1 Background and Concerns

Child 15 is aged 16, who has had periods of involvement from CSC going back to 2006 related to concerns around mothers' mental health, alcohol and substance misuse and domestic abuse. Child 15 has been a looked after child since 2015 and is subject to a care order, she has been at risk of child sexual exploitation and has a history of being missing. In March 2021 she was admitted to hospital after ingesting a significant amount of medication and was detained under section 5(2) of the Mental Health Act 1983. Child 15 absconded from hospital and was located the following day.

2 Purpose of the Review

The purpose of a Line of Sight review is to identify learning for the multi-agency partnership which will strengthen the safeguarding system. Beyond individual cases reviews they also provide a window into wider systems (ways of working/ processes) which may need to be changed. In this case it was felt that there was an opportunity for learning and practice improvements in several areas.

3 Key Lines of Enquiry

- Was assessment based on previous harm?
- Were the YPS needs fully assessed and understood?
- Was specialist assessment undertaken?
- The impact of the plan on reducing risk.
- Was there sufficient focus on cognitive ability?
- Was there sufficient understanding of deprivation of liberty and support to residential settings?
- Was the voice of the YP heard and acted upon?
- Was care planning consistent and robust?

4 Key Practice Episodes

Expected good practice

- Vulnerable YP Services provided some excellent support to child 15
- National Referral Mechanism submitted based on assessed risk
- Evidence of follow up following A & E attendance by CLA health team and liaison safeguarding nurse.

Areas for improvement

- Repeat DNAs/ was not brought to health appointments
- Significant gaps in education, no continuity of accommodation (home/ placement), several placement and educational moves
- Focus on YPs behaviours not the drivers for these behaviours
- YP said she didn't feel listened to, advocacy not considered
- Lack of consideration bereavement support after mothers' death
- Lack of detailed care plan re approach to necessary/ proportionate restrictions e.g., phone/ internet access; failure to provide appropriate boundaries resulted in missing, criminal exploitation
- Ensuring residential placements are supported, equipped to enforce any deprivations of liberty
- Care/permanency planning was impacted by change of SWs/managers
- Inadequate access to specialist therapeutic support/self-harm/substance use
- Care Planning was reactive to risk and didn't secure permanency or reduction in overall risk

5 Learning (What needs to be done differently)

- Improve risk assessments, and target for early and consistent help
- Embed trauma informed approach to developing holistic care plans
- Active case management to ensure consistent access to care where relocations are unavoidable e.g., prompt GP registration
- Understand consent to care/ treatment, Gillick competence, and mental capacity
- Understand mechanisms for, and application of, imposing restrictions and/ or detention using Mental Health Act and Mental capacity Act
- Need to proactively assess, seek diagnoses of mental disorder and access specialist support
- Improve escalation pathways e.g., where YP has been out of education for a long time.

6 Progress/Impact

- An action plan has been developed and is being implemented.
- A group to explore use of interagency chronologies at key points
- Review of placement moves to be part of Placement Planning Process
- Development of early cognitive assessment disability model neural specialist assessment 0-18 to include guidance in when to undertake cognitive assessments
- Escalation pathways where child has been out education long period to be reviewed
- Available training on consent, competence/ capacity, restrictions and deprivation of liberty in respect of young people to be reviewed

7 Further information

- Graded Care Profile 2
- SCP Training
- Line of Sight process
- Threshold of Need
- Referral Process
- SCP Policies & Procedures
- The Professional Curiosity Tool will be published on the Safer NEL website when complete