LEARNING FROM SAFEGUARDING RAPID REVIEWS FOR TWO BOLTON LOOKED AFTER CHILDREN WITH COMPLEX MENTAL HEALTH NEEDS

CHILD G AND CHILD L

LEARNING FROM CHILD G RAPID REVIEW

Child G was aged 16 years at the time of the review. Child G's family are of Asian heritage and practice the Muslim faith. Child G was exposed to significant adverse childhood experiences whilst in the care of his parents and has also made allegations of sexual grooming. Child G had been in care for over a year however whilst in foster care he experienced a significant decline in his mental health and was sectioned under the Mental Health Act. On discharge from hospital a few months later he moved to a residential placement. He remained in this home for around 5 months with a repeat Tier 4 admission during this time. The placement ended suddenly because of significant concerns regarding the care and safety being provided in this home.

The rapid review was asked to consider if Child G experienced abuse or neglect in his care placement and if there were opportunities where alternative action could have been taken to promote better outcomes for Child G.

The review concluded that whilst there were clear challenges caring for Child G due to his significant complexity of need there was no evidence to suggest that the care at the home was neglectful, indeed evidence would suggest that the home were working with those around Child G to meet his needs. The ending of the placement created significant distress for Child G and stress is known to be a trigger for a deterioration in his mental health. The review also noted the longstanding local and national issue of placement sufficiency particularly for those children with highly complex mental health and trauma needs.

This said the review highlighted key learning points for partners

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LEARNING FROM CHILD G

WHAT WORKED WELL

The pastoral care provided by school was very good overall and education planning was good and timely despite there being no Education Health and Care Plan in place

There were examples of real tenacity in care for Child G i.e. follow up by the GP around G's wellbeing and support for the foster carer and the police made good attempts to encourage Child G to make a disclosure

The Local Authority responded swiftly and collaboratively to secure a placement for Child G following the immediate closure of the care home.

WHAT COULD BE BETTER

Better, early case formulation for looked after children in order to consider the likely impact of ACES and to provide trauma informed strategies to all involved
It was impossible for Child G to develop a relationship with a trusted adult due to the many changes to people involved in his life i.e. social workers, IRO, health staff, teachers, police and carers it was a cast of 1000's

It is not clear from the chronologies provided how well Child G's cultural, religious and gender identity was explored, understood and promoted

Child G's plans and his care journey appeared at times to be confusing from both a single and multi – agency perspective. Child G expressed that this was stressful to him

WHAT YOU CAN DO

When caring for a child in Tier 4 ensure multi-agency discharge planning begins at the point of a child's admission, continues post discharge and includes support for carers

When working with a looked after child consider if CAMHS consultation is needed early on in the child's care journey to provide case formulation and strategies for carers/ staff

Consider ways to maintain continuity of care and the use of advocates. Evidence tells us that this one key person is important for children who have suffered significant adversity and trauma and that children do not want to retell their stories.

Ensure that a child's cultural, religious and gender identity is explored, understood and promoted by all agencies. The NICE Quality Standards for Looked after Children and Young People NG 205 (October 2021) gives useful guidance on this

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LEARNING FROM CHILD L RAPID REVIEW

Child L was 15 years old at the time of the review and was looked after by Bolton Childrens Services. Child L has a diagnosis of ASD and OCD and a presentation of 'self neglect' although it is important to acknowledge this term is difficult to use in the context of a child and research is limited. Before becoming looked after he lived with his parents and sibling. A significant decline in his mental health in summer 2021 led to L being sectioned under the Mental Health Act. On discharge from hospital, he moved to a residential placement and became looked after. He stayed in this placement for 5 months. The placement ended suddenly because of significant concerns regarding the care and safety being provided in this home.

The rapid review as was asked to consider if Child L experienced abuse or neglect in his care placement and if there were opportunities where alternative action could have been taken to promote better outcomes for him. However, the evidence and information shared with the Rapid Review Group has demonstrated that L's presentation had been long-standing, both in his family environment and when an inpatient in hospital. It was evident to the Rapid Review Group that the placement was working hard with the team around Child L to manage and respond to his unique and very complex presentation.

The review also noted the local and national issue of placement sufficiency particularly for those children with highly complex mental health and trauma needs and it would be fair to say that the placement search had been longstanding and extensive, and this placement was a 'best fit' for Child L as opposed to a placement which could fully meet his needs.

That being said, a number of learning points have emerged, and these will be taken forward to strengthen local arrangements for children with mental health needs.

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LEARNING FROM CHILD L

WHAT WORKED WELL

Good pastoral care was offered to Child L and his school were flexible in engaging him. They provided a swift response to requests for information to inform his ASD assessment.

Child L had a trusting relationship with his GP. The GP was responsive to his presentation and also offered support to his mother.

Practitioners worked hard with L to try and put in place strategies to reduce and manage impact from his complex needs.

All partners responded swiftly and collaboratively to secure a placement for Child L following the immediate closure of the care home.

WHAT COULD BE BETTER

Opportunities for multi-agency early help were not taken.

While L was an inpatient, there were regular and consistent multi-agency meetings taking place, however following his move to the placement there is no evidence these continued. Regular MDT's would have supported the aftercare and provided a structured mechanism to track L's progress and adapt care plans to respond.

It is unclear what the team around L knew and understood about family dynamics and history. There was little indication as to how wider adverse factors were assessed and considered, particularly given L's extreme anger towards his family.

There was a range of health services involved but at times the health offer lacked coordination

WHAT YOU CAN DO

It is essential that discharge planning begins at the point of a child's admission to tier 4 and that all partners are be actively engaged for this to be fully effective. Where a child is likely to be discharged to a care/health placement, all partners should be involved in contributing to the specifications for the search and the plans for a child to move from one setting to another. Where the plan is discharge home, all partners should be involved in developing the care plan. This should include how family members will be supported.

All practitioners have a role in Early help and it is important to consider when a child and their family may need wrap around support at the earliest opportunity

Where there is involvement of multiple health partners consideration needs to be given to regular MDT, the lead professional role and the use of Early Help as a mechanism to bring people together

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