essex completed a thematic review of teenage suicides that focused on nine young people who had taken their own life between April and November 2017. Although the circumstances of each young person were unique, all of the young people had a number of specific vulnerabilities: a finding in common with a national study[10] which also noted cumulative risks and the greater prevalence of previous stresses in girls who had taken their own life. Separation, loss, bereavement, and the breakup of a relationship was a feature of the majority of young people in the Essex review and Child P's circumstances reinforces the need to make sure that the significance of these factors is understood, particularly where there are other stressors in the child's life.

4.3 The impression from all the information gathered for this review is that the number of stressors affecting Child P had stacked up to such an extent that her life must have felt out of control. At the time of her death Child P had lost many of the protective factors within her home, community and peer environments that help young people to cope with risk and adversity[11] .

4.4 Family friends and professionals within their own organisations were trying to help her. Father still feels very strongly that the family's perspective was not considered in finding solutions, most significantly their view that the best solution was to provide the practical help to enable Child P to live with the family friend.

4.5 EWMHS responded to referrals and did try to engage with Child P, changing the therapist when it became clear that this might help engagement. Her school knew her well, understood her distress and were also working hard to support her. However, the school had to manage the difficult task of balancing a response that met the needs of Child P and the friend who had been in receipt of Child P's dangerous texts. It was recognised that the School's Designated Safeguarding Lead had offered continual and consistent support to Child P and provided her with considerable time, emotional support and kindness. Police officers tried to make sure their responses were sensitive to her mental health needs and social workers were concerned to find a long-term solution for her care. However, despite individual attempts to help, the safeguarding

[10] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017. http://documents.manchester.ac.uk/display.aspx?DocID=37566

[11] See for example: Rutter M. (2012) Resilience as a dynamic concept. Dev Psychopathol. 2 :335-44 and Dias, P and Cadime I (2017) "Protective factors and resilience in adolescents: the mediating role of self-regulation. Psicologia Educativa 23 1 pages 37-43

system did not manage to grasp the extent of her distress and provide a holistic coordinated response. Specific aspects of this system are discussed in section five below and recommendations made for practice improvement:

- Child P's behaviours were not always understood as a form of communication and when decisions were being made about her future, the system was not successful at hearing her voice and taking this into account. This is explored in Finding One.
- Assessments did not take account of all the information that was known about Child P's life, both in the past and as her situation changed and evolved over time. This is explored in Finding Two.
- The underlying causes of Child P's online sexual behaviour were not explored and pathways for a coordinated response were not clear. This is explored in Finding Three.
- Finding a permanent home for Child P was dominated by a belief that her family should be responsible for her care and there was insufficient flexibility in finding and supporting alternative solutions. This is explored in Finding Four.
- The Child in Need assessment and planning process struggled to manage a situation where there were evolving and complex issues that needed to be addressed. These issues cut across not only services for children but also adult services. This is explored in Finding Five.

4.6 Threaded throughout all these findings is the need for practitioners to really understand the totality of a child's life over time, listen to children and their families and, in these complex situations to weigh up several apparently competing views. In this case there was the added impact of Child P's behaviour on the child of the family friend with whom she had a close relationship. Child P's family and the close family friend feel strongly that there was inadequate thought given to the child of the family friend, the family were not listened to and equally there is evidence that Child P's "voice" (verbally and through her behaviour) was not always heard. This is challenging work for busy practitioners in all agencies who need time and space to reflect on their work as well as the capacity to develop good working relationships with all those involved. The role that supervision can play in this process has been highlighted in other recent reviews in Essex and there is therefore no specific finding regarding supervision in this case. One final recommendation does prompt Essex Safeguarding Children Board to follow up actions regarding supervision that should be already being taken as a result of previous reviews.

5 REVIEW FINDINGS AND RECOMMENDATIONS

Finding One
Listening to children and young people through verbal and nonverbal behaviours and incorporating this into an assessment of need and risk is a skilled task which must be at the heart of safeguarding practice in all agencies.

5.1 This finding is not unique to this review and a consistent theme from reviews and research over many years has been the need to listen to young people. The responses to Child P indicate that this is still an area of practice that needs attention, particularly in complex situations where the child's "voice" is one of several different perspectives.

5.2 Child P communicated her distress in many ways and some of her behaviours were not always easy for family and practitioners to interpret. For example, her father and grandmother told the review that they were not listened to when they described Child P's behaviours to professionals as manipulative and indicative of a serious mental health problem. Practitioners may not have understood Child P's behaviours in the same light but there is little evidence of discussions focused on hearing her voice in the context of her behaviours. In short, the whole system could have been more clearly focused on listening to the voice of Child P even though at times this may have meant confronting uncomfortable issues which were hard for others to hear.

5.3 For example, perhaps most challenging was the meaning of Child P's online behaviour at age eleven and later just before her death. This behaviour would have been very difficult for family members to address but it did provide an opportunity for practitioners to ask searching questions about what she might have been trying to communicate about her feelings and emotions. Issues relating to the response to online behaviour is specifically explored in Finding Three.

5.4 The challenge in hearing and responding to Child P is particularly apparent in the final days before her death where she was verbalising clearly that she did not want to live with her father. By this point it seems that she believed that her presence was not valued or valid and she became invisible as the adults tried to agree the best way forward.

5.5 The capacity of practitioners within Children's Social Care to hear her voice seems to have been influenced by a legal framework which requires local authorities to promote the upbringing of children with their families and this is discussed further in Finding Four. What is clear is that her views at this point were clearly stated, as was her distress when she did not feel that she was being listened to. Practitioners need the confidence and skills to actively listen, value, and respond to the voice of the child in the moment, whilst weighing up several competing perspectives. This is a difficult task

and practitioners in all settings must have the training and support to carry out this challenging work.

Recommendation One
All partner agencies within Essex should review their practices to ensure that practitioners:

- Are supported to hear what is being communicated to them verbally and non-verbally.
- Are expected to explore the meaning of communication at all stages of their work and record this within the child's records.
- Are encouraged to use practice tools that can help communication.

Recommendation Two
All partner agencies should be able to articulate what the barriers might be to hearing the voice of the child at a system and practice level and work with practitioners to support them in this aspect of their practice.

Finding Two
Assessments should understand a child in the context of their history and current family and friend's network. Positive action needs to be taken to include all people who are important to the child in developing and updating effective plans.

5.6 This finding has also been a feature of other reviews and is particularly important in situations such as this where cumulative stresses in a young person's life need to be understood. As the thematic review into suicides in Essex found, it is the way in which vulnerabilities stack up over time that is important in assessing risk and this will be possible where a broad analysis of the child's history alongside current stressors in their relationships is carried out. All practitioners involved with the child need to be aware of the part they can play in contributing to the overall picture.

5.7 Although not all information about Child P's very early life was explored in detail during this review, there is sufficient information to conclude that later assessments could have considered more thoroughly the accumulation of stressors that she had experienced from her early years. These included parental separations and bereavements and a complicated relationship with her father who, for various reasons, had not been a consistent presence in her life.

5.8 The impact of bereavement and loss on Child P's emotional wellbeing is particularly significant and help with this was offered by individual practitioners. It is less clear how effectively child and family assessments understood the multiplicity of losses experienced by Child P and ensured that the right help was an integral aspect of Child

in Need plans. This seems to have stemmed from a focus within the assessment on the referring issue at the time rather than carrying out a broader analysis of the child and family's needs.

5.9 This broader analysis would have been an opportunity to explore the breadth of information known about Child P's current circumstances and relationships. Adults who looked after Child P had a range of needs of their own that would have impacted on Child P, but these were not always understood well enough in relation to the impact on Child P. Specifically:

- Her maternal grandparents were receiving support from Essex Adult Social Care, and it is positive that staff from adult services attended at least one Child in Need meeting. However, assessments in respect of Child P did not always explore the issues known to Adult Social Care about relationships within the home, including relationships affected by the poor health of her maternal grandfather, and consider what life was like for Child P in this environment. Part of the problem is that liaison between adult and children's services can be hampered by IT systems that are not shared – although in this case there were opportunities to "think family" after information was directly shared by the family and adult services in a Child in Need meeting.
- Linked to family needs and relationships are the challenges for any grandparents in taking on the care of a child two generations removed from their own. There was little ongoing assessment of the specific support that the grandparents might need from both health and social care as Child P moved through adolescence. Plans could have been more proactive in considering support that might be needed specifically in relation to online activities.
- Information suggests that Child P had developed a close relationship with her father's female friend who had moved into the family home, and Child in Need assessments could have been clearer about the implications of this relationship and her death, as this was likely to have been significant for Child P.
- Child P's father was known to Probation and the focus of their work moved from his index offence to his concerns about the loss of his relationship with Child P. This work took place in isolation from an understanding of Child P's circumstances and as a result any knowledge in Probation did not inform plans for Child P and vice versa. How to encourage joint working across the criminal justice system and services working with children where there are no obvious safeguarding concerns is an area for further debate and development.

5.10 The family friend's offer to accommodate Child P is explored in more detail in Finding Four. Responses by professionals at that stage could have been helped if her importance in Child P's life over many years had been understood and she had been

included in the Child in Need planning process. In addition, a greater understanding of the family friends' own needs and how she could be supported to care for Child P would have been enhanced if information about Child P that was discussed at the MARAC meeting convened due to risks to the family friend because of domestic abuse, had been incorporated into the assessment of Child P's needs. The system needs to make sure that there is not a disconnect between discussions at MARAC and plans for all children affected by domestic abuse as happened in this case.

5.11 The Child in Need planning process is an opportunity for family friends and professionals to work together to make sure assessments are based on the best information and are regularly reviewed to take account of any changing circumstances. The role that Child in Need meetings can play is discussed further in Finding Five, but more generally there were opportunities for a more joined up approach across the network, particularly in relation to understanding relationships (both positive and negative) between Child P and the adults in her life.

5.12 Specifically, there was no assessment of Child P's father and his relationship with Child P when it was muted that he could provide long term care. Plans for Child P's long-term living arrangements are discussed further in Finding Four, but one aspect of these plans was a move towards reunification without an updated assessment which properly explored their relationship over time and his current circumstances.

5.13 Both child mental health services (EWMHS) and Child P's school made every effort to meet her needs. There is evidence in both organisations of internal meetings and discussions focused on Child P, with individual members of staff doing their best to form positive relationships with her. There is evidence of some cross agency discussions at Child in Need and strategy meetings but less evidence of a coherent multi-agency plan that everyone understood and signed up to. The challenge in developing and maintaining such an approach was partly a result of changes in personnel within Children's Social Care alongside Child P's changing behaviours and circumstances which needed a swift reassessment of the most appropriate response. In the future, greater use of virtual meetings should enable rapid reconvening of professional groups to reassess responses in the light of developing needs.

Recommendation Three

All agencies should make clear the expectation that all practitioners working with vulnerable children are alert to the depth and breadth of knowledge that they hold about the child's history and current networks and ensure that this is incorporated into ongoing assessments and plans.

Recommendation Four

Child and Family Assessments must move beyond a sole focus on the referral issue to an approach which understands the child and their needs within the context of their history and current family and social networks.

Recommendation Five

Where there is a significant change in a child's circumstances a swift meeting should take place with relevant practitioners and family members in order to agree a multi-agency response and any adaptations to the Child in Need plan.

Finding Three

Work with harmful sexual behaviour online requires knowledge and confidence and is especially challenging where the young person involved in the abuse has their own vulnerabilities. Practitioners need an approach which balances risk to others alongside the needs and vulnerabilities of the young person themselves.

5.14 Understanding the impact of young people's engagement with the digital world needs to be incorporated into our thinking and practitioners will need to feel confident and skilled to explore this within assessments and plans. This also means being able to identify where knowledge and skill gaps exist, and more specialist support is needed.

5.15 Whilst young people report social and emotional benefits of digital technology there are risks attached which may not always be recognised by the young people themselves and their carers[12]. This is particularly apparent for Child P and her peer group and there was the opportunity to understand this aspect of her life from the first episode of online activity when she was still at primary school.

5.16 This first episode of "cat fishing" when Child P was still at primary school, indicates a degree of sexual knowledge unusual for her age and her behaviour online could have been putting her at risk. The reasons underlying her behaviour are not clear, but more consideration should have been given to understanding these at the time and in later social work assessments. For example, had she possibly been sexually abused or was someone inciting her into this behaviour? Later, her family expressed concern during a Child in Need meeting about Child P sharing her feelings via Instagram, that she had gained many followers and that there was a "weird situation" with a group of her peers. It seems that this was not explored further by any practitioner and was understood as normal teenage behaviour rather than being considered in the light of all that was known about Child P's situation. There was also no consideration given to any education and support that her family might need in managing this aspect of her life.

5.17 When Child P was found to have been creating online personas and inciting another young person to take her own life, the system appeared to struggle with the best way

[12] Young Minds (2016) Resilience for the digital world https://youngminds.org.uk/media/1491/resilience_for_the_digital_world_ym_positioning.pdf

to respond to Child P as a potential risk to others alongside Child P's own mental health and wellbeing. Central to this was who should inform Child P of what was happening about police investigations into her behaviour, and it was not appropriate that in the end the family were left to explain this to Child P.[13]

5.18 Strategy meetings are an important aspect of the safeguarding system in these circumstances. The challenge is to make sure that the meetings are child focused, consider the impact on the child of all decisions taken and what help and support is needed. In short, strategy meetings need to be integrated into the Child in Need planning system so that there is a comprehensive coordinated plan that addresses all the issues that are important to the child at that time.

5.19 In this case there were opportunities to take a more integrated approach. For example, at the final Child in Need meeting, the issue of Child P's online behaviour was not addressed directly with her and feels like the elephant in the room. Child P alluded to her feelings, referring to feeling angry and crying 'because of everything I have done'. It is likely that she was also scared and worried about what would happen, but no one spoke to her about this aspect of her circumstances. This may well have contributed to her feeling that life was spiralling out of control.

5.20 More generally, the whole system, would benefit from being clear about the steps that need to be taken in situations where children are displaying harmful sexual behaviour. For example, clarity about when and how to access specialist assessments such as AIM[14], roles and responsibilities in addressing risk to others and the needs of the young person themselves and specific questions that need to be addressed throughout a process involving the criminal justice system. In this case the situation was particularly challenging for the school who needed to work with a very complicated situation involving two pupils and it is not clear how effectively they were supported in this task by a clear multi-agency approach.

Recommendation Six

Essex Safeguarding Children Board should work with partner agencies to clarify the expected steps to take when young people engage in sexually harmful behaviour. The approach should respond to the young person's needs alongside reducing potential risk to others and working effectively together with specialist agencies.

[13] Father still feels that this was the right course of action.

[14] As recommended by NICE: https://www.nice.org.uk/guidance/ng55/chapter/Recommendations#risk-assessment-for-children-and-young-people-referred-to-harmful-sexual-behaviour-services. (although there is a word of caution in respect of use with girls age 12-18 in that the 'level of supervision scale may misrepresent the levl of risk)

Recommendation Seven

Partner agencies should ensure that staff have the knowledge and skills to work confidently with young people and support families, where there are risks associated with their engagement in the digital world.

Recommendation Eight

Essex Safeguarding Children Board should work with partner agencies to ensure that strategy meetings/discussions are child focused and separately identify the vulnerabilities of the young person alongside risks to others. Decisions and plans are integrated with any other plans in place to help the child and family.

Finding Four

The culture in Essex which supports children being cared for within their families should also overtly support flexible approaches where alternative solutions may be necessary.

5.21 The legal framework in England and Wales places an overarching duty on the state (delegated to local authorities) to provide support to promote the upbringing of children within their family[15] .

5.22 This legal framework underpins work within Essex Children's Care, and it is evident that social workers tried to find a solution from within the family that would meet the long term needs of Child P. However, Child P's situation was not straightforward and there were opportunities to take a more flexible approach including the provision of a support package when there was the possibility of her living with a family friend and latterly, listening to Child P's views about not wishing to live with her father.

5.23 Throughout planning for Child P's future there was a lack of clarity about who held Parental Responsibility for her. There is nothing within records held by Children's Social Care, Health agencies or the Probation Service that states unambiguously who was able to make decisions for Child P and it seems that planning for her future was based on assumptions rather than fact. The only place where this was set out was within the school records where there was a copy of the Residence Order in respect of her mother and grandmother and confirmation that her mother and father were both named on her birth certificate. Other agencies need to adopt a similar approach to gathering and recording clear information regarding Parental Responsibility when working with children and their families.

[15] September 2020. First Thought Not Afterthought: Report of the Parliamentary Taskforce on Kinship Care. https://www.frg.org.uk/involving-families/family-and-friends-carers/cross-party-parliamentary-taskforce-on-kinship-care

5.24 The situation regarding the family friend highlights learning in relation to the implications of private fostering, whether this is properly understood by practitioners in all agencies. There are examples within the records of references to foster care which indicate that there is a lack of differentiation between children looked after with local authority care and private fostering arrangements. There is also the issue of whether private foster care should be considered a suitable long-term option when there may be concern about how effectively Parental Responsibility can be exercised. In Child P's situation, although the family friend was able to give her a caring home, Parental Responsibility would have remained with her grandmother (who was unwell) and her father, who had not been a consistent figure in Child P's life. The family friend was not able to take on the financial burden of another child and did not have the space in her home to do so. The message heard by the family friend was that she would need to organise larger accommodation herself and make financial arrangements directly with the family, leaving her feeling unsupported and vulnerable to not being able to cope long term with Child P.

5.25 There is reference to social workers talking to the family friend about funding legal fees for a Special Guardianship Order, which would have been preferable to private fostering as it would have given the family friend Parental Responsibility. However, there was no structured discussion regarding the potential for Children's Social Care to exercise their discretion to provide support services and the situation remained that the family friend feared not being able to cope. As a result, she did not agree to sign any of the private fostering documentation or consider a Special Guardianship application and felt that the only solution was to become a local authority foster carer. The need for financial support for anyone providing kinship care is well documented[16] and had this been more formally considered a different outcome to discussions with the family friend may have resulted. As it was, her suggestion of becoming a foster carer would have resulted in Child P becoming a looked after child: a situation which as far as social workers were concerned would not be entertained by their senior managers.

5.26 The message that is heard by social workers in Essex regarding entry to the care system is that this should be a last resort. This is in line with the spirit of the legislation and the knowledge that care is unlikely to result in the best outcomes for the majority of young people. This does not take account of the need for a more nuanced approach and the flexibility to at least entertain the possibility that care may be in a child's best interest. The response of the chair in the final Child in Need meeting, when Child P is asking to go into care, that the social worker would not get a green light for care from senior managers, indicates that conversations about young people on the edge of care do not consistently reach managers within the organisation who could either support social workers in holding the risk or authorise accommodation.

[16] Hunt, J (2020) Two decades of UK research on kinship care: an overview FRG

5.27 There is a need to move to a position where front line staff understand that it is acceptable to have professional conversations about whether a young person needs to be looked after and to take this conversation to senior managers. An unintended consequence of a policy aimed at reducing children in the care system may be a belief that good social work practice involves not discussing the possibility even within their own supervision except in extreme circumstances. This practice as it currently stands is in danger of following the "garden path" syndrome whereby a fixed point of view predominates, and all information is understood within that frame. In these circumstances new information is discounted if it does not fit the predominant point of view and in this case, the signs that Child P was becoming increasingly distressed at the option of living with her father was not given the attention that it deserved.

Recommendation Nine

Essex Children's Social Care should take steps to promote a balanced approach to discussions about whether a child should become looked after. This should ensure that the Family First principle is maintained whilst encouraging debate and professional conversations about individual cases at a senior enough level so that risks can be shared, and decisions challenged.

Recommendation Ten

Essex Children's Social Care should clarify the process for the provision of financial support for family and friend carers and make sure that this is used creatively to prevent children becoming looked after.

Recommendation Eleven

All partner agencies should take steps to ensure that practitioners understand the status of private fostering in order to differentiate between children looked after and those in private fostering arrangements.

Finding Five

There is potential to develop the use of Child in Need meetings from a procedural/case management approach to one where they are understood to be part of the process of intervening and helping children and their families.

5.28 Unlike the majority of children who were subject of the Essex thematic review into teenage suicides, Child P was known to Children's Social Care and EWMHS. She was subject of a Child in Need plan and there were three Child in Need meetings during the review period. The independent reviewer has had the opportunity to listen to a recording of two of the Child in Need planning meetings which had been made by Child P's father and the final meeting was a pivotal moment in this case.

5.29 Child in Need meetings are designed to review the Child in Need plan and to keep this on track. However, they are also meetings involving several professionals, family members and sometimes the child or young person; as such they are much more than a business meeting and need to be understood as part of the process of work with the child and family. If they are really focusing on achieving meaningful change and improvement in the young person's circumstances it is likely that the chair will need to facilitate discussion of contentious issues/painful topics whilst assessing any blocks to achieving the objectives of the plan or need to change the plan itself. Managing group dynamics and complex relationships both across agencies and between the family and professionals must be part of the skill set of anyone chairing in these circumstances.

5.30 Child in Need meetings for Child P did not always include the right people - for example, the family friend who was offering to care for Child P was not invited at the point this would have been helpful – and the opportunity to really work with the family, explore difficult issues and adjust the plan accordingly was not evident. For example, the impact on Child P of her grandfather's behaviour, concerns about her use of Instagram and her feelings about where she wanted to live.

5.31 The majority of Child in Need meetings are chaired by the child's social worker or their manager. Not all those asked to chair will be given the training and ongoing development opportunities they need and have time to prepare adequately for each meeting. Equally, not all professionals attending meetings may be aware of their role and the importance of fully participating in the development of a multi-agency plan.

5.32 Chairs need to be able to anticipate tensions that might develop and prepare carefully for meetings. For example, it would have been helpful if preparation before the last meeting had included the chair's discussions with EWMHS and the school to understand their positions vis a vis Child P's schooling and living arrangements. The impact of this not happening is evident in the final Child in Need meeting. This meeting took place when the allocated social worker was on holiday and lack of opportunity to think together about Child P's circumstances meant that the meeting went ahead, when a better decision would have been to delay – this was even more the case when on the day it was clear that EWMHS could not attend. Delay may have prevented the mixed messages to Child P and a situation where each agency (with the best intentions) appeared to focus on their own agenda. For example, the school focused on the positive aspects of a managed move and tried hard to be positive about how intelligent Child P was and the possibility of a bright future for her and the chair focused on the importance of her being cared for by family rather than going into foster care. The unintended consequence seems to be that Child P believed that her voice was not heard, and her distress not recognised.

Recommendation Twelve
Guidance regarding the purpose and conduct of Child in Need meetings should be disseminated to all partner agencies in order to develop an effective multi-agency approach which gives all practitioners the confidence to take an active role.

Recommendation Thirteen
Essex Children's Social Care should review the training and development opportunities for staff who are expected to chair Child in Need meetings to ensure that all staff are adequately supported to undertake this complex task.

Recommendation Fourteen
Systems should be in place to ensure that time is taken to prepare for Child in Need meetings including:

- Full consideration of who from the professional and family network should attend.
- Conversations between key attendees to establish key areas for discussion.

Recommendation Fifteen
A system should be established for the ongoing monitoring of the quality of Child in Need meetings.

Recommendation Sixteen
Essex Safeguarding Children Board should ask Partners to evaluate progress in developing and supporting effective supervision practice for all staff working with vulnerable children and their families.

6 SUMMARY OF RECOMMENDATIONS

Recommendation One

All partner agencies within Essex should review their practices to ensure that practitioners:

- Are supported to hear what is being communicated to them verbally and non-verbally.
- Are expected to explore the meaning of communication at all stages of their work and record this within the child's records.
- Are encouraged to use practice tools that can help communication.

Recommendation Two

All partner agencies should be able to articulate what the barriers might be to hearing the voice of the child at a system and practice level and work with practitioners to support them in this aspect of their practice.

Recommendation Three

All agencies should make clear the expectation that all practitioners working with vulnerable children are alert to the depth and breadth of knowledge that they hold about the child's history and current networks and ensure that this is incorporated into ongoing assessments and plans.

Recommendation Four

Child and Family Assessments must move beyond a sole focus on the referral issue to an approach which understands the child and their needs within the context of their history and current family and social networks.

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Essex Safeguarding Children Board should ask Partners to evaluate progress in developing and supporting effective supervision practice for all staff working with vulnerable children and their families.

7 APPENDIX ONE – LEAD REVIEWER

7.1 Jane Wonnacott qualified as a social worker in 1979 and has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on child protection practice. She has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed in excess of 200 serious case reviews, many of national significance. She has a particular interest in safeguarding practice within organisations and was the lead reviewer for two reviews into abuse in nurseries and the serious case reviews into St Paul's School and Southbank International School London. She has contributed to the literature exploring effective safeguarding education settings. Jane is a member of the National Child Safeguarding Practice Review Panel pool of reviewers.

8 APPENDIX TWO – TERMS OF REFERENCE

Partnership Learning Review

Terms of Reference

1. Subject of Review

Child: Child P

Family Members:

Mother (deceased):
Father:
Maternal Grandmother (deceased)
Maternal Grandfather (deceased)

2. Reason for the Review

Child P was approaching her 14th birthday when she took her own life. At the time of her death, she was living with her maternal grandparents following her mother's death four years earlier. The post-mortem report stated that the cause of death was multi-drug ingestion and overdose.

Child P had a number of significant vulnerabilities, which appeared to have impacted upon her life, and these were known to agencies who worked with her.

3. Relevant time period for the review

January 2015 (the date Child P's mother died) to 2nd September 2019, the date of Child P's death.

4. Organisations who should contribute to the review

1) Children & Families, Essex County Council
2) East of England Ambulance Service
3) Education, Essex County Council
4) Emotional Wellbeing and Mental Health Services (EWMHS)
5) Essex Child and Family Wellbeing Service (ECFWS)

6) Essex Community Rehabilitation Company (CRC)
7) Essex Police
8) Family Solutions, Essex County Council
9) CCG
10) Acute Hospital Trust
11) School
12) Bereavement Counselling Project

5. Review Team Representatives

1) Children & Families, Essex County Council
2) Education, Essex County Council
3) Emotional Wellbeing and Mental Health Services (EWMHS)
4) Essex Community Rehabilitation Company (CRC)
5) Essex Police
6) CCG Designated Nurse
7) CCG Designated Doctor

6. Questions to be considered

1) Child P had a wide range of significant vulnerabilities, did agencies work together effectively to support her?

2) Would "Team Around the Family" meetings have helped support Child P and her family?

3) There had been allegations that Child P may have been exposed to indecent images and possible earlier sexual abuse – was this ever explored by professionals?

4) Did agencies sufficiently support Child P in respect of her online / social media activities and the associated risks

5) Were professionals aware of the strained relationship between Child P and her father when her living arrangements were being considered?

6) What understanding was there amongst professionals of the impact of grandmother's diagnosis on Child P given her mother's own illness and subsequent death 4 years earlier?

7) Had involved agencies undertaken a risk assessment; had they jointly identified the potential risks and created a meaningful safety plan for Child P; did the risk assessment recognise what Child P was feeling and fearing at that time.

8) Child P felt that she was not being listened to; is there more that agencies could have done to ensure that she felt listened to?

9) Could anything have been done differently in relation to the discussions or conversations with family friend about Child P staying with her, including the private fostering assessment, the family friend's request to be considered to become a paid foster-carer etc?

10) Is it felt that the learning from the Thematic Review undertaken by the ESCB in 2018 had been considered in respect of Child P -particularly in relation to "stacking factors" for Child P?

11) How collectively did agencies respond to Child P's bereavement?

7. Methodology

The review process is designed to ensure an open and collaborative approach which includes the perspectives and views of practitioners and family members, that there is a focus on *what* happened and *why* practice decisions were made. The review seeks to move beyond a focus on individual practice to an understanding of lessons for the safeguarding system the as a whole.

The process of the review will be:

1. Gathering and analysing written information via chronologies and other relevant reports.

2. Agreeing key practitioners who should be offered an opportunity to contribute. Meeting with family members.

3. Meeting with family members.

4. Meeting with practitioners either individually or in small groups. These meetings will be led by the lead reviewer along with a panel representative with professional expertise in the area bring discussed.

5. Key themes and learning to be agreed with the Review Team.

6. Production of a draft report to be agreed by the Review Team.

7. Sharing of the final draft with all those who have contributed.

8. Production of final report agreed with the Child Safeguarding Practice Review Sub-Committee and presented to ESCB Executive.