

Essex
Safeguarding Children Board
Child Safeguarding Practice Review
Child C

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March 2023

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1 INTRODUCTION

- 1.1 This child safeguarding practice review has been commissioned by Essex Safeguarding Partners following the death of a seventeen-year-old girl known in this report as Child C.
- 1.2 Child C died in October 2020, and an inquest in November 2022 determined that she took her own life. In August 2020 Child C was discharged from an in-patient psychiatric unit. She had been admitted in December 2019 under s2 Mental Health Act for assessment and remained there under s3 Mental Health Act until that was rescinded in July 2020. Following this this remained as an informal patient until her discharge in August 2020. On discharge she moved to accommodation adjacent to her paternal grandmother's property.
- 1.3 The note Child C left before her death describes her feelings of being not good enough for anyone or anything, a belief that her life was pointless and not wanting to be let down any more by professionals. She also expressed empathy and love for members of her family.

The decision to carry out a Child Safeguarding Practice Review

- 1.4 Child C and her family had been known to various statutory agencies for several years and immediate reviews of practice were carried out by children's social care and the Emotional Wellbeing and Mental Health Service¹. A referral for a child safeguarding practice review was subsequently made to Essex Safeguarding Children Board in July 2021 as it was considered that there should be a full multi agency review. A Rapid Review of all available information was carried out in July 2021 and the Rapid Review meeting agreed that this was a serious child safeguarding case that might highlight improvements that could be made to safeguard and promote the welfare of children. As such, Child C's death met the criteria for a child safeguarding practice review as set out in Statutory Guidance.²

The Process of the Child Safeguarding Practice Review

- 1.5 This review has been led by Jane Wonnacott an experienced independent consultant.³ Although Statutory Guidance no longer requires the lead reviewer to be independent of all agencies involved with the child, in this case the Essex Safeguarding Partners wished to ensure there was no conflict of interest and that there was appropriate independent scrutiny.

¹ Previously known as CAMHS

² Working Together to Safeguard Children 2018, Page 87.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

³ Please see Appendix Two for a brief biography

- 1.6 The purpose of child safeguarding practice reviews as set out in statutory guidance is:
... to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage. (P84)
- 1.7 This review is therefore firmly focused on learning for the safeguarding system as a whole. This has involved a detailed analysis of *what* happened but as required by statutory guidance, it has aimed to move beyond a focus on individual actions to explore *why* events occurred and whether there are opportunities to improve the safeguarding system for other young people in similar circumstances to Child C.
- 1.8 The starting point for this report is Child C's life and her experience of the world around her. She was a much-loved child and granddaughter and her parents and grandmother have been willing to help us understand more about Child C's life than can be gleaned from professional records. Although this has not been easy for them, the review team are immensely grateful to them for their participation in the review and their views and comments have been integrated throughout this report. They have seen the final draft of this report and are content that the details of Child C's life have been represented fully and fairly.
- 1.9 The detailed exploration of professional practice has been achieved through a review of paper records alongside discussions with practitioners who knew Child C. Practitioners across Essex have been deeply affected by Child C's death and the review team are grateful for their willingness to reflect openly and honestly about their contact with Child C.
- 1.10 In summary the review process has included:
- Appointment of an independent lead reviewer and review team.
 - Terms of reference and questions for the review agreed by the review team.
 - Preparation of agency chronologies and summary reports (detailed chronologies started in 2018)
 - Discussion with Child C's mother and father.
 - Discussion with Child C's paternal grandmother.
 - Discussions with practitioners who had worked with Child C and the family.
 - Review team discussions to clarify factual accuracy, analyse information and agree findings and recommendations.
- 1.11 The review has also had access to statements and other material prepared for the coroner.
- 1.12 The review has included consideration of Child C as an autistic young person. Language used to describe people who have a diagnosis of autism is acknowledged to be a

sensitive subject that needs careful consideration⁴ and there are different views within the autistic community as to the preferred language. Autism Spectrum Disorder is the official way of describing autism, but many autistic people and families feel that the term 'disorder' is too negative for everyday discussions as autism is a difference rather than a disorder. We have also taken account of the comment that *Research shows that there isn't a single way which is accepted by everyone. However, autistic and on the autism, spectrum were the preferred terms among most autistic adults and families. People with autism is still used quite a lot, but more and more people do not like it.* We are aware that the terminology used within Child C's records generally referred to Autistic Spectrum Disorder and on occasion that terminology is used in this report. A more general reference to autism is used where appropriate. Agencies in Essex are actively considering their use of language in order to inform practice and record keeping in the future.

Parallel Processes

- 1.13 An inquest into Child C's death was opened in October 2020 following her death and was adjourned until the final hearing in November 2022. The coroner requested a draft of this report before the final hearing and in order to assist the inquest there is more specific detail in this report than might be usual in an LSCPR. The lead reviewer was called to give evidence at the inquest, which confirmed the cause of Child C's death as suicide.

2 CHILD C'S LIFE UP TO THE AGE OF 13

- 2.1 Child C was born in 2003 and had one older half sibling (Sibling 1) who was eight when she was born and another older Sibling (Sibling 2) who was 21 months older than her. In 2012, when Child C was age nine, Sibling 3 was born and was subsequently diagnosed with Downs Syndrome and developmental delay.
- 2.2 Child C and her family are all White British. The family lived in their own home and her parents were able to provide a financially secure home for their children. Child C's parents were active members of a local church and records indicate that their religious beliefs were a strong driving force behind their approach to parenting.
- 2.3 Child C attended a local nursery and primary school and was quiet and calm, never drawing attention to herself. She had few friends and was described by her parents as never being interested in other children.

⁴ <https://www.england.nhs.uk/learning-disabilities/about/get-involved/involving-people/making-information-and-the-words-we-use-accessible/#:~:text=Autism%20Spectrum%20Disorder%20is%20the,autistic%20people%20and%20their%20families.>

- 2.4 Relationships within the extended family are complex. Mother describes her family as willing to be supportive, but support was limited due to her father's poor health. Father grew up in a busy household where his mother (Paternal Grandmother), at various times, had one or more of her sisters' five children to live with her (funded by children's services) after her sister had died of cancer. This is relevant to later discussions with Paternal Grandmother about funding when Child C moved into accommodation provided by her.
- 2.5 The most significant issues for Child C within her family relate to her siblings, who all had various challenges and needs. A detailed review of records shows that the depth and extent of these challenges would have had a profound effect on all the family during Child C's formative years. One or other of her older siblings were known at various times to children's social care, youth offending and probation services and it is significant that the impact of their circumstances on Child C as a young child exposed to a variety of challenging behaviours was absent from assessments in agencies who were working with them.
- 2.6 At the age of 13 Child C had been diagnosed with coeliac disease, a condition where the immune system attacks a person's tissues if they eat gluten. Child C was referred to a dietician for advice and monitoring of her condition and from the start she was adamant that she was not going to follow a gluten free diet although her parents report that she was compliant within the home. The implications of not consistently following this diet are discussed later in this report.

By this stage, Child C had been living for most of her childhood in a household disrupted by her older siblings challenging behaviour. Her younger brother had been born with downs syndrome/developmental delay and as a result needed time and attention from her parents. Within this environment Child C did not stand out as needing special attention, she caused no problems in school and although her lack of social interaction and other traits associated with Autism Spectrum Disorder caused her mother some anxieties there were no other overt signs that prompted an assessment or diagnosis.

3 AGENCY INVOLVEMENT IN ESSEX: CHILD C AGE 13 ONWARDS

- 3.1 By the time Child C was 13 there was recognition by a supervisor in the team working with Sibling 2 that the needs of Child C and Sibling 3 should be considered via a child and family assessment to be completed within four weeks. This assessment did not start, and a further review by the service manager resulted in a request for Child C and Sibling 3 to be opened to children's social care and assessments completed. This also did not happen as the assessment was going to be completed by Sibling 2's social worker but they were on long term sick leave.

- 3.2 In September 2018, Sibling 2's Child in Need Review referred to Child C self-harming with visible scars on her arms.
- 3.3 In November 2018, an assessment in respect of Sibling 2 did note that Child C had started to self-harm. The assessment noted that she had been referred to the child mental health service (EWMHS), but she had said that she would not talk to anyone about her worries; although Sibling 2 did say she would talk to him. The recommendations and plan from the assessment focused on support for Sibling 2 and also the need to identify family dynamics, rebuilding family relationships and support for Child C.
- 3.4 Later in November 2018 Sibling 2 was accommodated by the local authority under s20 Children Act 1989 after an incident which included threats to kill his younger siblings. He was placed in semi-independent accommodation.

Records relating to Sibling 2 from 2016 – 18 document a deteriorating situation with serious concerns and it would have been obvious that living in this environment would have an impact on his siblings and this was confirmed when Child C began to self-harm.

The need for Child C and Sibling 3's needs to be assessed was recognised at a service manager level within children's social care but when staff sickness and lack of capacity meant that an assessment was not possible, the impact of this was not recognised and escalated to senior managers. It is likely that Child C experienced extreme fear as a result of Sibling 2's behaviour. The issue of power and control in their relationship was identified and thought to be a reason why Child C would only talk to her sibling, but this did not prompt any detailed analysis of what needed to be done to support Child C. It is not known the *exact* degree to which Child C may have felt threatened or afraid living within the same community as her sibling and practice today would be more likely to consider this situation within the frame of "risk in the community"⁵ which aims to understand risk of harm outside the immediate family environment.

There appears to have been little by way of a multi-agency holistic response to the family and it is notable that Child C did not draw attention to herself at school and generally did well. The school did not identify any concerns about self-harming behaviour but did notice that she had one close friend and remained on the periphery of other friendship groups. Paternal Grandmother has told this review that Child C was very aware that teachers knew her as the younger sibling of her two older brothers and it seems she did all she could not to draw attention to herself. It is also likely that Autism Spectrum Disorder would have impacted on the way she interacted with her peers.

⁵ This is the terminology in Essex for an issue which in other areas is referred to as "contextual safeguarding".

- 3.5 Child C's coeliac disease had been managed by the paediatric team at the local hospital and in the December before her 16th birthday she was referred to the transition team who are responsible for managing smooth transfer into adult health services. She was seen with her mother in February 2019 and the transitions nurse was concerned to hear from Mother about her low mood and self-harming. Mother also mentioned family difficulties and during the appointment Child C appeared withdrawn with poor eye contact. After this appointment, the transition nurse spoke to the safeguarding lead and the consultant at the hospital, and the decision was that a referral should be made to the local child mental health service (EWMHS). This referral was made and when EWMHS's triaged the referral they suggested to Mother that she should request an autism assessment. EWMHS attempted to contact Child C, but she would not engage at that point and was referred for an initial assessment.
- 3.6 The transitions nurse also tried to call "the social worker" (i.e. the social worker responsible for Sibling 2) and was advised that the social worker was on sick leave. The transitions nurse also liaised with the school nurse and had a further discussion with the safeguarding lead who recommended a TAF (Team Around the Family) meeting. When children's social care were told of the plan for a TAF, a newly allocated social worker confirmed concerns about self-harm and advised that Child C was open for assessment and agreed to attend the TAF which the school nurse was organising at school.
- 3.7 The transitions nurse also spoke to EWMHS as Mother was concerned to receive a letter which said that EWMHS could not support Child C as self-harm had not been identified. EWMHS confirmed that Child C was still open to the service and was on a waiting list for an appointment. The transitions nurse also requested that EWMHS attended the TAF meeting.
- 3.8 The TAF meeting was hosted at the school. The GP had given apologies and EWMHS also did not attend. The plan from the meeting was that an ADOS (autism assessment)⁶ referral should be made by the school nurse supported by a report from the school. The social worker would continue with the assessment and the transitions nurse would continue to provide support.
- 3.9 Child C attended an appointment with EWMHS and although she did not initially want to engage, she then 2 months later changed her mind and agreed to start regular therapy.
- 3.10 The community paediatrics team received the referral for the ADOS assessment in April 2019 and an initial telephone consultation with Mother was arranged for August 2019.

During this period the transitions nurse was tenacious in trying to get the right support plan in place for Child C. The nurse has told this review that she had a "gut reaction" that something was not right and as a result worked hard to liaise with all the key

⁶ Autism Diagnostic Observation Schedule.

services who could provide support. It seems that the nurse informally assumed the role of lead professional.

The ADOS assessment system at that time was under some pressure – hence the delay and the initial process at that time was a telephone consultation.

Grandmother believes that there should have been opportunities for the school to identify the extent of Child C's self-harming behaviour. The school would also have been aware of Child C's family, the behaviour of her siblings and could have been an important source of support as a partner in a multi-agency plan. It seems that the concerns of the school were reduced, due to Child C's continued quiet demeanour and good behaviour.

- 3.11 The social worker saw Child C four times during the assessment and Sibling 3 on three occasions. Information from the school to the social worker was that there was no one who had a relationship with Child C, she was quiet and withdrawn, attendance was 99.2% and she was making good progress. The GP reported no causes for concern for either Child C or Sibling 3. Mother was adamant that Child C's demeanour and issues were the result of a medical condition such as autism or depression. Sibling 3's sleep problems and aggressive behaviour at school is also mentioned and Child C spoke of Sibling 3 having all the attention from her parents although she was often left to discipline him. Mother confirmed how stressed she was due to lack of sleep, and she has told this review that she found the social worker's comment during the assessment that she lavished attention on Sibling 3 and did not touch Child C very hurtful. Mother feels that the social worker did not understand that lack of physical contact was related to Child C's autism.
- 3.12 During the period of the social work assessment the EWMHS clinician spoke to the social worker. The EWMHS record notes that the social worker said that there were concerns that there *may be a deep underlying disclosure that is waiting to come out and [Child C] is too scared to tell anyone*. The EWMHS clinician explained that they cannot force young people to engage and although the social worker was concerned that Child C may be suicidal and try to act it out, there had been no evidence to suggest this, so a mental health act assessment was unlikely to be requested. Following this conversation, the EWMHS clinician accessed clinical supervision and it was agreed that an assessment by a psychiatrist should be carried out. This did not happen immediately as Child C did not agree to a psychiatric assessment.
- 3.13 The social work assessment was completed in May 2019 and concluded that Sibling 3's case could be closed as he did not reach the threshold for a service. Child C's needs could be met via a Team around the Family approach led by the school and the case closed to children's social care.

This seems to be an example of the difficulties of adopting a whole family approach which considers the interrelationships within the family and moves beyond understanding children's needs in isolation from each other. By this time, the

complexity of Child C's family circumstances (possible ASD, disrupted family background and distress communicated via self-harm) was apparent and she spoke consistently about her worries regarding Sibling 3 and the impact he had on her life. This complex situation would have benefited from a coherent multi-agency plan focused on meeting both children's needs.

The decision that Sibling 3 did not reach the threshold for a service was made by a social worker who did not have specialised expertise in working with disabled children. In fact, Sibling 3's behaviours and the struggles that his parents were experiencing in responding to his needs should have led to Sibling 3 being defined as a Child in Need, his care and support needs identified, as well as consideration being given to a carers assessment⁷. This would have been more likely to be recognised if a joint assessment had been carried out with the children with disabilities team and this is explored further in the review findings and recommendations.

Although comment is made that the school could lead work via a TAF there is no record of any further liaison with the school regarding this plan and their lead role is not clear. It is also significant that Child C was due to leave school and move to 6th form college in the coming months.

- 3.14 The transitions nurse called Mother. At this point Mother told her that the social worker had left, and it was unlikely that she would be allocated another social worker. At this stage there does not seem to have been any clear communication with the family or between professionals about the team around the family plan.
- 3.15 In June 2019, a request for support from early help for Sibling 3 was received by the children's services hub. Sibling 3 was recorded as experiencing sleep apnoea, Downs Syndrome and significant learning delay and support was requested with respite and direct payments. The hub assessment notes the current concerns in relation to Child C and that support needed to be in place for the family including Child C feeling valued and supported. However, because this was deemed by the Hub to be information on an open case the request for support was not progressed. In fact, the only open case was Sibling 2.
- 3.16 In August 2019, the telephone consultation took place with Mother as part of the ADOS assessment. The usual set questions were asked as part of the assessment and Child C's low mood and self-harm were also spoken of. As a result of these concerns about Child C's mental health, a letter was sent to Mother recommending chasing EWMHS; this was copied to the GP. There were sufficient indicators of autism to move to the next stage of requesting a screening questionnaire from the school. Child C had just left her secondary

⁷ Under section 17 of the Children Act 1989, disabled children are automatically considered to be "children in need". This means they are entitled to have their social care needs assessed, and to receive any support they are eligible for.

school to move to 6th form college, but it was felt best to ask the secondary school to complete the questionnaire as they knew her best. Nothing was returned and the consultant paediatrician wrote to the 6th form college who replied that they did not have enough context to complete the document.

- 3.17 Child C had started 6th form college at the start of September. Her application had included information about coeliac disease but no other potential vulnerabilities. Her English teacher immediately raised some concerns about her demeanour (withdrawn tense and not able to engage with others) and contact was made with Mother and some family history noted. The college began to formulate a plan for supporting Child C and when the child protection record was received from the secondary school, there were only two concerns noted relating to fainting due to lack of food in 2017 and a s17 response which noted no concerns.

There is evidence of good proactive work by 6th form college, but a worrying lack of information handed over by the school. Although there had been no formal child in need or child protection plan the school had detailed knowledge of the complex family circumstances that affected Child C and had also been involved in a Team Around the Family meeting. This information should have prompted a discussion as to Child C's vulnerabilities and needs.

- 3.18 In September/October 2019, there was communication between the transitions nurse and EWMHS. The transitions nurse was able to let EWMHS know that the ADOS assessment was not complete because the school had not yet returned the ADOS questionnaire.
- 3.19 Child C had her first session with the EWMHS clinician in June but due to staff sickness regular sessions did not start until September 2019. There were regular weekly sessions through October during which Child C did speak about family tensions, secrets and suicidal thoughts and attempts. During this time the clinician suggested referral to the intensive support service, but Child C declined. Risk assessments were updated, and Child C noted to be high priority. By the end of October Child C had reluctantly agreed to a referral to the psychiatrist.
- 3.20 In November, the EWMHS clinician was so concerned about Child C that she contacted her mother. Mother was not immediately available and according to Mother this was due to the multiple demands on her time associated with Sibling 3's care. The EWMHS clinician also called the intensive support service for an assessment. The assessment took place with Child C, Mother and younger brother and the outcome was that inpatient treatment was not in her best interests at that time but there would be a safety plan reviewed by the intensive support service in seven days' time. The care plan was:
- parents to monitor and lock potentially harmful items up
 - parents to call EWMHS if needed
 - in an emergency 999 to be called

- ISS to arrange urgent psychiatrist review
- ISS to discuss assessment at the multidisciplinary team meeting (MDT) for formulation

- 3.21 The next day Mother e-mailed the 6th form college to explain that Child C was experiencing significant mental health problems and was now under the crisis team. Mother asked to be informed if Child C did not arrive for lessons and the college made sure all relevant staff were aware.
- 3.22 The EWMHS records note that the care coordinator also liaised with college the same day and was told that Child C was in college but had not attended lessons. It was agreed that she should be sent home and that an urgent psychiatry appointment would be arranged for that day. College records note that she was found on site and after a discussion with her mother it was agreed that she was not well enough to be in school and was sent home by taxi. The result of the psychiatric assessment was medium risk of deliberate self-harm, and it was agreed with Child C that she would start taking medication prescribed by the GP.
- 3.23 The intensive support service clinician discussed Child C in supervision, and it was agreed that a referral would be made to children's social care for more support. A referral was sent by EWMHS and the same day the 6th form college met with Child C and her mother to plan a return to college the next day.
- 3.24 In November EWMHS clinician met Child C who said she had been late for college the previous week because she was attempting to hang herself on a tree near her home with a skipping rope but unable to complete it so went to college. She would not disclose where the rope was and reported she would not be at the next session the following week as she would have completed suicide by then. She disclosed some of the trauma she witnessed between her brothers and parents and was asked if she needed to be accommodated elsewhere but she reported there was nowhere else to go. Child C reported she would continue to find things to hurt herself with despite her parent's attempts to hide everything.
- 3.25 As a result of further referrals in November 2019 a child and family assessment was triggered in respect of Child C, the outcome of which was that Sibling 3's needs should be assessed by the children with disabilities team. The assessment in respect of Sibling 3 noted the strain on Mother due to lack of sleep/exhaustion and the subsequent strain on the rest of the family. Child C was seen at the first home visit but did not engage with the social worker and hid under a hoodie. By the end of the assessment Child C had been admitted to the mental health unit. A plan was put in place for Sibling 3 which included behavioural strategies and support via the children's and young people's support services. The need for a paid support package was also to be reviewed after implementation of the behaviour management plan.

- 3.26 Later in November, Child C told the EWMHS clinician that she had an argument with her father and said she would not be around for the next appointment. After this the EWMHS clinician attempted to contact Mother but did not receive a reply to voice messages.
- 3.27 The intensive support service clinician received a text message from Child C reporting she had tried again to hang herself and could not go home as she did not want to scare other people but just felt she needed to die. The clinician advised in a direct text response to call an ambulance and attend A&E. Shortly afterwards the clinician followed this up with a phone call to Child C advising her to call an ambulance and have her neck checked for any injury, but she declined and was more concerned about how she would explain the mark it had left. The intensive support service clinician alerted the duty clinician who would follow up the issue. The EWMHS care coordinator and clinician on duty were informed of the incident. An evening intensive support service welfare check was scheduled.
- 3.28 The clinician on duty telephoned Child C who said she was walking home. She was made aware that her mother would be informed and asked to take the rope from her.
- 3.29 The next day the intensive support service clinician spoke with Child C via telephone. She declined to be seen for an appointment and reported feeling OK. Her mother told the clinician that because of the risks, she was going to spend the day with her daughter rather than her attending college and telephone call from Mother explaining the situation is noted in the college records. The same day, a multi-disciplinary team huddle was convened by the intensive support service team to discuss Child C. They scheduled a joint meeting with EWMHS, intensive support service, Child C and her family. Child C was reluctant to attend but agreed she would come.
- 3.30 Child C was seen by the EWMHS pathway lead, the intensive support service practitioner and a student nurse so that a risk assessment could be completed. (The usual EWMHS therapist was on holiday.) She spoke of suicide attempts, was reluctant to answer some questions but did say her EWMHS therapy and medication was helpful. The plan included continuation of support from the usual EWMHS clinician who was to liaise with college and arrange a professionals meeting. Child C's psychiatric appointment was to be moved forward and a joint home visit carried out between EWMHS care coordinator and pathway lead to observe interactions within the family and complete home risk assessment.
- 3.31 There was contact with Mother by the intensive support service team who was concerned that the medication was causing agitated and restless behaviours.
- 3.32 Child C was closed to the intensive support service and prime responsibility for mental health care remained with the EWMHS care coordinator.

This period of involvement by the intensive support services demonstrates the positive support the service can give to the community EWMHS team. The fact that Child C sent a text to the intensive support service clinician suggests that this clinician was skilled in quickly forming positive relationships with young people such as Child C. The team's

involvement is by definition short term but there was evidence of timely response and effective joint working to support the EWMHS clinician.

The assessment of Sibling 3's needs took place in isolation from the increasing worries about Child C's emotional wellbeing and there was little opportunity for the children with disabilities practitioner or the EWMHS clinician to consider the whole family situation.

3.33 In early December, the EWMHS care coordinator discussed Child C in safeguarding supervision. The decision was to consider escalation to social care due to repeated closure of case and support required not being provided.

3.34 On 11th December Child C walked out of a therapy session at EWMHS leaving an envelope with £100. This precipitated a call to the police who located her, were concerned about her behaviour, detained her under s136 and took her to hospital. The next day she was transferred to the local mental health unit intensive care ward where she remained first under s2 of the Mental Health Act and from 3rd January 2020 under s3.

The EWMHS clinician responded swiftly to the critical incident and promptly called the police.

Throughout the previous months the EWMHS clinician had forged a therapeutic relationship with Child C and has been described by family as one person Child C felt positively about. However, although this clinician had access to internal supervision where she could explore the emotional impact of the work, she was increasingly carrying a great deal of responsibility for Child C. In many instances she was providing support that should have been the responsibility of a social worker.

Consideration needs to be given to when complex circumstances such as these can be supported by a more structured multi-disciplinary approach. It appears that young people such as Child C are not seen as "fitting" within the services as they currently are configured and, in this case, did not trigger formal Child in Need planning.

3.35 Child C's paternal grandmother has told the review that as soon as she was told by Mother that Child C was in hospital, she visited her every day. Paternal grandmother has described positive relationships with ward staff but felt concerned that Child C was not getting the right food for her coeliac disease as the hospital were not aware that she needed gluten free food, although from the hospital's perspective they did make this available. There was no direct contact with the paediatric medical team who had cared for Child C for many years and the transitions nurse was not aware that she had been admitted to hospital. Similarly, the hospital were not aware that the transitions team were involved, and usual hospital practice was followed which is to ask the GP for a medical summary.

- 3.36 Following admission Child C was placed in the psychiatric intensive care unit for assessment. She was initially nursed on level 3 nursing observations (within eyesight) and as she began engaging with staff and peers this was reduced to level 2 checks in social areas although she remained on level 3 in isolated areas. She was encouraged to take her prescribed medication and was offered family therapy, occupational therapy, individual psychological therapy and therapeutic education.
- 3.37 In February 2020 Child C was diagnosed with autism based on her clinical presentation, developmental history and an ADOS assessment.
- 3.38 The provision of family therapy proved challenging as Sibling 3 needed to accompany parents to the sessions and parents therefore joined the session individually whilst the other cared for Sibling 3. From the start of her time on the unit it was clear that Child C did not want to return home.
- 3.39 At a care programme approach meeting on 31st January, it was agreed that Child C needed a further period in hospital and that it would be appropriate to consider a step down to a general adolescent ward as the least restrictive option, and to work towards discharge. This transfer occurred on 12th March 2020
- 3.40 The hospital social worker had become involved in February 2020 and made a referral to children's social care requesting a s17 assessment because Child C was adamant that she did not want to return home. The referral identified that a Child in Need assessment was needed to ensure safe discharge from hospital with a robust exit plan. It noted she was entitled to s117 aftercare⁸ and Child C had requested supported living in the community.
- 3.41 On 11th March, the hospital social worker received notification from children's social care that an assessment would be carried out and a social worker attended the Care Programme Approach meeting on 13th March 2020. The minutes of this meeting note that *we discussed how over the next six weeks all the agencies will need to work together formulating the 117 plan around where she will live and what kind of immediate and ongoing support she will need.*
- 3.42 The social work assessment was completed on 8th April 2020. It was a thorough assessment which set out family history, showed an understanding of tensions within family relationships. It included three sessions with Child C, discussion with wider family and a visit to both grandmother's and the parental home. It noted that Child C was clear she did not want to return to the parental home and had said she would kill herself if made to do so. She also expressed a fear that if she went into supported accommodation, she would be abandoned in the way that her older brothers had been. Child C told the social worker that she wanted to move in with her paternal grandmother but keep in contact with her parents. The assessment noted that Child C's parents were not in agreement with her moving in with paternal grandmother and if she could not

⁸ S117 aftercare is help and support that people are entitled to when they have been kept in hospital under the Mental Health Act.

return home, she should move to supported accommodation. The assessment recommended that as Child C was still an in-patient and would have a home with grandmother when she left hospital there was no role for children's social care at that time. It noted "*should mental health services have concerns for [Child C] at the point she is discharged from hospital they can re-refer*".

- 3.43 Child C continued to engage well with individual therapy and at a care programme approach meeting on 1st May 2020 was noted to be ambivalent about engaging in family therapy. Child C did agree that incidents of attempted self-harm and anti-social behaviours within the unit could be shared with her grandmother so that Grandmother understood the risks and could better support her on discharge.
- 3.44 On 7th May 2020, children's social care received a complaint from Mother and Father who strongly disagreed with the recommendation that Child C should be discharged to the care of Grandmother. The response to this complaint from the team manager explained that an assessment had not uncovered any safeguarding risks and Child C was 16 and had the mental capacity to make her own decisions. Children's social care would support her to live in the community wherever she decided to reside.

This is an example of a good social work assessment which gathered and analysed appropriate information. However, it is hard to understand the decision that there was no role for social care. The assessment identified Child C's eligibility for s117 aftercare at the point of discharge, but how this was to be addressed was not reflected in the conclusion that the case should be closed, and referral could take place if there were concerns. A gap in knowledge within children's social care and other agencies regarding s117 is explored later in this report.

The assessment correctly identified the complexities of family relationships, and it was clear that whatever decision was made regarding Child C's accommodation she would be caught in the middle of different strongly held views. This was going to require careful negotiating and planning as well as understanding the impact on other siblings, especially Sibling 3. It would have been sensible to ensure that Child C was treated as a child in need and an allocated social worker. This would have allowed time to form relationships with all the family including Child C and be in a position to work together with the mental health unit to develop a smooth transition to the community.

- 3.45 On 4th June 2020 the EWMHS therapist referred to children's social care requesting a s85 assessment⁹ as Child C had been in hospital for more than 12 weeks. This request was closed down by the assessment and intervention team on the basis that that they had

⁹ A s85 (Children Act 1989) assessment is the responsibility of the home local authority when a child has been living in hospital or residential care for more than 12 weeks. The focus of the assessment is on ensuring the child's welfare and safety.

recently completed an assessment. This was a misunderstanding regarding the purpose of a s85 assessment and this is explored below and in Finding Three of this report.

3.46 As a result of Child C's autism diagnosis, on 16th June 2020 a CETR (Care, Education and Treatment Review) meeting¹⁰ took place chaired by NHS England and NHS Improvement Panel. Child C's views were represented but she did not give permission for the Panel to talk to her wider family prior to the meeting. The decision of the meeting was that Child C was not ready for discharge. This decision and additional recommendations for support for Child C were sent to the Consultant in a letter dated 6th July 2020. These recommendations included:

- ensuring a robust discharge plan and a professionals meeting to agree the plan
- ensuring a leave plan (Covid permitting) to her grandmothers which is regularly reviewed
- engage a speech and language therapist (SALT) to undertake an assessment to inform the treatment and discharge plan
- compile a risk formulation on the risks associated with living in the community at her grandmothers and how these can be mitigated
- Local authority to refer for a PA (Personal Assistant)
- Local authority to refer to family solutions¹¹
- plan transition to adult services
- consider applying for an Education Health & Care Plan.

3.47 On 26th June, the EWMHS clinician wrote a report for a forthcoming mental health tribunal which was taking place due to Child C contesting her s3 admission as she wished to be discharged. This report noted the difficulties in managing risks within the community and the need for a robust community plan if Child C was to be discharged. The clinician also carried out a risk assessment of grandmother's home and met with Child C who said that she would not take her own life in grandmother's home, if she did so it would be out in the community.

3.48 Also on 26th June, the mental health unit social worker made a referral to children's social care requesting extra support in the form of family solutions and a personal assistant. The response from children's social care was that Grandmother needed to give consent for family solutions involvement, but she did not pick up the phone when they had rung to seek consent. From Grandmother's perspective she had contacted children's social care but had not received calls back.

¹⁰ An inpatient CETR meeting is a multi-disciplinary meeting focused on the safety care and future planning for people with autism and/or a learning disability who remain in specialist inpatient assessment or treatment services. The meeting reviews the reasons for an extended hospital stay, whether correct treatments are being provided and any barriers to discharge.

¹¹ Family Solutions offer intensive support to families in Essex in order to prevent the need for statutory intervention.

- 3.49 Children's social care records note that Grandmother contacted them on 16th July 2020 to let them know that a discharge planning meeting had been arranged and that although the mental health unit had asked for support from children's social care none had been forthcoming. Grandmother described feeling scared and anxious and wanting support. This contact was triaged by an advisor who concluded that there was nothing to indicate that would imply a need for a s85 assessment as Child C "had not been in hospital long enough". After discussion with Grandmother, it was agreed to request support from family solutions. The children's social care summary report for this review highlights that there was continued confusion about the role of s85 and s117 assessments at the point of allocation within the family solutions team.
- 3.50 During this period Sibling 2 continued to be supported by a personal advisor in the leaving care team and the children with disabilities team continued to provide support for Sibling 3. They were unaware of plans for Child C's discharge.

This episode highlights a lack of knowledge and clarity within all agencies about the legal duties when a young person is living in a mental health unit. There was no understanding of the duties associated with s117 Mental Health Act and neither the referral by the EWMHS clinician nor the response from children's social care made mention of s117. There was also repeated confusion about the meaning of a s85 assessment. As a result, there was a lost opportunity to work with the mental health team to identify the practical and emotional support that Child C would need at the point of discharge.

The Care, Education and Treatment Review (CETR) was an additional layer of planning linked to Child C's needs as a young person with autism. The integration of this process with other care planning systems is discussed later in this report but it is apparent that there was additional confusion on the part of the CETR in the plan for the local authority to refer for a personal assistant. A PA can only be accessed if a child is eligible for a children with disabilities service when an assessment for Direct Payments can be initiated. Again, this is an illustration of Child C not neatly fitting into the services as they are currently configured.

- 3.51 On 17th July 2020 a professional's discharge meeting took place. Child C's diagnosis was recorded on the minutes as ASD and depression. The meeting was attended by staff from the mental health unit (including the mental health unit social worker), EWMHS, CAMHS (East of England) and the Transforming Care Team. There was no local authority social worker at the meeting. A leave plan was noted including three overnight leaves – two for two nights and one for four nights. EWMHS were to provide input and support during overnight leaves and Child C and Grandmother were to be given a crisis plan. Money was discussed. It was not anticipated that Child C would receive much by way of PiP payments (an application had been made) as she could look after herself, but it was hoped that family solutions could help Grandmother apply for carers allowance and Child C to apply for universal credit. It was noted that Child C's discharge Care Programme

Approach meeting was scheduled for 31st July at 3pm. Child C also had a tribunal scheduled for that day but if home leave had gone well the consultant would rescind the mental health section before 31st and the tribunal would not be needed. If leave had not gone well the tribunal would take place and a Care Programme Approach meeting held to develop a new plan. If all went well Child C was to be officially discharged on 3rd August 2020.

- 3.52 The discharge meeting took place on 31st July 2020. The Consultant had spoken to Grandmother and Child C on the phone that day and the meeting noted that Child C had been coping well during overnight leave at her grandmothers and had been accessing support from the EWMHS therapist during leave periods. On discharge, weekly EWMHS sessions would be in place. It was noted at the meeting that no representative from social care was in attendance and that following the Care Education Treatment Review (CETR) meeting the mental health unit social worker had made a referral to children's social care. They were informed that the case had been allocated to the family solutions team, but Grandmother reported that family solutions had recently suggested that there was nothing they could provide to her and Child C. The mental health unit social worker had followed this up and had been told that the person originally allocated the case had handed it over to the practice supervisor and someone would be allocated to complete the assessment in due course. The meeting noted Child C's needs and s117 rights and the lack of support from children's social care. Mother mentioned that her son's social worker had verbally stated she would be happy to be Child C's social worker. It was agreed that discharge will be delayed by a few days to give the mental health unit social worker and EWMHS therapist a chance to escalate their concerns with the relevant managers, as well as for the social worker to contact children's social care again.
- 3.53 On 3rd August the family solutions team were informed of Child C's s117 needs via e-mail from the mental health unit. This was followed by the EWMHS therapist on 5th August who also suggested the possibility of a family group conference to address the differences between parents and grandmother. The EWMHS therapist had visited Child C and Grandmother the previous day and it had become clear that Grandmother had thought Child C would be treated as a "looked after child".
- 3.54 Records of a visit by the family solutions worker on 5th August highlight Grandmother's concerns about the financial implications of Child C living with her and support she needed with purchase of clothing for her college course, gluten free food, and general clothing. It is significant that grandmother has told this review that it was Child C's wish to start to live independently and that financial arrangements needed to reflect this.
- 3.55 There was then a significant incident on 7th August 2020. The mental health unit heard from other patients that they had seen worrying social media posts by Child C and they called Grandmother to alert her. She checked on Child C who was reported to be fine. Half an hour later Grandmother called mental health direct to inform them that Child C had absconded taking tablets from the kitchen. She was later found in a bush in the woods. She was drowsy, there was evidence of self-harm, she had tied a ligature and there were empty pill packets of her prescription medication beside her. She was

tachycardic and taken to A&E. Although A&E records note blood results which did not identify an overdose, the tests in A&E are limited and would not have identified the overdose from her prescription medication.

- 3.56 Child C then returned to the inpatient mental health unit where she was assessed whilst she was in hospital Sibling 2 contacted Grandmother to check on Child C saying that he knew she had been threatening to kill herself.
- 3.57 The Consultant at the mental health unit had received a discharge letter from A&E. This did not fully describe all of the information from the ambulance service and the severity of Child C's condition when she arrived in A&E, but it did describe the information from the paramedics regarding their view that she had overdosed on her prescription medication and the ligature tied with her shoelace. The Consultant noted that blood results did not identify an overdose¹² and although aware of the possibility of an overdose she felt that this was positive in terms of Child C's general health. Child C admitted being upset that she had not been successful in taking her own life, but she was also showing insight, positive signs of talking about the future and wanted to return to grandmother's home. The ward manager spoke to Grandmother and the EWMHS clinician to confirm that both were in agreement with the plan for her to return home. Child C returned to Grandmother on 10th August.

This was a clinical decision to allow Child C to return to her grandmother made in good faith. Child C was clearly at a high level of risk, but other factors were taken into account including how distressing Child C found the unit especially in the context of her autism. The decision was based on somewhat limited information from A&E which did not give the same picture of the seriousness of her condition as described within the ambulance records. There are differing views as to whether it was the right decision and Grandmother has told this review that she feels strongly that Child C should have remained in hospital.

Child C's parents are upset that they were not informed of this incident and feel excluded from decision making at this time. Expected practice within the mental health unit is that risk incidents including should be shared with families. However, at the time of this significant incident Child C was living with her grandmother and this seems to have influenced the decision as to who should be informed. A clearer policy is needed regarding informing those with Parental Responsibility of risk incidents, taking into account their age, living circumstances and wishes and feelings. Both A&E and mental health unit records note Mother as next of kin but neither records who held Parental Responsibility. The accurate recording of Parental Responsibility is an area for development in both settings.

The issue remained that at this time the main burden for providing ongoing mental health support sat with the EWMHS clinician and although there was Family Solutions

¹² The medication she had taken would not have necessarily shown in a blood test

input the fundamental concerns of Grandmother as to how Child C was to be supported financially had not been addressed. This would have increased the stress for Child C who was aware that her grandmother had given up income from a tenant to give her the self-contained annex.

- 3.58 During this period the EWMHS practitioner continued to maintain regular contact with Child C and Grandmother. The practitioner was aware that Grandmother was feeling unsupported by professionals and was very angry that she could not access benefits. The options within EWMHS for additional support were considered including input from the Intensive Support Team. EWMHS noted that joint working was agreed but the Intensive Support Service have recorded that they could only get involved if EWMHS were offering sessions twice a week and this was not enough. They would be open to another referral if this was the case. Child C was formally discharged on 17th August.
- 3.59 After her return to her grandmother's house, Grandmother told the family solutions worker that Sibling 2 had upset Child C by sending nasty texts. Grandmother also recalls Sibling 2 saying to Child C "*If you can't do it properly, I will show you how it is done*". The Police subsequently visited Child C about the texts from Sibling 2 and she said that she did not want to press any charges. There was also discussion between Grandmother and the Family Solutions worker identifying the emotional pressure on Child C as she was caught between her parents and her grandmother. Financial pressures and Grandmother's anger at lack of support continued to be a recurring theme during visits by the family solutions worker and Grandmother asked on more than one occasion for a social worker to be allocated. The records show that Grandmother had believed that Child C living in her annex amounted to independent living, but she was not receiving the right support for this to be possible.

By this time the risks stemming from family tensions and dynamics had become more and more apparent. This was overlaid by increasing evidence of an unhealthy relationship between Sibling 2 and Child C. Work with Sibling's 2 and 3 within children's social care seems to have been carried out separately from work with Child C meaning that there was little opportunity to really understand the whole picture. The children with disabilities team were trying to facilitate some contact between Child C and Sibling 3 and report that Child C enjoyed going for walks with her mother, father and sibling. This initiative does not seem to have been integrated with the work being carried out by the family solutions service.

It is also significant that during this period there remained confusion with children's social care about the legal framework for assessments of Child C's needs. When Child C returned to Grandmother after the episode on 7th August, the family solutions team manager asked the allocated worker to explore with the mental health unit the benefits of a s85 assessment as she had been an in-patient for three months. Although it was recognised that some form of assessment needed to take place, s85 was not the right framework as this places a duty on local authorities to check on the safety and welfare

of children living in residential education or hospital provision for any continuous period exceeding and/or likely to exceed 12 weeks. The focus is on assessing the provision rather than the needs of a young person on discharge. These should have been met via s117 planning but there continued to be limited understanding within children's social care of the role of the local authority in contributing to these plans.

There is no evidence that formal escalation processes involving discussions with senior managers across mental health (EPUT or EWMHS) and children's social care took place. This review was told that as the case had been closed on two occasions by children's social care, the team at the mental health unit did not feel there was much more they could do. They accepted that social workers were expert in their own field and that "our expertise is mental health". The confident use of escalation processes and professional challenge across agency boundaries is a continued area for development. This is discussed further in Finding One.

- 3.60 During August, Child C obtained a place at a vocational college and the family solutions worker contacted them to discuss Child C's mental health needs including suicide attempts. The college were concerned about their capacity to keep Child C safe and called Grandmother to discuss their concerns. It was agreed that someone would meet Child C on her first day and be a point of contact for her.
- 3.61 Grandmother continued to talk to the EWMHS therapist about the lack of support from children's social care and the stress that she was under. The EWMHS practitioner attempted to contact children's social care and sent a referral to MIND, young person's autism service asking for help with travel training, routine planning, self-esteem issues and helping the young person to understand what the diagnosis of autism meant to her. There had previously been a referral to MIND by the education department of the inpatient unit resulting in a phone call from MIND to Child C, but on receipt of this second referral MIND made several attempts to contact Child C without success and when they did manage to contact Grandmother, they described a "rude response" including that she did not want to share all of the historical information again. The call ended by an agreement to work together to try and engage Child C.
- 3.62 The EWMHS clinician also contacted the personal advisor from the leaving care team who was working with Sibling 2, and later the same day saw Child C who began to talk about issues with her older brother and the threats he had made to her. A psychiatry assessment was scheduled for 4th September 2020.
- 3.63 Before the start of the college term, the college spoke with EWMHS on two occasions to discuss Child C's mental health and noted that the EWMHS practitioner thought that the move to college would be positive for Child C. The college made sure that Child C's course area were aware of Child C's mental health needs and asked them to risk assess but reiterated their concerns about keeping her safe.

- 3.64 During early September Grandmother continued to express anger to the family solutions worker, EWMHS and the college at the lack of support. She repeatedly asked for Child C to be accommodated under s20 Children Act 1989. The explanation given to EWMHS by family solutions was that Child C *does not meet threshold for s20 and is NOT LAC. Living with her grandmother is a private arrangement and they are not entitled to a social worker or certain benefits. Nan is above the pension age and so cannot claim universal credit. [Child C] is in full time education and is also not an 'estranged child' so cannot claim universal credit.* Family solutions are noted as feeling that a lot of anger and unrest was due to the financial implications not being properly explained to Grandmother when the plan was for Child C to move in with her. Grandmother was described as speaking a lot about finances and Child C often stated, "well I might as well kill myself then".
- 3.65 On 10th September 2020 there was a post discharge CETR meeting. During the meeting there were concerns expressed about the suitability of Child C's living arrangements and that a review of the s117 support was needed with representatives of health, social care and education. A formal request for an assessment under s117 was then made to children's social care.
- 3.66 A children's social care assessment started on 21st September 2020.
- 3.67 Meanwhile, twice weekly EWMHS sessions continued, and notes refer to concerns about Child C's relationship with Sibling 2 who was still sending abusive messages. Child C also expressed worries about his unborn child. The EWMHS records note that Child C was taking her prescribed medication. CETR meeting invites for 16th October 2020 were discussed with Child C. She was agreeable if her parents were invited.
- 3.68 On 7th October Child C was noted to be crying in class and was spoken to by the college welfare team. When they spoke to Grandmother, she suggested that a meeting with the new social worker may have upset Child C. The same day Child C saw her social worker and spoke about witnessing violence from her Sibling toward her mother and also made references to trees and how they would be a good place to hang herself again.
- 3.69 On 9th October a Care Programme Approach meeting was held. This was predominantly a virtual meeting and only the EWMHS therapist was in the room with Child C and Grandmother. It is described to this review and recorded in the EWMHS notes as a very difficult meeting during which Grandmother was very upset about the lack of financial support and Child C became visibly upset and at times had to leave the meeting as she was unable to cope. At the end of the meeting Grandmother tried to hug Child C but she walked away, and Grandmother is noted as saying that Child C will *go and kill herself now because if I had just heard all that in a meeting, I would be thinking they don't want me it is all about money. I know I will make everyone's lives easier and kill myself.*" The EWMHS therapist spent an hour after the meeting giving Grandmother emotional support.
- 3.70 On 15th October the social worker carried out a home visit and went for a walk with Child C. The notes of this record Child C appeared quiet when I first arrived but quickly became

relaxed and chatty. However, her mood did appear to change when her grandmother joined us, and Child C appeared quieter and did not get involved in the conversation. During our walk Child C relaxed again and although appeared sad that it was my last assessment visit, said she would text me about meeting up to give her the assessment. It appears that Child C's mood is influenced by those around her. She also described to the social worker that the behaviours of her older brother during her childhood had scared her and left her with a sense of guilt as she felt she hadn't protected her parents when he had threatened them with a gun. She made two references to harming herself, using the trees around her as a means to self-ligature and referencing hiring a hitman from the dark net to kill her. The social worker was unclear if these were attempts to alarm or unsettle the worker. Child C also spoke about her concern that she was unable to pay her grandmother rent, and her experience of college.

3.71 The next day on 16th October, a member of the public found Child C hanging in the woods.

By the time of Child C's death, the significance for Child C of the confusion over financial arrangements whilst she lived with her grandmother had become clear. Grandmother believes that the overriding issue for Child C was that she wanted financial support to live independently within grandmothers' accommodation, but this did not seem possible. The financial arrangements were the main topic considered by the last Care Programme Approach meeting and Grandmother's distress was apparent to all involved including Child C. It would have been very hard to manage and contain emotions appropriately within a mainly virtual meeting with only one person in the room to provide support to both Grandmother and Child C. By the end of the meeting Child C had left the room and no one was available to follow up the impact of the meeting on her.

Issues relating to the financial situation and the impact of Covid on practice are explored further in Finding Three and Five.

4 ANALYSIS – A SUMMARY

4.1 The narrative of Child C's life shows a child/young person who was having to navigate an increasingly complicated set of circumstances. These included:

- Living with and trying to make sense of the behaviour of her siblings within her home. It is likely that this was extremely frightening, and we will never know the full extent of any trauma that she experienced as a result.
- The birth of a younger sibling with a high level of need. Although it is clear that she felt protective towards her sibling there were also times when her parents could not manage to meet the needs of all their children at the same

time and Child C felt they she did not receive the support and attention that she required.

- Fractured and complex family relationships which meant that her loyalties were divided between her parents, siblings and her grandmother
- Autism was not formally diagnosed until the months before her death. By this time Child C was reluctant to see herself as a neurodiverse young person but in retrospect, the lack of diagnosis and support from an early age meant that the way she would have experienced the world was not understood by either herself or others. This is especially relevant in terms of the adjustments that could have been made in education and other settings and the way in which her mental distress could have been understood.
- A health condition (coeliac disease) which required a strict diet and would make her stand out from her peers.
- Financial worries, specifically her capacity to properly reimburse her grandmother for providing accommodation for her on her discharge from the mental health unit.

4.2 The combination of all these issues resulted in a vulnerable young person at risk of taking her own life. She was experiencing serious mental health issues, low self-esteem and thoughts that her life was not worth living. She had made a number of suicide attempts and had made it clear that she would make further attempts to take her own life, although the exact timings of these attempts could not be predicted by practitioners working with her. These risks and the challenges facing Child C were not well managed within our health and child-care system, although individual practitioners did their best to form positive helping relationships. The overarching picture is of a system that was fragmented and unable to work effectively across agency boundaries to provide a coordinated response to her complex needs.

4.3 Mental health services became the prime provider of help to Child C in the year before her death, but her needs were much broader than mental ill health. Throughout her life no one person had properly understood the impact of her wider social context, family dynamics, physical health challenges and neurodiversity. Child C was not identified as a Child In Need and help for Child C lacked a coherent joined up approach across agency boundaries. This is explored further in Findings One and Two.

4.4 There were two pivotal moments toward the end of Child C's time in the mental health unit. The first was when she attempted to take her own life whilst on home leave. It was a matter of professional judgement that she should not remain in hospital, and she returned home to live with her grandmother. The second pivotal moment was the formal discharge of Child C from the mental health unit after being an in-patient for eight months. The development of an effective discharge plan was inhibited by:

- The lack of recognition that she was a child in need and required a social work led child and family assessment during her time in the unit which could have taken a broad look at psychological and physical needs within her wider family

and social context. This issue was linked to a misunderstanding about the role of s85 assessments.

- A lack of understanding within health and social care of s117 requirements and roles, responsibilities and funding arrangements.
- A Care Education Treatment Review (CETR) process led by NHS England which focused on Child C's needs and readiness for discharge as a young person with autism but was not sufficiently integrated into the system as a whole. Hence, recommendations such as referral to the local authority for a personal assistant were not based on an understanding of what could be provided. It is also not clear that practitioners within the system understood the role of the CETR and how is aligned with other care planning pathways.

This explored further in Finding Three and Four.

- 4.5 Recognition of neurodiversity and the impact on the way young people experience the world and the support they need was not evident as a consistent thread throughout the way that professionals worked with Child C. There is evidence that her mother explained to a social worker that the way she physically responded to Child C (lack of touch) was driven by a belief that she was autistic. This information should have informed professional understanding of her behaviour and been at the forefront of professionals planning and responses. This is explored further in Finding Four.
- 4.6 Finally, work with Child C took place within the context of the Covid pandemic. In many respects professionals did their utmost to make sure that work with Child C continued uninterrupted. There was an impact on visiting arrangements within the mental health unit, the social work assessment just prior to her death noted the potential negative impact of mask wearing and social distancing on relationship building and perhaps, most significantly, a sensitive planning meeting took place virtually. This is explored further in Finding Five.

5 FINDINGS AND RECOMMENDATIONS

Finding One

The interplay between Child C's physical, emotional and mental health needs combined with neurodiversity was not fully understood – the system was fragmented and did not take a whole person approach.

- 5.1 This is a thread that ran through all the contacts that various professionals had with Child C. Individuals did try hard to bring people together to develop a joined-up approach, but this was largely unsuccessful.
- 5.2 One example of the interplay of individual factors within Child C's life is her response to her diagnosis of coeliac disease and the need to follow a gluten free diet. Noncompliance

with a gluten free diet may cause anaemia/tiredness and low mood and in addition the refusal to adhere to the diet could be understood as a form of self-harm. Despite the relationship between physical disease and mental health the services responding remained separate. Consideration needs to be given to ways of working together more effectively so that the young person can be understood as a whole person with interrelated emotional and health needs and that this interrelationship drives responses. This issue is discussed further in relation to responses to young people with Autism Spectrum Disorder in Finding Four.

- 5.3 The positive approach of the transition nurse was notable in that she did attempt to follow up what was happening in other agencies. She was instrumental in organising a Team Around the Family meeting but there was then no follow up, with the social worker assuming this would be a role for the school. There is no indication that the school were aware that this was an expectation placed upon them. There is also no indication that information from the Team Around the Family meeting was noted within the school records.
- 5.4 Because Child C did not present any problems within school, it seems that her education then proceeded without an overarching understanding of any broader concerns about her wellbeing. With hindsight, her limited interaction with peers could fit the profile of a young person with autism and the overall response to her autism is discussed below. Although her parents had suspected autism their concerns were not heard by professionals and the late diagnosis and lack of recognition of how this would be affecting her experience of school meant that there was no prompt to develop a plan to support her within this environment.
- 5.5 When Child C was admitted to the mental health unit the knowledge about previous health input relating to her coeliac disease was not integrated into care planning and the knowledge of the transitions nurse about Child C's struggles with the management of her diet was therefore lost. This is not due to any individual error, but a result of a system whereby staff at the in-patient unit were not aware that the transitions nurse had been working with Child C, as all their contact regarding broader health needs is with the GP. The transitions nurse was not aware that Child C had been admitted to an inpatient unit and would have welcomed the opportunity to be involved in Care Programme Approach meetings. This would also have been especially helpful at the point of discharge.
- 5.6 Despite her complex circumstances, at no time had Child C been identified as a Child in Need in her own right and her complex family circumstances meant that for much of the time Child C's own needs became lost and were not assessed. This was coupled with the challenge of working with a young person whose needs often arose from risks she posed to herself rather than risks posed by others.
- 5.7 Within the mental health unit there were sustained attempts to engage children's social care in developing a coordinated plan and involve them in discharge planning, but this was unsuccessful, she did not have an allocated social worker and there was therefore no direct continued support from community social workers during her time in the unit. The

concerns of the mental health team were not escalated, and the position was too readily accepted that since their expertise was mental health, the decision within children's social care could not be formally challenged. The lack of understanding within children's social care about their roles and responsibilities where a young person has been admitted to a mental health facility is specifically explored within Finding Three below.

- 5.8 The clinician within EWMHS did their utmost to maintain a therapeutic relationship with Child C and also worked hard after Child C's discharge to liaise with other professionals and assumed a lead professional role. The review has heard that practitioners sitting outside children's social care became very frustrated at the lack of social work assessment immediately pre and post discharge and felt that no one person really understood the complexity of the situation and could provide the necessary support to Child C and her family. If Child C had been identified as a Child In Need either before or during admission it would have been clear that an identified social worker should work with her and her family to agree a coordinated multi agency plan that addressed all her varying needs.

Recommendation One

Safeguarding partners should agree that a child and family assessment and child in need plan is the appropriate and expected mechanism for coordinating a whole person approach where a child/young person has complex physical, emotional and mental health needs. All practitioners should be able to challenge and escalate any decisions which do not meet these expectations.

Recommendation Two

The mental health unit should equip practitioners with the knowledge and confidence to use the escalation processes when professional differences cannot be resolved through more informal means.

Recommendation Three

Acute Hospital Trusts should note the positive impact of the transitions nurse in the case and consider whether the service is adequately resourced to continue to make such an impact in all similar cases.

Finding Two

The multi-agency system did not address the multiple challenges/complex relationships within the whole family.

- 5.9 As described throughout this report, Child C lived within a complex family situation and all her siblings had been individually involved with statutory agencies at various points in their lives. Child C also had the challenge of living with coeliac disease as well as neurodiversity. The latter had been undiagnosed for much of her childhood yet would have had a profound effect on her experience of the world.

- 5.10 This was a white British family and there was little evidence that culture, including religion was explored in any depth although there is evidence that Mother's strong religious beliefs were important to the family dynamics and needed more discussion. The church was a source of support, but equally, other family members including the children had more negative views about the role that religion played in family life. Child C's siblings would have been well known within their local community and the extent to which this increased family isolation was not explored. The need to develop "culturally competent practice" has been discussed in other reviews within Essex. This is a situation which confirms the need to give clear messages through supervision and management oversight about the importance of this aspect of practice and giving support to develop the required skills.
- 5.11 Child C was therefore a young person whose needs cut across several aspects of our health and social care system. Whilst our system is designed to make sure each young person's individual needs are met within each agency, this does not work well when there is a multiplicity of (possibly interrelated) issues for each family member and physical and mental health care needs.
- 5.12 Probation and youth offending services working with Sibling 1 focused on their client and there was no effective consideration of the impact of his behaviour on the rest of the family. It is likely that even though he had minimal contact with home, Sibling 2 and possibly Child C may have been aware of his ongoing criminal behaviour, and we will never know how Child C might have felt about this.
- 5.13 The behaviours of Sibling 2 resulted in him becoming a child in care accommodated outside the family home. He was allocated his own social worker and latterly leaving care advisor, but there was no formal joint assessment and planning when concerns about Child C's mental health began to emerge. There is clear evidence that Sibling 2 had a great deal of contact/influence over Child C near to her death. From a children's social care perspective this was partly influenced by the long-term sick leave of Sibling 2's social worker but there should have been management oversight that ensured a whole family approach was taken.
- 5.14 Sibling 3's practical needs have been responded to, although initially when the assessment did not include specialist input from the Children with Disabilities team he was not recognised as a Child in Need. He did eventually have an allocated social worker and there is evidence that this social worker tried to take a more holistic approach and facilitated meetings between Child C and Sibling 3 but there was no formal integration of assessments and plans.
- 5.15 Management oversight aimed at understanding the needs of the family was evident at a senior level but the request for a child and family assessment for Child C and Sibling 3 became extremely delayed. It was a sensible plan for this assessment to be carried out by Sibling 2's social worker but when this was not possible due to long term sickness, the focus on an integrated whole family assessment became lost. It will be important to make

sure that in future there is a mechanism for making sure that whole family assessments are possible where all the children in the family have differing needs.

- 5.16 Working with this level of complexity required assessments and interventions that drew on a wide range of professional expertise as no one practitioner could be expected to have the practice knowledge and expertise to understand all the factors that were affecting Child C's life. Alongside expertise, the emotional impact on practitioners of working with young people where there is a risk of self-harm and suicide should not be underestimated and this impact will be exacerbated where service limitations and frustrations affect the capacity to respond. In these circumstances the opportunities for reflective practice critical thinking and challenge with and between agencies is crucial.
- 5.17 Within Essex there is a strong, positive ethos of working in partnership with families and to avoid holding any meetings where families are not included¹³. This approach is the foundation of good practice, but this has prevented the development of multi-professional supervision meetings which could provide a safe environment for critical reflection and challenge of each other's practice in work with complex families. Achieving this opportunity for support and critical reflection whilst maintaining the ethos of working together with families (with families being fully aware that this occurs) is an area for practice development.

Recommendation Four

Children's social care should establish an expectation that disabled children living in a family environment where there are multiple stressors affecting their siblings, the disabled child is recognised as a child in need in their own right, all assessments include specialist expertise and carers assessments are included in any response.

Recommendation Five

Safeguarding partners should consider how to achieve a safe environment which supports critical reflection and challenge in multi-agency work with complex families.

Finding Three

There was insufficient understanding throughout the system of the legal framework supporting the discharge of young people from mental health provision.

- 5.18 Planning for discharge of young people within a mental health provision needs to be integrated into care plans throughout their stay. The mechanisms for this include plans linked to the Care Program Approach (CPA) meetings and, in the case of a young person diagnosed with Autism Spectrum Disorder, the Care Education Treatment Review (CETR) process. Where a young person is detained on a mental health section, they also have a

¹³ Nb Child C's parents have informed the review that they did not experience this positive ethos in their contact with Essex children's social care.

right for their needs to be assessed and provision made for their aftercare under s117 Mental Health Act 1983.

- 5.19 The statutory role of children's social care in respect of young people such as Child C is the requirement to carry out an assessment under s85 Child Act 1989 which is focused on the child's welfare and safety whilst accommodated in the unit. It is also good practice to consider at the point of admission whether there is a need for a thorough child and family assessment. An assessment did take place but there was then a disconnect between the information within the assessment and the decision to close the case. It was clear from the assessment that this was a complex set of family circumstances which would impact on Child C when she was discharged. A better decision would have been to recognise Child C as a child in need and allocate a social worker who could develop working relationships with Child C and her family alongside other professionals who would be involved in her treatment plan at the point of discharge.
- 5.20 It is clear from the chronology that there was confusion within children's social care as to their statutory role and function and a continuing frustration within mental health services at the lack of engagement by children's social care in planning for Child C during her admission. The reasons for this appear to be:
- s117 procedures in respect of young people are not fit for purpose and used as a working tool across the partnership. The local procedures that are available by a google search^{14 15} are not well known or user friendly and are not specifically focused on children. There are examples of procedures elsewhere in England that seem to be more helpful in relation to the role of children's social care where a young person is detained in hospital.¹⁶ These example procedures are clear that when a young person is admitted to a mental health unit consideration should be given to a child and family assessment. The Pan Essex procedures were due for review in March 2022 and are currently being updated. This will be a good opportunity to update and ensure they address the specific interface with children's social care.
 - Practice knowledge within children's social care needs to be improved in relation to responsibilities under both s85 Children Act 1989 and s117 Mental Health Act 1983. Social workers and their managers displayed confusion about their role in assessing the safety and wellbeing of young people in hospital as well as the role they could play at discharge.
 - The mechanisms for accessing funding are not well known where a young person has needs identified via a s117 assessment. For children (unlike adults) the s117 Panel does not agree funds but this is the role of the JAP panel¹⁷ but not all practitioners understand this to be a possible route.

¹⁴ https://eput.nhs.uk/PublicationWF/PDF_Output/6318.pdf

¹⁵ <https://southendccg.nhs.uk/safeguarding/policies/3915-sccg-qp01-pan-essex-s117-protocol/file>

¹⁶ https://proceduresonline.com/trixcms1/media/3630/3_1_10_section_117_policy_2017.pdf

¹⁷ A multi-agency panel including continuing health care, education and social care.

- 5.21 An additional issue relating to the legal framework is the lack of consistency across all agencies in recording and responding to Parental Responsibility and next of kin status for young people. Specifically, health organisations rarely recorded Parental Responsibility although next of kin was usually noted. The situation was reversed in children’s social care. This is significant as this provides a prompt for practitioners to consider carefully who should be included in assessments decision and plans, taking account of the views of older young people. In this case Child C’s parents held Parental Responsibility but felt excluded from the last social work assessment and decisions about their daughter’s care. Practitioners would be helped by very clear guidelines and prompts to assist decision making.
- 5.22 The impression from the chronology and talking to family members and practitioners is that at the point of discharge Grandmother felt that she was not receiving the right support, emotionally and financially and that the EWMHS practitioner along with a family solutions worker were trying individually to address the concerns. Grandmother understood that the plan for Child C was “independent living” (in line with Child C’s wishes) and that she would receive the right financial support for this to be possible. This was a particular concern as Grandmother had given up income from a tenant to free the space for Child C. Alongside this, Grandmother had previous experience of receiving support from the local authority via s20 when caring for other children within the family and had assumed that direct financial support would be forthcoming via this route. However, the local authority understood that Grandmother had agreed to care for Child C as a “family arrangement” and s20 accommodation was therefore not appropriate.
- 5.23 Had children’s social care been fully involved in discharge planning this confusion as to the right means of providing financial support for Child C could have been explored. This is particularly significant as there is evidence that Child C became increasingly distressed by her grandmother’s financial situation and the perception that she was a problem and a burden on others.
- 5.24 At the point of Child C’s death, a social worker was at the point of getting to understand both her and her situation more fully and it is possible that this might have led to positive progress.

Recommendation Six

Children’s social care should embed into practice the principle that all young people admitted to a mental health unit require both a child and family assessment and a child in need plan.

Recommendation Seven

The protocol supporting implementation of s117 Mental Health Act 1883 should be updated specifically in relation to young people and steps taken to ensure that health and social care practitioners are aware of the protocol and how to implement it in their practice. This should include the mechanism for accessing necessary funding.

Recommendation Eight

Children's social care should ensure that all practitioners understand their responsibilities under s85 Children Act 1989.

Recommendation Nine

All agencies should review documentation to ensure that Parental Responsibility and next of kin are clearly recorded and provide guidance for practitioners as to how this should inform decision making in their setting.

Finding Four

Child C's diagnosis of autism at the age of 17 meant that she was not properly understood throughout her childhood as a neurodivergent young person. Consequently, this aspect of her identity including social, emotional and cognitive needs was not addressed in the response of the agencies working with her.

5.25 Child C was not formally diagnosed with autism until she was an in-patient, although an assessment had been started in the community. Her parents have told this review that they were aware of the likelihood that she was autistic from a much younger age and found it hurtful when criticised for not touching her, when they were aware that this was the way to respond given her neurodiversity. From the records it seems that Child C was probably good at masking her condition in school where her quiet demeanour and focus on work was seen as positive and did not draw attention to herself. The masking of autism by women and girls is well documented¹⁸ with evidence pointing to girls receiving their diagnosis later than boys. A 2019 study¹⁹ identified a general lack of understanding of female autism and the increased stress on girls with autism living in a neurotypical world. Child C's traits such as keeping herself to herself and being on the periphery of friendship groups were likely to have been part of her coping mechanism and contributed to higher levels of stress and anxiety.

5.26 The late formal diagnosis of autism meant that other interventions by social care and mental health could not be complemented by strategies specifically designed for autistic young people. By the time she did receive a diagnosis this was not welcomed by Child C, whereas if this had been understood by her as a positive aspect of her identity from an earlier age, strategies to work with her in relation to her autism might have been more readily received. The relationship between autism and risk of suicide is well

¹⁸ <https://www.autism.org.uk/advice-and-guidance/what-is-autism/autistic-women-and-girls>

¹⁹ Milner, V. et al (2019). A Qualitative Exploration of the Female Experience of Autism Spectrum Disorder (ASD). *Journal of autism and developmental disorders*, 49(6), 2389–2402.

<https://doi.org/10.1007/s10803-019-03906-4>

documented²⁰, with a greater risk for females²¹. Late diagnosis means that this risk cannot be considered and addressed in assessments at an early stage and this a significant gap if behaviours such as self-harm emerge.

- 5.27 Even following diagnosis, too often young people with autism and no additional learning disabilities do not reach the threshold for any one service. One contributor to this review contrasted the response of children's Services to Child C and Sibling 3. Sibling 3 met the criteria for support from the Children with Disability team and a range of practical support was available. At the point of discharge from the mental health unit, Child C did not meet the criteria for an equivalent range of support services from children's social care. This is not an issue confined to Essex. The Government Policy Paper (July 2021) recognises that legislation (Autism Act 2009) has exclusively focused on adults and that the most recent updated strategy now includes children and young people within its remit. Within Essex the Transforming Care Service is actively working to develop services that will support this cohort of children and young people in the future.
- 5.28 Across health provision Child C's physical and mental health needs could have been more successfully integrated. Child C was diagnosed with coeliac disease at the age of 13 around the same time that concerns were beginning to emerge about self-harm. It quickly began to be apparent to dieticians that she was not willing to follow a gluten free diet, although she was given information about the long-term physical damage this could cause. With hindsight it is impossible to be clear what the root cause of her reluctance was, but it is possible that it was influenced by both her mental state and also her autism as this is associated with hypersensitivity to textures and certain types of food²². Her first autism assessment was prompted by the paediatric team but capacity within the service and lack of speedy response from Child C's school meant that diagnosis had not occurred by the time she was admitted.
- 5.29 The Care Education Treatment Review (CETR) system is designed to work with young people with Autism Spectrum Disorder who are inpatients or are at risk of inpatient care. The aim is to bring together all relevant professionals with the family and agree a plan to reduce the likelihood that admission or readmission to hospital will be needed. The transforming care team in Essex support this process and a key worker was appointed who began to work alongside the mental health professionals to consider what needed to be in place to support a successful discharge. The CETR panel did give some funding to assist Child C with accessing education, but the panel found it hard to understand

²⁰ Cassidy, S et al. *Autism and autistic traits in those who died by suicide in England*. BJPsych; 15 Feb 2022; DOI: 10.1192/bjp.2022.21

²¹ Hirvikoski T, et al (2020) Individual risk and familial liability for suicide attempt and suicide in autism: a population-based study. *Psychol Med*. 2020 Jul;50(9):1463-1474. doi: 10.1017/S0033291719001405. Epub 2019 Jun 26. PMID: 31238998.

²² There are many research papers citing the link between ASD and "picky eating" or sensitivity to taste. E.g <https://www.sciencedirect.com/science/article/pii/S221315821830113X> and <https://www.urmc.rochester.edu/labs/bennetto/projects/past-projects/taste-smell-and-feeding-behavior-in-autism-a-quant.aspx>

Grandmother's broader concerns about accommodation and the position of children's social care and lack of engagement in s117 planning. To work effectively the CETR process will need to be fully integrated into all other aspects of planning with young people in order to make sure young people and families receive a streamlined response.

- 5.30 By the time of Child C's discharge, it is apparent that the CETR process had become another element within a system that was struggling to provide a coherent coordinated approach to meeting Child C's needs.

Recommendation Ten

All agencies working with children and young people should increase awareness of neurodiversity across their workforce and ensure that practitioners develop skills in:

- Recognising signs, indicators and impact on the young person in their day-to-day life
- Ensuring all reasonable adjustments are made when providing support in line with the Equality Act 2010
- Promoting positive self-identity as a neurodivergent young person
- Identifying when a young person may need to be offered a formal assessment.

Recommendation Eleven

Essex safeguarding partners should work together to develop an Essex autism strategy to ensure that where a young person has complex needs which cut across mental health, social care and disability services there is a coordinated response with access to services, roles and responsibilities being clearly defined.

Finding Five

Lessons from the pandemic should consider carefully the place of virtual meetings – i.e. when they are appropriate and when they are not.

- 5.31 The implications of Covid restrictions were evident during Child C's time in the mental health unit with restrictions on visiting in line with regulations. This had an impact on family and other professionals such as the EWMHS clinician who wished to maintain a relationship with her throughout her stay.
- 5.32 The clearest impact on the outcome for Child C from the evidence reviewed is the challenge associated with managing sensitive, emotionally charged meetings virtually. The final care programme approach meeting brought to the fore Grandmother's extreme distress at what she perceived to be a lack of financial and other support. She and Child C were alone at home, and the rest of the professionals joined the meeting virtually. When Child C became distressed and walked out, it was not possible for anyone to be with her and try to understand and work with her feelings at that point. After the meeting the EWMHS practitioner stayed online to support Grandmother but there was no one there to provide face to face support for Child C.

- 5.33 As services move to a “new normal” post pandemic it will be important to reflect on the positive and negative aspects of engagement with the virtual world. The strong message from this review is that there is unlikely to be a one size fits all approach and that the circumstances for each young person and their family needs careful consideration.

Recommendation Twelve

Guidance on the use of virtual meetings should ensure that the circumstances of each child and young person is assessed and steps taken to mitigate any risks associated with using this approach.

6 SUMMARY OF RECOMMENDATIONS

Recommendation One

Safeguarding partners should agree that a child and family assessment and child in need plan is the appropriate and expected mechanism for coordinating a whole person approach where a child/young person has complex physical, emotional and mental health needs. All practitioners should be able to challenge and escalate any decisions which do not meet these expectations.

Recommendation Two

The mental health unit should equip practitioners with the knowledge and confidence to use the escalation processes when professional differences cannot be resolved through more informal means.

Recommendation Three

Acute Hospital Trusts should note the positive impact of the transitions nurse in the case and consider whether the service is adequately resourced to continue to make such an impact in all similar cases.

Recommendation Four

Children’s social care should establish an expectation that disabled children living in a family environment where there are multiple stressors affecting their siblings, the disabled child is recognised as a child in need in their own right, all assessments include specialist expertise and carers assessments are included in any response.

Recommendation Five

Safeguarding partners should consider how to achieve a safe environment which supports critical reflection and challenge in multi-agency work with complex families.

Recommendation Six

Children’s social care should embed into practice the principle that all young people admitted to a mental health unit require both a child and family assessment and a child in need plan.

Recommendation Seven

The protocol supporting implementation of s117 Mental Health Act 1983 should be updated specifically in relation to young people and steps taken to ensure that health and social care practitioners are aware of the protocol and how to implement it in their practice. This should include the mechanism for accessing necessary funding.

Recommendation Eight

Children's social care should ensure that all practitioners understand their responsibilities under s85 Children Act 1989.

Recommendation Nine

All agencies should review documentation to ensure that parental responsibility and next of kin are clearly recorded and provide guidance for practitioners as to how this should inform decision making in their setting.

Recommendation Ten

All agencies working with children and young people should increase awareness of neurodiversity across their workforce and ensure that practitioners develop skills in:

- Recognising signs, indicators and impact on the young person in their day-to-day life
- Ensuring all reasonable adjustments are made when providing support in line with the Equality Act 2010
- Promoting positive self-identity as a neurodivergent young person
- Identifying when a young person may need to be offered a formal assessment.

Recommendation Eleven

Essex safeguarding partners should work together to develop an Essex autism strategy to ensure that where a young person has complex needs which cut across mental health, social care and disability services there is a coordinated response with access to services, roles and responsibilities being clearly defined.

Recommendation Twelve

Guidance on the use of virtual meetings should ensure that the circumstances of each child and young person is assessed and steps taken to mitigate any risks associated with using this approach.

7 APPENDIX ONE: REVIEW QUESTIONS

- 7.1 How well were the Section 117 aftercare arrangements and the Section 85 duties understood and followed by agencies?
- 7.2 To what extent did the discharge arrangements from the mental health unit follow the Essex Practice Guidance and Care Pathway for Young People admitted to psychiatric adolescent units in Essex?
- 7.3 What was the understanding of all agencies of the role and remit of the Care Education Treatment Review?
- 7.4 What was the assessment of risk by agencies when Child C tried to kill herself whilst on home leave from the mental health unit.
- 7.5 How well were requests for support for Child C clearly understood in terms of need and risk including referrals to social care and non-statutory agencies?
- 7.6 How well were the family dynamics for Child C understood including staying with her grandmother, involvement of her parents and siblings? What was the extent to which professionals understood what the lived experience was for Child C within her family, and what interventions were undertaken to address the areas of concern?
- 7.7 How effective was professional challenge when other partners were not collaborating with services or when referrals were not accepted?
- 7.8 How effective was communication and Information-sharing to ensure that all agencies had a clear understanding of levels of risk for Child C?
- 7.9 Child Chad a wide range of vulnerabilities and additional needs. What were professionals' understanding of the family dynamics and what impact this had on Child C?
- 7.10 How much did Social Care assessments take into account the historical involvement and previous assessments of the family?
- 7.11 Did professionals have any understanding of references to traumas that Child C had said she would take to the grave with her?
- 7.12 Were the correct processes followed in respect of Child C's admission to the mental health unit.
- 7.13 How did having coeliac disease impact on Child C physically and emotionally?
- 7.14 The review is to also explore:
 - Discharge planning meetings
 - The confusion around whether Child C living with her grandmother was a "family arrangement" or a "placement".

- How agencies worked together
- Difficulty working with young people who do not always engage
- Impact of Covid-19

8 APPENDIX TWO: THE LEAD REVIEWER

Jane Wonnacott qualified as a social worker in 1979 and has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed well in excess of 250 child safeguarding reviews, as well as Safeguarding Adult Reviews and Domestic Homicide Reviews. Jane has a strong interest in safeguarding practice and culture within organisations and has been the lead reviewer for two reviews into abuse in nurseries and complex and challenging reviews into non recent abuse in public schools. She has contributed to the literature exploring effective safeguarding in education settings and has had books and training materials published to support reflective practice and staff supervision. Jane is a member of the National Child Safeguarding Practice Review Panel pool of reviewers and in this role has completed thematic reviews and was part of the team who completed the National Review into the deaths of Arthur Labinjo-Hughes and Star Hobson.