Child Practice Review Report

Cardiff & Vale of Glamorgan Regional Safeguarding Children Board Extended Child Practice Review

Re: C&VRSCB 07/2015

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal Context

An Extended Child Practice Review was commissioned by Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (C&VRSCB) on the recommendation of the Child Practice Review Sub-group in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi Agency Child Practice Reviews (Welsh Government 2013). The criteria for this Review were met under section 6.1 of the above guidance namely:

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development;

and,

the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Domestic Abuse

The cross UK government definition of domestic violence and abuse is:
Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.

The terms of Reference for this review are at Appendix 1.

Circumstances Resulting in the Review

The 17-year-old child subject to this review was reported missing by her family in the summer of 2015 and was found deceased 9 days later having taken her own life.

At the time of her death, she was a looked after child subject to a full care order living in the family home under Placement with Parent Regulations. This Extended Review concerns the steps taken to safeguard the child during the period 2013-2015 although there had been

extensive multi-agency working involving the child prior to this time period which will also be considered.

Significant Events prior to the period under Review

A number of adverse childhood experiences have been identified in the child's life. She was the victim of child sexual abuse between the ages of 7 and 9 years of age, a victim of domestic violence and child sexual exploitation; there was also a history of drug and alcohol misuse and numerous attendances to the Emergency Unit due to her self-harming behaviour.

The reviewers were mindful, that whilst the information in the report may suggest a sense of blame on the child, this was clearly not the case. The language used within the report was intended to clearly demonstrate the child's feelings of the low opinion and worth that she had of herself.

Aged 13 years the child disclosed sexual abuse. A strategy meeting was held where two males were identified aged 16 and 18, though it does not appear the matter was reported as a crime and from this point on there was on-going multi-agency involvement with the child and the family. In autumn 2010, the first assessment using the SERAF (Sexual Exploitation Risk Assessment Framework) was undertaken which placed the child in the significant risk category for Child Sexual Exploitation (CSE), but there is no record of any action emanating from the assessment. Since this time, there has been significant improvements in all cases where CSE is identified and such cases would now be dealt with differently. During the latter part of this case, CSE was beginning to be seen as a clear factor and matter of concern.

There followed a period throughout the next year of the child demonstrating increasing risks associated with substance misuse, self -harming, a declining school attendance with a pattern of aggressive outbursts resulting in exclusion from school, going missing and being at risk of child sexual exploitation. An Initial Child Protection Conference was held in early 2011, which resulted in no child protection registration.

In early 2012, the child returned to education having been out of school for over 18 months with an Individual Educational Plan being implemented to support her, but attendance again soon declined.

An Initial Child Protection Conference held in Spring 2012 placed her name on the child protection register under the category of Neglect and a core assessment found there to be a high risk of CSE. At the Review Child Protection Conference, the category of registration was changed from Neglect to Child Sexual Abuse reflecting sexual abuse as the main risk factor for her.

The child was receiving home tuition and in July 2012 was allocated a place at a Pupil Referral Unit. Child protection planning continued alongside Public Law Outline (PLO) in July 2012. There were increasing periods of her going missing (in one month alone there were 8 reported missing episodes) disclosures of sexual abuse involving older men and the child was voluntarily accommodated by the local authority in Autumn 2012 after a disclosure to professionals that she was subjecting herself to sexual abuse in return for drugs. Domestic abuse was also a feature of the child's intimate relationships.

The child was also arrested for a shoplifting episode and became known to the Youth Offending Services. Child and Adolescent Mental Health Services (CAMHS) were involved. A referral to Barnardo's Family Support Services was also initiated at this time. There was multi-agency agreement that it was in the child's best interest that a place in a secure unit was required. Following a Care Order being granted to the Local Authority she was transferred to a secure unit just before Christmas 2012.

Significant Events during the period under Review

By Spring 2013, it was agreed secure accommodation was no longer required and residential provision was identified out of county followed by a brief period back at home. Care plans, at this time, clearly indicate the need for a placement to ensure her safety. These plans, however, fail to demonstrate robust, long-term arrangements, including progression to a step-down facility, which should have included throughout, her voice and opinion. This lack of future planning was highlighted in the case notes by the local authority officer who authorised a placement for her at the Out of Area Panel on the 31st of July 2013.

During this period, the child was in contact with known CSE perpetrators in the area and there were repeated missing incidents. Because of the CSE concerns and the missing incidents, the child was readmitted to a residential setting in the summer of 2013. There followed a six month period of placements in a number of residential units with continued issues of overdosing and going missing from these settings.

At the beginning of 2014, Placement with Parents was agreed and she was returned home. The Placement with Parents plan recommended that the placement should be reviewed regularly, and missing episodes should be reported at all times.

The next eighteen months of the child's life highlighted a repeated pattern of:

- Numerous missing incidents – in one six-week period alone there were 18 reported missing events recorded. At this time, one of the siblings in the family home was a young baby and it was unfortunate that, despite the wishes of the mother who did not want police attendance at the home due to fear of disturbing the baby, the police had to comply with their procedures which meant that the police often attended the home address to deal effectively with the missing and found reports around the child.
- It is recognised within the child's care plans that the mother had been told to report the missing incidents to the police, but the plans lack clarity as to the support that could have been provided to mother to understand why she had to report these incidents. On reading the plans for the child, there is significant detail regarding the child's history. These could have included wider implications for other family members i.e. mother and siblings, who may also have been in need of support at this time.
- Increasing and escalating incidents of domestic abuse resulting in serious injuries being sustained. Attempts to prevent the child and the perpetrator meeting, including the issue of a Child Abduction Warning Notice were tried. However, the targeting by the perpetrator was too strong for the child to break away.
- The child admitted to increased sexual abuse with numerous older males. She, however, would never disclose actual detail of who the alleged males were. She admitted that such sexual abuse was in return for drugs and/or alcohol.
- Sexual risk taking also increased with the child failing to attend numerous Department of Sexual Health (DOSH) appointments and refusing to consider contraception as a means of keeping safe.
- Non-engagement with education services, despite concerns being raised by professionals. The child was referred to the Pupil Referral Unit in early 2014, although there is little detail within the timeline as to the involvement or effectiveness of this resource. Arrangements were then put in place a year later for the child to receive 1 day a week education for a 6-week period, but the child only attended once.

By the Spring of 2015, the child was noted as being low in mood, showing episodes of self-harm and attempts to take her own life. It was noted that she could see no positives in life, and was presenting with marked feelings of hopelessness. Children's Services case notes at the time described her as "emotionally very unstable". Child and Adolescent Mental Health Services (CAMHS) involvement began again at this time, and mental health assessments were undertaken, with the recommendation being that she should receive on-going support from the

CAMHS and Community Intensive Therapy Team (CITT). The child's engagement with both services, however, was variable, with appointments and meetings being repeatedly missed.

In mid-2015, the child undertook a serious attempt to take her own life, a method that she had researched online. She was found by her mother and stepfather who promptly initiated cardio pulmonary resuscitation (CPR) and requested urgent emergency services intervention. The child was discharged home following the incident with CAMHS and CITT support in place. Eleven days later the child was again reported missing by mother, and nine days later, was found deceased, having taken her own life by identical means to the attempt earlier in the month.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

As part of this Child Practice Review a Learning Event was held engaging practitioners involved with this young girl. The Reviewers would like to thank all those who attended the learning event and their contribution to the learning from this Review. The death of a child in such circumstances is always distressing and we are grateful to all the practitioners for their attendance. Much of the practice and organisational learning considered below was raised at the Learning Event.

The importance of the voice of the Child

Throughout the period identified in the timeline the panel noted that the voice of the child was difficult to find, and the history shared with the panel showed little evidence of what her personal thoughts and feelings were, and what was important to her at various points in her life When accommodated the child's wishes to return home were expressed to the SERAF worker and she did express some fears when she was experiencing domestic abuse. There were one or two notable references to occasions when she expressed personal interests, concerns and hopes for the future. For example, in one conversation at the residential placement, she discussed her hopes of becoming a RAF nurse or a marine biologist, but there was little follow up by professionals to confirm how she could be supported to deal or progress with her ambitions.

During her period in a secure placement, there are numerous records of discussions where the child makes clear links between her current behaviour and her early childhood, but notes that so much of the involvement reflected only negative aspects, and that key positives were not looked at or discussed. During a psychological assessment early summer 2013, it was noted that she "feels Children's Services are always very negative about … and don't recognise … positive achievements". When the child disclosed her historical child sexual abuse by mother's partner to a worker in the secure unit, she commented, "there is nothing worse that can happen to me now".

Because of the numerous interventions planned for her, the result was several different workers being involved in her care at the same time. It also became evident during the learning event for this review that assessments were often completed during initial visits but not seen as an ongoing continuing process. This may have proved difficult for her to maintain and develop relationships with professionals when discussing personal and intimate matters.

Partnership working with the child's family

The reviewers met with the child's mother as part of this review and were told that she and the family were extremely grateful for the support and guidance given by the social worker involved with her daughter in the last few months of her life. She was, however, critical of the initial support provided from social workers and the CAMHS service. In the reviewer's conversation with her, it was evident that the family felt disempowered to support their child. Mother

explained that, at times, they were anxious not to offer possible solutions or alternative methods of support for fear that this would be perceived as posing further risks to her daughter and the other children in the family, and as such would lead to other siblings coming under the scrutiny of statutory services.

One such example was that maternal grandmother had considered and discussed with the family the option of taking the child subject of this review to the maternal birth family's country of origin for an extended period (as the maternal family still have a large extended family there). The aim of such a trip being to distance the child from the individuals who were seen as being abusive and exploitative of her. The family considered that this would have been an opportunity for the child to experience an alternative lifestyle and attitude to, for example, social media. This option was never raised with statutory professionals, and sadly demonstrates ~~t~~their general mistrust of the services supporting the child and her family.

The time line clearly demonstrates that mother regularly and consistently contacted the police to report her daughter missing, because she was advised by Children's Services that she had to. There is little to suggest that she fully appreciated what the process would entail, and how she could be an active partner in locating and supporting her daughter. There is no evidence to suggest that Children's Services attempted to support mother to actively participate when her daughter would go missing. There is also an inference here that she, again, felt that to not comply with the directive and advice given by statutory services, that she and her family would be treated punitively by the agencies involved. This is corroborated within the child's plans.

During the last two years, Cardiff Council has introduced the Signs of Safety model of working across Children's Services. One of the key aims of the model is to ensure the voice of the child is clear, and the tools it adopts underpin this requirement. Recent developments in CSE arrangements have identified the need to support, advise and work with families when dealing with children who present at risk of CSE.

Some issues raised by the mother with the reviewers concentrated on the 9-day period ~~where~~ when she was missing and subsequently found having taken her own life. This part of the child's life has not been considered within this review, but an internal Investigation, which is usual practice, was conducted by the Professional Standard's Department of South Wales Police. The findings from the investigation were fully shared with mother via the Investigating Officer during a home visit. That report has also been shared with the Safeguarding Board.

RECOMMENDATION 1

- **All agencies should aim to ensure that children and their families are listened to and are enabled to fully engage and this be consistently reflected in their care planning.**

RECOMMENDATION 2

- **Cardiff and Vale of Glamorgan RSCB should satisfy themselves that all agencies should actively support and engage in a model of CSE intervention that allows every child at risk of CSE the opportunity to have a consistently available, trusted individual person to provide them with advice and support.**

Recognition of link between self-harm and sexual abuse in childhood

Although outside the timeline for this extended child practice review it is pertinent to acknowledge that the child was a victim of child sexual abuse between the ages of 7 and 9 by her mother's partner, who subsequently received a custodial sentence. Following the conclusion of the criminal proceedings, the child and her mother undertook therapeutic work with CAMHS. When the reviewers met with mother, she reflected the view that she did not feel

that the CAMHS intervention had been useful following the sexual abuse of her daughter. She commented that some of the interventions were not tailored to her child's developmental needs.

It is clear that child sexual abuse (CSA) was a critical factor in her early years development and though this information was present in minutes of meetings e.g. Child Protection Conference and the majority of planning documents, but there is little connection between her early years abuse and her presentation at this time, which supports the category for registration as neglect as opposed to CSA. Its significance and increased risk to CSE was not recognised in her presentation at that time. Research indicates a clear link between self-harm and sexual abuse in childhood. (Romans et al 1995). When the child later started exhibiting signs of low self-esteem, self-harming, under age sexual abuse and going missing, there is very little reference to her previously being a victim of child sexual abuse, which had a clear influence on her later years. For example, at the initial child protection conference in Spring 2012 her name was placed on the child protection register under the category of neglect rather than child sexual abuse even though she had disclosed under age sexual abuse.

There are difficulties and challenges associated with working with a child who has been the subject of sexual abuse; however, practitioners need to recognise that children's behaviour is a means of communication and should be interpreted as such to be the unheard voice of the child. Much of the behaviour this child was exhibiting can be seen in the context of her previous abuse. It appears that this child was a victim not adequately supported to recover from the trauma of child sexual abuse with the resulting behaviours. It is not clear from the timeline which agencies, apart from the police and Children's Services were aware of her previous child sexual abuse. For example, when the child was resident in secure accommodation and talked about her previous abuse to a worker, the worker made a child protection referral (appropriately) as she was not aware of the child's history. She was then informed by Children's Services that this was known historical information. It is evident and acknowledged that information was shared with the placement about the previous sexual abuse, but it remains unclear if the provider fully understood or were conversant with this detail of her history.

RECOMMENDATION 3

- **Cardiff and Vale of Glamorgan RSCB to satisfy themselves that all agencies understand the importance of historical events in a child's life, which may impact on future behaviours and outcomes**.
- **Cardiff and Vale of Glamorgan RSCB to ascertain the level of therapeutic support available for victims of child sexual abuse in the Board area and the timeliness of that therapeutic support.**
- **When placing a child in another area, the local authority should be assured that the information shared has been read and understood by the care team supporting the child, so that people working with the child are aware of key issues in the child's life. This will enable better understanding and trusting relationships with the child.**

Missing children and CSE Processes

Sexual Exploitation Risk Assessment Framework (SERAF) scoring for the child during the period varied according to her placement at the time, as opposed to any actual change in her behaviour and risk taking activities. When placed at home her SERAF score was high, but when in residential or secure placement it reduced greatly. This was considered by the panel to be due to the child being unable to engage in risk taking CSE behaviour at the time due to her location, rather than due to any improvement in her circumstances or behaviour. For example, her SERAF scoring ranged from 66 when at home to 18 when in residential placement. This reduction in scoring influenced the agencies decision to support ending the residential placement prematurely and effectively returning the child back into the CSE environment.

Throughout the timeline identified within this review, it is evident that there were numerous and recurrent episodes of the child being reported as missing. The repeated episodes of her being reported missing by her mother suggested that the family co-operated in raising concerns about the child's whereabouts and activities. It is noted, however, that there was a lack of clarity on behalf of the family as to why they needed to inform. The reports within the timeline, however, raise clear concerns within the process:

- On contacting the police, mother would openly share details with officers responding to the incident, but when asked why she had phoned, replied that she had been told by social services to report missing incidents.
- The child was subject of a Care Order and the conditions of that Order were not consistently applied by agencies with regard to residence e.g. Whilst resident at a residential care home the child was located at her mother's address and refused to accompany the care staff back to the establishment. The police attended and it was established that the care order did not give the police any powers to physically remove the child. Following a welfare check, a decision was made to take no further police action and the child was allowed to remain for the night with her mother. Inconsistencies like this does have an impact on the way in which the police are able to implement their police powers. Similarly, there was an incident where the child was missing overnight and when she was located by a social worker the following day she was allowed to make her own way home. The child failed to return resulting in the mother re-contacting the police.
- Intelligence concerning addresses and individuals of note were shared with the police during the reported missing incidents. The police always took positive action and attended addresses to locate the missing person, very often to no avail. However once the child was located as safe and no formal disclosures were made, the lines of enquiry were closed down. The intelligence was effectively captured and recorded but as a consequence of no formal complaint, police did not follow up on the initial intelligence. It is acknowledged that it is difficult to turn intelligence into evidence without cooperation from witnesses; however, these could be considered missed opportunities.

It must be noted that CSE and missing persons awareness has increased greatly since 2012 and further since the child's death. Clear policies, procedures and legislation, and greater inter-agency involvement now ensures that many of the missed opportunities identified in the child's case would not occur today. The implementation of the Multi Agency Safeguarding Hub arrangements and the creation of the Missing Persons Team within South Wales Police ensure that intelligence is shared and acted on proactively. Similarly, the development of the Barnardo's return home interview arrangements are seen as a positive step and liaison with family members is much improved.

The implementation and awareness of wider Trafficking legislation has ensured that intelligence is acted upon in a speedy and effective manner. The increasing use of powers such as the Child Abduction Warning Notice (CAWN) mean that police officers now more frequently intervene and disrupt perpetrators more effectively.

RECOMMENDATION 4

- **The SERAF risk assessment should reflect the underlying risk of behaviours rather than the environmental changes, and the resulting SERAF score should remain at the higher level during the period a child is placed in secure or residential settings, and should only be reduced when clear positive changes have been implemented that demonstrate there are clear reductions in the CSE risk. Current arrangements in the process in Cardiff have been adopted to ensure this occurs.**

- **For agencies to promote better engagement and partnership working with families where CSE is a presenting factor by all staff having access to training which is trauma informed, enabling them to work with and develop interventions for young people and their families who experience issues such as child sexual exploitation, substance misuse, missing from home and domestic abuse in a holistic way.**

Domestic Abuse in adolescence

During the two-year period covered by this review there are nine reported occasions when she had been harmed by a perpetrator of domestic abuse. Some of the incidents were so severe hospital treatment was necessary.

Following one abusive incident, the child, aged 17 years, attended the Department of Sexual Health (DOSH) where it was recorded that she had sustained a black eye but there is no evidence of any referral to Children's Services, or any domestic abuse service. A social worker visiting the home on a statutory Looked After Child visit the following day observed her black eye and initiated an investigation in respect of an assault. The police were notified, and although the child chose not to engage, a PPN (Police Protection Notice) was shared with agencies, and consequently a strategy meeting was convened. Positive action was taken and an arrest was made but the investigation concluded that there was insufficient evidence to proceed to court.

In early spring 2015, the child sustained injuries including a bite mark to the face from an adult male abuser, whip marks on the legs from a USB cable and marks on the thighs from a baseball bat. The child was also threatened with a hammer. The police acted appropriately in their response to domestic incidents they were called to and shared information with partner agencies. During the timeline, a MARAC Referral was considered and a rationale was recorded for not referring due to the child being dealt with under Child Protection Procedures. The police submitted a PPN, which was shown to have been shared with Cardiff Women's Aid (CWA). It is worthy of note that just 12 days prior to this incident the police had responded to an incident which would appear to have been a verbal argument between the child and a different boyfriend.

A Multi Agency Safeguarding Hub (MASH) is now in place in Cardiff. All Multi Agency Referral Forms are sent to Children's services who assess the information shared and agree a threshold for action. If the threshold is reached where there are child protection concerns, it is shared with the partner agencies at the MASH. This includes the Domestic Abuse Unit (DAU), Public and Child Protection Unit of the Police, Probation service, Cardiff & Vale UHB, Education and Adult Social services. The concerns are then put onto a shared IT system where all agencies communicate the relevant information held on the individuals involved. A Strategy Meeting is then convened and an action plan is agreed. This will happen in a certain time frame depending on level of urgency.

With regards to domestic abuse concerns, the procedures are now far more robust, and all PPNs are risk assessed by the DAU and those that deemed high risk lead to all agencies summarising their involvement and any relevant information held, with the case being discussed at the daily discussion meeting. A safety plan will be agreed and a decision whether the case will need to be discussed at the forthcoming MARAC meeting. In some cases where child protection concerns are identified which are as a result of a domestic abuse incident, these will be discussed at a strategy meeting with the DAU invited to ensure that all risks are considered and who will then liaise with the necessary support services e.g. CWA and Safer Wales.

In 2012 the definition of domestic abuse was changed to include victims aged 16-18 and where domestic abuse is identified, referrals should be considered to appropriate services by all agencies to support those individuals. In 2009, the National Society for the Prevention of

Cruelty to Children (NSPCC) conducted research in a small selection of schools with young people aged 13-17, which examined their experiences of physical, emotional and sexual forms of violence in their partner relationships. The research found that 25% of girls and 18% of boys who were part of this study, experienced some form of physical abuse at least once, and 31% of girls and 16% of boys reported experiencing some form of sexual violence at least once. (Barter et al 2009).

RECOMMENDATION 5

- **Cardiff and Vale of Glamorgan RSCB should ask all agencies to remind their staff that victims of domestic abuse can be in the 16-18 year old age group and their awareness and response should be consistent with those of older victims.**

Looked After Children

The timeline demonstrated that despite regular review arrangements and meetings in place, these were either cancelled, not convened in a timely manner or often poorly attended; the reviews appeared, on several occasions, to undertake a rubber- stamping approach to care planning with little analysis of risk. There was evidence within the case notes of action planning being in place but whilst being in place, they lacked robust detail as to what actions were needed, how these would be implemented, and most significantly, how the child's wishes and views were incorporated and acted upon within the plans. Care plans regularly detail that "carers (to include mother) need to put firm boundaries and supply guidance on behavioural issues" but no wider detail as to how mother would achieve this aim. At the learning event, there was discussion how creative methods could be utilised to ensure full contribution to a child's Looked After Child care and support plan.eg tele or video conferencing, or the use of skype if a professional was not able to get to the venue for the meeting.

Throughout the period of this review, the child was in a number of Out of County placements, including a secure unit. Out of county placements are considered as a means of supporting children when their needs cannot be managed effectively within the resident local authority boundaries due to management issues, safeguarding risks or a lack of local resources to meet the need. Consideration and approval for such placements is considered at a formal Out of County Panel meeting. The secure unit was expected to keep the child safe, restore some stability to her life and assess the child's needs to identify support/intervention for the future. At the learning event, at which the secure unit were present, there was discussion regarding the criteria and the child's pathway to the secure unit. It was accepted that only short-term work could be achieved and this was a 'holding' time where the child could start to engage in some support. It was acknowledged that the child had complex deep-rooted issues, which required long-term work to bring about any sustainable change.

A number of out of county panel meetings were held after the child had been placed. There seems to have been some delay at times in filtering the information to partner agencies regarding changes of placements. There is a system amongst local authorities for notifying each other of an out of area placement of a child in care, but this does not include notifying the relevant police force within the receiving local authority. Clearly, the local police force are often the partner agency involved when looked after children go missing etc. and it may be helpful to consider them being informed.

At the time of publication of this report, we understand that the All Wales Protocol Missing Children was under review to reflect and incorporate recent legislative changes and developments in the support available for missing children. As such, the review changes may influence and guide the actions recommended in this report.

RECOMMENDATION 6

- **Arrangements and attendance at review meetings need to be improved with a clear expectation of appropriate involvement by all relevant agencies to ensure the care and support plan for a child is timely, effective and sensitive to the individual needs of a child looked after. Cardiff and Vale of Glamorgan RSCB to ask all agencies to remind their staff and include in training the importance of appropriate attendance at the review of a Part 6 care and support plan for a child. (Part 6 Code of practice (Looked after and Accommodated Children)**
- **Local Authorities when notifying the receiving local authority regarding placement of a child, must notify the local police force in the receiving local authority area where there has been a history of missing/CSE concerns with an accompanying completed and current risk assessment.**
- **All agencies should have available various methods of communication systems to support the attendance at meetings. These could include Skype, video conferencing and teleconferencing.**
- **Cardiff and Vale of Glamorgan systems should be fully embedded to ensure that reviews are timely and effective, and fully reflect the voice of the child and their desired outcomes.**
- **Cardiff and Vale of Glamorgan RSCB should receive a bi annual update on multi-agency attendance at LAC reviews so that patterns or trends of non-attendance can be identified and addressed in a strategic manner.**

Involvement of CAMHS

The child had repeated involvement with the CAMHS service, but her mother and other agencies involved in her care were unclear of the role and support CAMHS could offer. Following each admission to the Emergency Unit due to self-harm, a CAMHS doctor saw the child; however, there was no evidence of any risk assessment being shared with other agencies. NICE Guidance states that all people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include a psychosocial assessment. CAMHS have recently introduced the use of the WARRN Risk Assessment, which meets this criteria. At the learning event, the CAMHS representative said the risk assessment is now shared with other agencies, but in only paper format, as they do not have access to secure emails, thus resulting in a delay in information sharing. CAMHS did not attend any multi-agency meetings including CSE meetings and LAC reviews during the period of this review.

Whilst the service has aimed to improve their provision with the implementation of a crisis response service that is on call until 10pm, the child's experience highlighted the service to have a long waiting period, an assessment process that appeared to adopt a single agency approach, and no clear electronic information sharing arrangements that would promote greater integrated working.

RECOMMENDATION 7

- **CAMHS to improve the timeliness and method of sharing appropriate information between CAMHS and other agencies particularly when there are risk or safeguarding issues.**
- **With specific cases, key professionals should ensure that their inter-agency liaison is evidenced in case notes with the aim of improving professional communication and dialogue.**

Suicide and self-harm

The child had a number of adverse childhood experiences (ACEs) that made her particularly vulnerable to self- harm. She had an early childhood history of child sexual abuse, a family history of domestic abuse and parental separation, a recent family bereavement, was misusing alcohol and substances, was isolated, child sexually exploited and had been bullied. The suicide and self-harm prevention strategy Talk to me 2 2015-2020 and Together for Mental Health describes how more can be achieved through partnership working, to effectively address the risk factors associated with self- harm. This child had multiple stressors that contributed to her death. Care plans for the child, whilst acknowledging and aiming to provide support for the child during her periods of self-harm and suicide ideation, did not evidence the robust arrangements that should be initiated as necessary. The plans make no reference, for example, to escalating to the use of Mental Health Act powers if risks were increased, although case notes make reference when the child then goes missing, but lack clear risk assessment severity. The timeline for Care First the 26th of June 2015 noted the need for police to consider use of Mental Health Act powers if necessary, but there is no record of that being shared with the police, and the actions by the police concentrated on previous missing incident history and presentation. Responsibility should be shared across all agencies for involvement in suicide prevention. Self-harm services are crucial, and staff who work at the front line must be well skilled to work with those reporting self-harm. There needs to be effective multi agency working, especially for those children who are looked after. The child researched her method of death on the internet. Schools have a responsibility to educate pupils on safe use of the internet.

RECOMMENDATION 8

- **Cardiff and Vale of Glamorgan RSCB to explore opportunities to utilise broader experience and knowledge to secure coherent, collaborative and multi-agency approaches to the preventing of suicide and self-harm and wider efforts to support well-being.**

Educational involvement

At the age of 15 when this review commenced the child had recently become the subject of a Statement of Special Educational Needs, though was receiving very little educational provision. The Statement of Special Educational Needs specified placement in a Pupil Referral Unit (PRU), though following placement in a succession of Residential Placements in other Local Authorities, there was a period of time when the child was without education. She returned to the PRU she had previously attended during the Spring Term 2014. Her subsequent attendance at the PRU was noted to be poor. At the learning event, the education representative explained she should have been referred to the Educational Welfare Officer, but this appears not to have happened.

At the end of the Spring Term 2014 her place at the PRU was closed due to non- attendance.

A Youth Mentor subsequently raised concern about the child's lack of access to education. She was then provided with tuition for five hours per week. After an initial period of good attendance her attendance declined and a few weeks later, she indicated she no longer saw the point of attending the sessions as there was only five weeks to go to her sitting exams.

In examining the factors that led to the child 'falling out of education', the child's mother explained her daughter had been bullied in school, this had not been resolved, so mother moved her from the school. Unfortunately, the bullies then followed her online.

Children begin to 'fall out of education' for a variety of reasons. They cease to attend school for a variety of reasons; truancy, illegal or 'soft' exclusions, removal from roll, moving to a new Local Authority, and parents being unhappy that issues, such as bullying, are not satisfactorily

resolved. Recent discussion has shifted the focus from the 'abnormality' of the individual child to the factors that lead children to be intentionally or unintentionally 'pushed out' learners.

Such children may subsequently go missing from education or fail to receive a suitable education where schools and the Local Authority lack systematic processes to:

- identify those children at risk
- ensure that they re-engage with appropriate provision;
- ensure that re-engagement with appropriate provision is sustained through contact being maintained to ensure that they do not 'fall out of education' again.

During the period of this Child Practice Review and subsequently there have been a number of developments that lessen the risk of children 'falling out of education'. All maintained schools in Wales have a statutory responsibility to use the Common Transfer System (CTS) to transfer specific information electronically. Head teachers must pass on specific pupil information in electronic format when a pupil changes school using the Common Transfer System (CTS) within 15 days after the pupil ceases to be registered there.

Within the LA, the Education Welfare Service manages Children Missing Education enquiries. If a child is withdrawn from an LA school without the parent giving notice or without the school being advised of a new school, School and School Attendance (SAO) and Education Welfare Officers (EWO) follow the LA's Children Missing Education (CME) procedures to determine the child's whereabouts. The policy was implemented in 2011 and has recently been refreshed within the last few years to provide a more succinct summary document. This policy is now well embedded; however, it was not implemented successfully in this child's case. The SAO and EWO will follow up with our counterparts in other LA's areas to track through to new schools.

Once the Education Welfare Service have followed CME procedures and all 'reasonable efforts' to locate the child has been unsuccessful, then, after four weeks, the school, in consultation with the local authority can remove the child or young person's name from its roll and create a "lost pupil" common transfer file (CTF) with XXXXXXX as the destination. This CTF is uploaded onto the s2s secure site where it will be held in the 'Lost Pupil' area.

An independent review has recently been undertaken of Education Other Than at School (EOTAS) provision and recommendations made for future development. These recommendations have been reviewed and are being progressed by the LA, including increased provision for pupils on tuition.

RECOMMENDATION 9

- **Both Local Authority Education Departments to investigate the reasons why children stop attending education in order to reduce the risk of such outcomes in the future through prevention and an emphasis upon inclusion and introduce processes if deficiencies are identified. As noted above, the voice of the child and the family should be captured at all times.**
- **The Local Authority to continue, through a programme of ongoing self-improvement, to ensure that children at risk of 'falling out of education' re-engage, and continue to remain engaged, with appropriate suitable educational provision, defined as efficient full time education suitable to her / his age, ability and aptitude and any additional learning needs the child may have, as quickly and effectively as possible.**
- **The Local Authority to continue, through a programme of ongoing self-improvement, to ensure that children are safe from harm**

- **The Local Authority to ensure that those who are best placed to do so respond to incidents of bullying efficiently and effectively.**
- **The Local Authority continue, through a programme of ongoing self-improvement, to ensure that placements for children who are placed out of authority are well co-ordinated and appropriate provision is in place to meet all the child's needs.**

Effective Practice identified

- The decision of the police to attend a planning meeting due to the issues and risks around the child.
- Robust decision making and recording of the police with regard to the MARAC process thereby preventing duplication.
- Proactive response, planning and good communication between the police in conjunction with the Barnardo's SERAF service and mother of the child with regard to police progressing the issuing of a CAWN on the boyfriend.
- The initiative of the missing person coordinator to convene a strategy meeting to address the child's continued unauthorised absences. This evidenced good working practice and communication between agencies and listening to the voice of the child.
- The appointment of an experienced police officer to link in with the child and interview her. This is an excellent example of evidence when the voice of the child was heard and it really looked like she was turning her life around.
- At one point when the child ran away from a residential placement to her mother. The residential placement maintained daily contact and worked with the child in the parental home.
- The child made a number of disclosures to the Barnardo's SERAF service that were immediately shared with the social worker and police. Barnardo's repeatedly escalated concerns and requested strategy meetings to respond to these increased risks.
- The worker at the secure unit made a child protection referral following a disclosure of historical child sexual abuse. Whilst it is acknowledged that this was good practice, it is evident that the worker had not understood that this information had previously been shared, and as such, the matter had been considered with in the past.
- The social worker involved with the child in the latter stages, clearly acted as an advocate, and was praised by the child's mother for her support. She challenged the CITT process and was deemed to have supported the child beyond expectations. She and the wider social work team were also active in the physical search for the child in the last week.

References:

Romans,S. Martin,J. Anderson,J. Herbison,P.Mullen,P. Sexual Abuse in Childhood and Deliberate Self-Harm 1995

Barter, C. McCarry, M. Berridge,D. and Evans, K. Partner exploitation and violence in teenage intimate relationships Oct 2009 www.nspcc.org.uk.inform

Welsh Government. Social Services and Well-being (Wales) Act 2014 Part 6 Code of Practice (Looked After and Accommodated Children)

NICE guidance Self-harm Quality Standard (QS34)

Welsh Government. Talk to me 2 Suicide and Self Harm Prevention Strategy for Wales 2015-2020 Cardiff: WG;2015

Welsh Government. Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales 2012 Cardiff: WG; 2012

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the RSCB and its member agencies and anticipated improvement outcomes:-

RECOMMENDATION 1

- **All agencies should aim to ensure that children and their families are listened to and are enabled to fully engage and this be consistently reflected in their care planning.**

RECOMMENDATION 2

- **Cardiff and Vale of Glamorgan RSCB should satisfy themselves that all agencies should actively support and engage in a model of CSE intervention that allows every child at risk of CSE the opportunity to have a consistently available, trusted individual person to provide them with advice and support.**

RECOMMENDATION 3

- **Cardiff and Vale of Glamorgan RSCB to satisfy themselves that all agencies understand the importance of historical events in a child's life, which may impact on future behaviours and outcomes**.
- **Cardiff and Vale of Glamorgan RSCB to ascertain the level of therapeutic support available for victims of child sexual abuse in the Board area and the timeliness of that therapeutic support.**
- **When placing a child in another area, the local authority should be assured that the information shared has been read and understood by the care team supporting the child, so that people working with the child are aware of key issues in the child's life. This will enable better understanding and trusting relationships with the child.**

RECOMMENDATION 4

- **The SERAF risk assessment should reflect the underlying risk of behaviours rather than the environmental changes, and the resulting SERAF score should remain at the higher level during the period a child is placed in secure or residential settings, and should only be reduced when clear positive changes have been implemented that demonstrate there are clear reductions in the CSE risk. Current arrangements in the process in Cardiff have been adopted to ensure this occurs.**
- **For agencies to promote better engagement and partnership working with families where CSE is a presenting factor by all staff having access to training which is trauma informed, enabling them to work with and develop interventions for young people and their families who experience issues such as child sexual exploitation, substance misuse, missing from home and domestic abuse in a holistic way.**

RECOMMENDATION 5

- **Cardiff and Vale of Glamorgan RSCB should ask all agencies to remind their staff that victims of domestic abuse can be in the 16-18 year old age group and their awareness and response should be consistent with those of older victims.**

RECOMMENDATION 6

- **Arrangements and attendance at review meetings need to be improved with a clear expectation of appropriate involvement by all relevant agencies to ensure the care and support plan for a child is timely, effective and sensitive to the individual needs of a child looked after. Cardiff and Vale of Glamorgan RSCB to ask all agencies to remind their staff and include in training the importance of appropriate attendance at the review of a Part 6 care and support plan for a child. (Part 6 Code of practice (Looked after and Accommodated Children)**
- **Local Authorities when notifying the receiving local authority regarding placement of a child, must notify the local police force in the receiving local authority area where there has been a history of missing/CSE concerns with an accompanying completed and current risk assessment.**
- **All agencies should have available various methods of communication systems to support the attendance at meetings. These could include Skype, video conferencing and teleconferencing.**
- **Cardiff and Vale of Glamorgan systems should be fully embedded to ensure that reviews are timely and effective, and fully reflect the voice of the child and their desired outcomes.**
- **Cardiff and Vale of Glamorgan RSCB should receive a bi annual update on multi-agency attendance at LAC reviews so that patterns or trends of non-attendance can be identified and addressed in a strategic manner.**

RECOMMENDATION 7

- **CAMHS to improve the timeliness and method of sharing appropriate information between CAMHS and other agencies particularly when there are risk or safeguarding issues.**
- **With specific cases, key professionals should ensure that their inter-agency liaison is evidenced in case notes with the aim of improving professional communication and dialogue.**

RECOMMENDATION 8

- **Cardiff and Vale of Glamorgan RSCB to explore opportunities to utilise broader experience and knowledge to secure coherent, collaborative and multi-agency approaches to the preventing of suicide and self-harm and wider efforts to support well-being.**

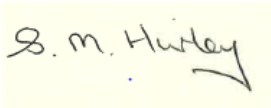
RECOMMENDATION 9

- **Both Local Authority Education Departments to investigate the reasons why children stop attending education in order to reduce the risk of such outcomes in the future through prevention and an emphasis upon inclusion and introduce processes if deficiencies are identified. As noted above, the voice of the child and the family should be captured at all times.**
- **The Local Authority to continue, through a programme of ongoing self-improvement, to ensure that children at risk of 'falling out of education' re-engage, and continue to remain engaged, with appropriate suitable educational provision, defined as efficient full time education suitable to her / his age, ability**

and aptitude and any additional learning needs the child may have, as quickly and effectively as possible.

- **The Local Authority to continue, through a programme of ongoing self-improvement, to ensure that children are safe from harm.**
- **The Local Authority to ensure that those who are best placed to do so respond to incidents of bullying efficiently and effectively.**
- **The Local Authority continue, through a programme of ongoing self-improvement, to ensure that placements for children who are placed out of authority are well co-ordinated and appropriate provision is in place to meet all the child's needs.**

Statement by Reviewer(s)			
REVIEWER 1	**Kathy Ellaway** (Designated Nurse Safeguarding Children National Safeguarding Team, Public Health Wales)	**REVIEWER 2** ***(as appropriate)***	**Alys Jones** (Operational Manager Safeguarding Social Services, Cardiff Council)
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	K Ellaway	**Reviewer 2** *(Signature)*	Alys Jones
Name *(Print)*	Kathy Ellaway	**Name** *(Print)*	Alys Jones
Date	May 2019	**Date**	May 2019

Chair of Review Panel (Signature)	
Name *(Print)*	Sue Hurley
Date	May 2019

Child Practice Review process

To include here in brief:

- *The process followed by the RSCB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The Cardiff and Vale Local Safeguarding Children Board (CVRSCB) Chair notified Welsh Government in 2015 that it was commissioning a Child Practice review in respect of Case CPR 07/2015.

External Reviewer:	**Kathy Ellaway** Designated Nurse Safeguarding Children National Safeguarding Team Public Health Wales
Internal Reviewer:	**Alys Jones** Operational Manager Safeguarding Social Services, Cardiff Council (At the commencement of the review, the internal reviewer was employed by the Vale of Glamorgan, and transferred to Cardiff Council mid- way through the review.)
Chair of Panel:	**DCI Neil Jones** South Wales Police **Sue Hurley** South Wales Police (took over as Chair on 01/02/2017 when DCI Jones retired).

The services represented on the panel consisted of:

- Police (Chairperson)
- South Wales Police
- Social Services Cardiff Children's Services
- Public Health Wales (Reviewer)
- Vale of Glamorgan Education
- Cardiff & Vale University Health Board
- Cwm Taf University Health Board: CAMHS
- Cardiff Council Education

- Barnardo's
- C&VRSCB Business Unit

The Panel met between the period April 2016 and January 2017 in order to review the multi-agency information and provide analysis to support the development of the report.
A learning event was held on the 22nd of November 2016 and was attended by representatives from the following agencies:

- South Wales Police Missing Persons Unit
- C&V University Health Board – Primary Care, Department of Integrated Sexual Health, Child Health
- Cwm Taf University Health Board- CAMHS
- Youth Offending Service
- Barnardo's – Better Futures
- Cardiff Social Services – IRO/Chairs, Looked after Children 14+
- Cardiff Education
- Residential Services – Cefn Cottage, Hillside Secure Children's Home

The mother of the subject of the Review was visited on the 14th of November 2016 to seek her views prior to the learning event and to guide and support the review outcomes.

The Reviewers have undertaken to share the learning from the report with the mother prior to publication.

The panel are aware of the following parallel reviews and processes, the learning from which has been included in this review:

- Cwm Taf UHB Root Cause Analysis Following the Death of a Patient known to CAMHS
- Multi Agency Professional Forum

The panel has drawn on the learning from the reviews that had been completed at the time of writing this report

The Panel was also aware of the following single agency reviews that dealt with specific aspects of the process and were excluded from the scope of this review:

- Police PSD Investigation – Death After Police Contact

☐ Family declined involvement

For Welsh Government use only

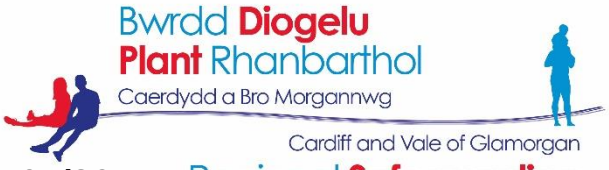
Date information received ……..

Date acknowledgment letter sent to RSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Appendix 1: Terms of reference



Child Practice Review C&V RSCB 07/2015

Extended Review Terms of Reference

Background

The child was the victim of domestic violence, child sexual exploitation and child sexual abuse; she also had a history of drug and alcohol misuse and had numerous attendances to Emergency Unit/GP due to self-harming. She was often reported as missing.

The child initially became a looked after child in September 2012 after concerns escalated regarding risk taking behaviour and sexual exploitation. Children's Services have a long history of involvement as does CAMHS.

A care order was granted to the Local Authority and the child was placed in secure accommodation in December 2012 after taking a significant overdose.

At the time of the child's death she was living in the family home under Placement with Parent regulations, and had been there since December 2013. Concerns were raised about the Child's mental health in March 2015 after an increase in self-harming. There was also were multiple attempts to take her own life.

The child was reported as missing by her family and was found deceased on in July 2015.

Timeframe of Review:

5th November 2012 – 5th July 2015

The timeframe has been extended to ensure continuity with another review which includes the index child.

Criteria for an Extended Review

The criteria for extended reviews are laid down in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended in 2012 are:

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has –

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development;

and

the child was on the child protection register and/or a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

- the date of the event referred to above; or

• the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and RSCB.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- The panel are aware of the following parallel reviews and processes, the learning from which has been included in this review:
    - Cwm Taf UHB Root Cause Analysis Following the Death of a Patient known to CAMHS
    - Multi Agency Professional Forum
- The Panel was also aware of the following single agency review that dealt with specific aspects of the process and were excluded from the scope of this review:
    - Police PSD Investigation – Death After Police Contact. As part of that investigation the police will personally engage with the mother of the deceased to provide a clear understanding of the parameters of the investigation and her entitlements with regard to the same. At the conclusion of that investigation the findings will be share with safeguarding board.
- Hold a learning event for practitioners and identify required resources.

In addition, as an extended review, the Panel will have particular regard to the following:

- Was previous relevant information or history about the children and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the children, their family and their circumstances? How did that knowledge contribute to the outcome for the children?
- Was the child protection plan for each child (and/or the looked after child plan or pathway plan) robust and appropriate for the children, the family and their circumstances?
- Was the plan for each child effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan(s)?
- What aspects of the plan(s) worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan(s), including the progress against agreed outcomes for the children?

Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the children and family fulfilled?

- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?
- Were the statutory duties of all agencies fulfilled?

The specific tasks of the Review Panel

- Agree the time frame for the review including any necessary reference to any significant background information or previous incident.
- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Child Practice Review Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken. The Panel has determined that the appropriate agencies to be engaged in this review and therefore participate as members of the review panel are:
    - Health: Cardiff and Vale University Health Board
    - Children Services: Cardiff Local Authority
    - Education Services: Cardiff Local Authority
    - South Wales Police
    - CAMHS
    - Education Services: Vale of Glamorgan Local Authority
    - Barnardo's
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback. Based upon the timeframe within which the Panel will conclude the review the learning event will be scheduled for the **22nd of November 2016**.
- Plan with the reviewers contact arrangements with the relevant family members prior to the event. Advice will be sought about how to engage any relevant family members of the children subject to the review.
- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Child Practice Review Sub Group and the RSCB for consideration and agreement. The final report will then be signed off and submitted to Welsh Government two week before publication.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before ratification at RSCB. The Panel Chair and Reviewer will provide feedback to the family in advance of the RSCB meeting.

The tasks of the Regional Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Pane*l complete the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2

CPR 07/2015 Summary Timeline

Date	Event	Outcome
Sept 1997	Child was born.	
2004-2006	Reference to child sexual abuse and referral to Children's Services.	Perpetrator imprisoned. Child received support from Children's Services and CAMHS.
March 2012	Child's name placed on Child Protection Register under category of 'Neglect'.	Core assessment found a high risk of CSE. Referral made by Children Services to Barnardo's Family Support Services. Case allocated to project worker.
May 2012	Review Child Protection Conference held.	Change of registration to category of sexual abuse. Core assessment recommended.
May 2012	SERAF risk assessment submitted.	CSE Strategy to be convened in line with protocol.
Oct 2012	Review Child Protection Conference held.	Revised category of neglect instead of sexual abuse. Reference to possible Secure Order due to her non engagement and continued risk taking behaviours.
Nov 2012	Mother reported to police that her child was missing – had not returned home. (8 reported 'missing' incidents in November).	PPD1 form was submitted and recorded and shared with Children Services.
Nov 2012	Case discussed at Safeguarding Children Board Sexual Harm Meeting on 20.11.12.	Interim Care Order being sought through Court by Local Authority. Risk assessment undertaken with a view to placing the child out of area.

Nov 2012	Secure application made on 21.11.12 which was adjourned until 7.1.13.	Child was accommodated at secure unit via ICO/Secure Accommodation Order.
Nov 2012	Case discussed at Out of Area Panel meeting.	Retrospective fostering placement ratified by panel.
	Mother reported child as missing.	PPD1 form completed and shared with Children Services.
Dec 2012	Admitted to hospital, suspected overdose.	Referral sent to Social Services. SERAF Risk Assessment submitted by social worker – reporting significant risk factors. Section 25 secure order.
	Strategy meeting held.	Interim Care Order and Secure Placement Order now in place.
March 2013	Secure Criteria Review meeting held.	No longer meets criteria for secure accommodation. Residential provision to be identified.
March 2013	Readmitted to secure accommodation.	Package of additional support provided.
April 2013	Looked after Child - name now removed from child protection register.	
July-Dec 2013	In a number of residential units.	Similar issues around overdosing and going missing.
Jan 2014	Placement with parents agreed and signed off by chief officer.	Risk surrounding placement with parents have been thoroughly examined.
Jan–June 2014	A number of domestic abuse incidents, risk of CSE and misuse of drugs remain.	
April 2015	Strategy meeting held in response to assault by boyfriend.	Boyfriend subject to bail conditions.
	Admitted to Emergency Unit. Need for CAMHS assessment.	CAMHS appointment arranged. Involvement by CITT requested for a psychiatric assessment.

June 2015	Admitted to hospital - attempted suicide.	PPN submitted and shared with Social Services for a strategy discussion to take place. Warner marker created on NICHE.
	Mother made emergency call to police to report child is missing.	Police looking for child and are aware of mental health condition. Children Services provided support in search. Strategy meeting convened. Ongoing support provided by Children Services.
July 2015	Local authority notified that a body had been found.	