Safeguarding Children in Stockport

7MB – Child F

7-minute briefings (7MB) are intended to be simple and quick to read, teams can use them within meetings as a team-based learning exercise.

www.safeguardingchildreninstockport.org.uk

To read the full review:

http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2022/10/Child-F-local-child-safeguarding-practice-review.pdf

How did we Review?

Referred in 2020, and deemed to be a notifiable incident, the rapid review panel agreed to progress a child safeguarding practice review. A desktop review was conducted, followed by a practitioner event which explored key themes further.

Background

Child F is a caring, thoughtful person, a talented singer, she likes movies, sports and animals. She has Tourette's syndrome, Obsessive Compulsive Disorder (OCD) and Autistic Spectrum Disorder (ASD). She was sexually exploited at 12 and this continued for several years. The traumatic experiences F had impacted on her emotional wellbeing and mental health. As a teenager F entered and left Care of the Local Authority, experiencing placement moves due to placement breakdowns, disrupting her education. F would regularly go missing and would at time harm herself. She was subjected to a Deprivation of Liberty Safeguards (DOLS) to keep her safe due to her disabilities and vulnerability to sexual exploitation.

Changes in Practice

- Reform and implementation of the Staying Safe Panel offers assurances information is being shared between agencies.
- A Dynamic Support Database (DSD) has been put in place anyone on the Dynamic Support Database (DSD) will now have a Care Programme Approach (CPA) which will help practitioners have a better understanding of a child's needs and service access.
- A process for ensuring health attendance at reviews for cared for children who reside outside the borough is being reviewed.

Incident

Child F was placed in a 16+ CQC registered placement outside of Stockport. Her complex needs and DOLS meant she required 2:1 staffing care. This was not provided at times and the DOLS was not adhered to as agreed, this left Child F vulnerable and she was able to go missing from the home. On one missing occasion she was a victim of sexual assault. SMBC ended the placement on safeguarding grounds and Child F was placed with a family member until a longer term plan was agreed. A police investigation is underway and a Care Education and Treatment Review (CETR) was held given the repeat crisis attendances at A&E at the time.

Learning from the Practitioner Event

- Practitioners didn't always understand health pathways and what they mean or how to access them for children with complex needs
- There was evidence of strong multi-agency working and with a lot of care and concern for child F. However, it was not clear that there was co-ordination between all the services working with child F. This appeared to be due to a lack of knowledge of processes and policy within various health systems
- There was confusion over multiple and changing diagnoses for child F in the context of what this means for child F and access to services or placement provision
- Information sharing and file sharing challenges with systems were noted
- Throughout the placement, there were signs that it was not fulfilling its responsibilities, a risk assessment should have been undertaken to understand whether it was safe for child F to continue to be cared for by the provision
- Professionals working with child F were not clear on the use of the Dynamic Support Database (DSD) and the Care Education and Treatment Review (CETR) process

Format of the Practitioner Event

A practitioner event held in December 2021, brought together professionals involved in Child F's care. Practitioners reviewed significant events in child F's life to set historical context to the incident. They were asked to reflect on and answer questions informed by the initial rapid review and desktop review.

Learning from the Desktop Review

Focusing on 11 children, the review found Child F was a unique case with multiple needs, which increased the difficulty of finding a suitable placement to meet her needs. The other children reviewed appeared to have informed decision-making around placement planning, but, the greater use of outside area locations suggests a lack of local availability or specialist facilities. The challenges associated with commissioning specialist placements and availability of these will be raised with the National Panel as this is not unique to Stockport and is a national issue of importance.