Merton Safeguarding Children Partnership
STRICTLY CONFIDENTIAL

Partnership Review – "Eddie"

Lead Reviewer – Debbie Eaton

1. Executive summary

In May 2019, a child, referred to in this review as 'Eddie', took an overdose of 9 Ibuprofen following an argument with a friend on the phone and following negative comments from his father. Following a Critical Incident Notification from the Youth Offending Team, this was escalated to the QA Sub-Group and then to Statutory Partners to consider whether the incident met the criteria for a Local Child Safeguarding Practice Review under Working Together 2018[1]. At an Extraordinary Meeting of the MSCP in June 2019, it was agreed that the case did not meet the criteria for a Local Safeguarding Child Practice Review and did warrant further investigation through a Partnership Review - Working Together 2018, chapter 4, paragraph 17**.**

What worked well for Eddie is that he was held in mind across agencies over time. Youth Justice workers used a holistic assessment framework, including self-assessment and made efforts to develop a relationship with Eddie and his sister. The SMART centre kept an oversight of Eddie's education when in alternative education placements and tuition. The decision to undertake the Education Health and Care Plan was effective and the assessment well informed. The Child and Adolescent Mental Health Service (CAMHS) provided an immediate response to crises and tried to work with the views of Eddie's mother to meet his needs. When Eddie was on remand his vulnerability indicated he would struggle to settle with strangers and there was good partnership working between Children's Social Care (CSC) and Youth Justice to find a carer in the family network rather than foster care. Police officers were able to engage with him and family members to find out his circumstances at different times, which helped inform the action taken.

Since the end date of the period under consideration a number of changes have been made across agencies in response to adolescents. The MARVE Panel (Multiagency Risk, Vulnerability and Exploitation) provides robust oversight of contextual harm and decisions are agreed with a multi-agency approach. Contextual Harm tools have been developed to understand risk and are being embedded in practice in Children's Social Care and Youth Justice Services. The tools should support an integrated assessment and response to missing, exploitation, offending, mental health needs and substance misuse.

In addition, Youth Justice workers are embedding attendance at the weekly Missing Panel to ensure allocated workers know about young people going missing and the need to complete follow up actions. As part of the Youth Justice Liaison and Diversion Service there is a multi-agency panel which considers all Merlin reports from Police and screens for a child's vulnerabilities that may require further work to divert them from the criminal justice system and the court disposal process also considers this further.

CSC has implemented a leadership alert process for the notification of serious or worrying events, which provides key and important information as and when events happen for leaders and are reflected in records for children. In addition, there have been improvements to documentation and recording to ensure information is shared appropriately to inform decision making.

Worries about the response to Eddie:

Safeguarding adolescents: Where behaviour forms part of the risk, especially within the context of familial harm, this proves a challenge to the multiagency partnership. Adverse Childhood Experiences (ACEs) are significant childhood traumas that may affect a child's learning ability and social skills, and can result in long-term health problems. Adolescents can turn to a number of potentially destructive behaviours in an effort to avoid or defuse the intense negative emotions that accompany traumatic stress, including self-harm. Any child or young person, who self-harms must be taken seriously, as risky behaviour in response to distress can be serious, even accidentally. There were times when Eddie was involved with Police and tried to harm himself, this information should have reached CSC. This may have been an opportunity for assessment and intervention, particularly if considered in the context of other events and behaviours at the time e.g. aged 12.

Service fatigue: The chronology indicates similar concerns and continued referrals between agencies where support had not previously achieved change. Holding and sharing information is a step in the right direction but of itself is inactive in safeguarding children, how the information influences plans and the child's trajectory is the use of information in practice. It is difficult to see how the multi-agency knowledge, information and activity over time have informed planning with Eddie and the family to impact on outcomes. Assessments and interventions should have fully considered historical information as part of a comprehensive assessment; these were sometimes focused around single events. At times, there was a reliance on the interpretation of events and discounting of concerns by Eddie's mother and sister without the context of Eddie's views.

It is important, if accepting family views and their discounting of concerns, to consider the potential of disguised compliance and resistance so decisions are made in the child's best interests. Parents may have difficulty in consistently seeing good intent and be suspicious of the worker's motives or may not agree interventions are purposeful or making a difference. Workers described being braced for confrontation with family members while still keeping Eddie and his needs in mind which also would have contributed another element of fatigue.

A 'Think Family' approach would have supported family members to address their own needs to increase their caring capacity to meet Eddie's needs. This was of particular significance given the family plan was for Eddie to be cared for by his older sister who had experienced her own unaddressed trauma, which was witnessed by Eddie.

The handover of responsibility between agencies when stepping up or down was inconsistent and meant there was a fractured approach to support for Eddie and his family. When making a decision to end social care involvement, in the context of repeat referrals and concerns, there should have been a step-down Team Around the Child/Family meeting (TAC/TAF), including the family to find a TAC/TAF lead and agree a support plan within targeted and universal services. When there was no social worker involved and there was consideration of worries increasing for Eddie or re-referring to CSC any of the involved agencies could have held a complex case discussion and reviewed the step down plan to consider the level of safety as well as risk. Agencies should have constructively challenged each other about commitment and responsibility if concerns remained about safeguarding and risk.

Impact of preconception on response: when professionals received similar information or referrals and considered the history for Eddie there may have been a preconception of him and his family. This was likely to be based on family history/knowledge - particularly male family members' mental health, offending and substance misuse and potentially influenced the ambition to achieve positive outcomes and drive forward plans and intervention. Eddie expressed a clear view he wanted to be in education and being out of school was seen negatively by Eddie, adding to his low sense of success. Given the few hours of occupation from education and youth justice activities, it is understandable he struggled with his emotions and was vulnerable to criminal exploitation and activity, particularly if he felt his ambitions were unsupported. While it was understood Eddie wanted to talk to and work with adults with whom he had a trusted relationship, it does seem that organisational structures and service limits meant his perspective was not always sought or given weight.

Racism in the form of low expectations: The Lammy Review 2017 and research since shows although there are fewer young people offending and going into custody, the BAME proportion has risen. The review acknowledges many causes of and solutions to BAME over-representation in the criminal justice system lie outside the CJS itself, for example, black and mixed ethnic boys are more likely than white boys to be permanently excluded from school. The Youth Justice Service first became involved with Eddie in 2016 when he was aged only 12. In 2017 Eddie (aged 13) received a Referral Order for Possession of Knife, the order was extended for two common assault matters. Before the Referral Order ended, in early 2018 (not yet aged 14), he received a 12 month Youth Rehabilitation Order. It is possible the organisational, structural and environmental domains of explicit and implicit racism and unconscious bias in the wider criminal justice system are influencing decision making and outcomes for BAME youth locally in Merton.

'Helplessness' in responding to emotional distress and trauma for adolescents: It is challenging within current constructs to safeguard children and young people who are expressing their distress in their behaviour and asking for help, especially where there are no current significant concerns around parenting. A Plan to increase safety and reduce risk should be family and community based with the support of professionals, it can be led by CSC or any other TAC/TAF Lead. A safety plan would have underpinned the work with Eddie and his family, setting out the family's input and agreement, and designating people to do what and by when. TAC/TAF or Child in Need (CIN) meetings, with clear and direct overview, analysis of risk and safety, and the use of Signs of Safety/Wellbeing scaling would highlight both family and professionals view of risk and see the progress being made.

2. Recommendations

Racism and low expectations Rec. 1	MSCP to engage partners, in particular Police, Youth Justice and Education, to review the implementation of the Lammy Review recommendations (2017). This review should utilise the tools provided by the Youth Justice Board to consider organisational, structural and environmental domains of explicit and implicit racism and should hear from those who have been subject to the system.

Think Family Rec 2.	Partner agencies to agree what a Think Family way of working means. This needs to be supported by a practical approach and the tools to deliver this.
Constructive Challenge Rec 3.	MSCP to request all partner agencies refresh their escalation procedures with a reminder of professional responsibility to escalate if they consider a child is in need or remains at risk. MSCP should also alert partners that the multi-agency Escalation Policy can be found on the MSCP website.
Contextual Safeguarding/ Harm Rec 4.	Training to be provided for awareness of the social and professional tolerance of cannabis use and associated harms, including use for self-medication to manage trauma and contextual harms. It is recommended this is refreshed for all practitioners.
Rec. 5	Contextual Harm tools and guidance to be linked to updated health guidance and disseminated throughout the MSCP to support a shared understanding of the presenting needs and experiences of harm that compound risk, and of how contexts can increase harm or provide safety and protection.
Rec. 6	The Local Authority to consider whether changes since May 2019 to the adequacy of provision for children excluded from school, including those awaiting education placements on tuition, are sufficient. If not, can the risks to those children be reduced as part of the Children Missing Education process
Trauma Informed Practice Rec. 7	When tendering or specifying the delivery of training requirements MSCP to request all providers to incorporate trauma informed practice, Think Family and ACE's in course materials and delivery.
Rec. 8	Early Help and Neglect sub-group of the MSCP to review the provision of trauma based services for boys experiencing domestic abuse, neglect, poverty and risk of exclusion and present findings to the MSCP Executive to inform service development and delivery.
Rec. 9	Health and Wellbeing Board to be asked to review the commissioning of a targeted trauma informed service in accordance with NICE guidelines, ensuring a flexible and responsive service to children and young people who are demonstrating their trauma in their behaviours.
Self-harm and suicide prevention Rec. 10	All services should make sure staff know about the Stay Alive app. SWLStG have advised the CCG is to commission a community Dialectical Behaviour Therapy Service, in line with NICE guidance, for young people in SW London who struggle with their emotions.
Planning Rec. 11	In conjunction with a 'Think Family' approach MSCP to implement a universal family friendly template for a single plan designed with users of services. This should be able to combine single agency plans and be easily and regularly updated whether the services involved are universal or targeted. The family/young person friendly template should include the practical back up plan that can provide long term support if needed.

Stepping Down or Up and the TAC/TAF Lead Rec. 12	MSCP to agree and disseminate guidance about who can be a TAC/TAF lead (aka Lead Professional), who can convene a Team Around the Child (TAC) or Family (TAF) meeting, and, how and when it should take place.
Child's voice Rec. 13	To support a trusted adult approach in working with young people the MSCP should consider Ambit (Adaptive Mentalisation Based Integrative Treatment) Training. The Youth Justice Team have implemented this and have capacity to deliver and support partners.
Rec. 14	MSCP to use the s11 questionnaire (or similar) process to ask about service threshold and capacity limits and whether this impacts on children's access to services and continuity of support.
Rec. 15	The Children's Trust to be asked to consider an agreed protocol and guidance for workers to continue to deliver services within their remit and with the support of their organisations so young people can maintain relationships with trusted professionals
Multi-Agency Assessment of risk Rec. 16	When there is the potential that children and young people will return home from being in care MSCP partners should contribute to a CSC led multi-agency assessment of risk and need and parallel planning – similar to child protection processes
Rec. 17	MSCP to seek assurances from Met Police on the training and understanding of adolescent risk of self-harm and suicide to support the completion of Merlin's with full information in a short timescale.
Rec. 18	MSCP to ensure partners understand the introduction of Partnership Reviews (Working Together 2018), including the change from Individual Management Reports to Individual Agency Information Reviews, emphasis on learning, use of Terms of Reference and Key Lines of Enquiry.

3. Reason for the Partnership Review

This young person was escalated to the Merton Safeguarding Children Partnership's (MSCP), Quality Assurance Sub-Group on 15th May 2019, following a Critical Incident Notification from the Youth Offending Team. This was then escalated to the Statutory Safeguarding Partners to consider if the incident met the criteria for a Local Child Safeguarding Practice Review under Working Together 2018[1]

At an Extraordinary Meeting of the MSCP in June 2019, it was agreed that the case did not meet the criteria for a Local Safeguarding Child Practice Review and did warrant further investigation through a Partnership Review - Working Together 2018, chapter 4, paragraph 17**.**

[1] Working Together 2018, chapter 4, paragraphs 10-12, pages 83-85

On 7th May 2019, the child took an overdose of 9 Ibuprofen following an argument with a friend on the phone and following negative comments from his father. He had stayed with a friend overnight (details unknown) and gone to his mother's late morning. He told his mother what happened, she called 999 and he was taken to hospital. The child left the hospital the same day following a disagreement over doing a blood test. When he found out the Police were informed of him being missing, he had gone to maternal grandmothers. He returned home once he was advised by his mother she would ask the Police to call off the search. The child agreed to attend an appointment with CAMHS rather than having a MH assessment over the phone which he did not attend.

There have been four incidents of intentional self-harm since 2016.

3.1 Methodology

It was agreed that the methodology for the review would be an adaptation of the Welsh Practice Model. This will include a Collaborative Review event with frontline workers and supervisors who had direct involvement with the child and / or their family. This event will be an opportunity to complete an appreciative inquiry to make sure the information in the draft report is accurate, captures good practice and identifies learning across and within agencies. This methodology provides a significant change in both emphasis and learning and partners had not understood how this would need to be implemented.

3.2 Scope

The time period of this Learning Review is from October 2016 when Eddie first attempted to harm himself to 7th May 2019 when Eddie attempted further self-harm.

4. Family and Background

Content Restricted

5. Analysis and Lessons

While outside the timeframe of this review it is important to note there are two significant missed opportunities for Eddie, aged 9 and 12. Aged 9 Eddie was considered to be his father's favourite in a violent and abusive household and he identified with him as a means of safety. The assault during contact by his father was a significant trauma from which his mother was unable to protect him. It is unrealistic to expect a non-abusive parent, who is self-medicating to manage their own trauma, to be able to emotionally support and protect a child without safety planning that is jointly owned between parent/family and professionals. When aged 12 there is a series of incidents that should have been assessed holistically, this included his father's court appearance for assault, self-harm in a police cell, attacking his brother, assaulting his mother, school exclusion and cannabis use. This was a turning point for Eddie at a time when he was traumatised and services could have intervened to reduce the risk of Eddie becoming without hope of his life being meaningful.

In considering this review period individual agencies have met their statutory duties in general and have continued to support the family over a number of years in the hope of producing long-term

change. The information provided indicates interlinking factors that, in combination, have contributed to form the response to Eddie and his family, particularly when reaching adolescence.

These include:

- Service fatigue – continued similar referrals and concerns where support has not previously achieved change (chronology);
- Preconception based on family history/knowledge - particularly male family members' mental health, offending and substance misuse;
- Racism in the form of low expectations as black and mixed ethnic boys are more likely than white boys to be permanently excluded from school; and,
- 'helplessness' in terms of how to safeguard children and young people who are clearly expressing their distress in their behaviour and asking for help, especially where there are no current significant concerns around parenting.

5.1 Think Family is the recognition that families are complex systems and successful and long lasting change within the family requires working with all members as a whole. It means securing better outcomes for children, young people and families with additional needs by co-ordinating the support they receive and strengthening the ability of family members to provide care and support to each other.

Eddie is an adolescent with complex emotional and behavioural needs identified from age 9. There are strengths in the family in supporting him and there are elements of dysfunction and questions about whether they can maintain this over his childhood. They offer ongoing support and there have been changes in Eddie's behaviour, which may be in response to the family care in place.

Both immediate and wider family members while offering support, had their own emotional and physical needs. There was reference to knowledge about family functioning from a number of agencies with the only direct work being that of Transforming Families. Plans were either focussed on Eddie as an individual or were service based for family members i.e. parenting programmes. There does not appear to have been a network meeting for all relevant people that was effective in creating change, for example, using the Signs of Safety approach to consider how to change the trajectory and how to get there for the family.

There appears to have been a number of revolving doors across agencies, in part due to organisational constraints, which is not congruent with Think Family and the principle of 'no wrong door'. It is difficult to see how the multi-agency knowledge, information, and activity over time have informed planning with Eddie and the family to impact on outcomes. It is noted there is an action in the MSCP Business Plan from 2018 for a Think Family strategy which has not been realised.

5.2 Constructive challenge

Agencies should have constructively challenged each other about commitment and responsibility. A complex case discussion, led by the TAC/TAF Lead or the social worker if open to CSC or formal escalation procedures could have been used if needed. A case discussion could have mapped out the worries with Eddie, family and professionals, and agreed who would do what and the timescales for

each member of the network, including family. This could have encouraged Eddie and his family to participate and make use of the support available.

If, for example, trauma therapy is required, how does the child's network make sure this happens co-operatively and not in a blaming way that contributes to 'remaining stuck' if it is not available? For individual children concerns should be escalated and decisions challenged to improve their outcomes; for service provision and delivery to be changed to meet need overall the information needs to be escalated through agencies and to the MSCP.

5.3 Contextual Safeguarding/Harm

When professionals received similar information or referrals and considered the history for Eddie there may have been a preconception of him and his family that influenced ambitions to achieve positive outcomes and drive forward plans and intervention. For example, while respecting Eddie's need for fewer professionals to be involved, his substance misuse was not addressed. This may have been due to a normalisation and minimisation of cannabis use particularly among young people by practitioners.

Eddie has strong ties to a peer group, friends, and associates and there was a gap in knowledge for some agencies of possible gang affiliation, county lines, and drug use. Eddie's choices have been linked to incidents or events in his peer networks. Safeguarding adolescents whose behaviour forms part of the risk albeit within the context of familial violence proves to be a challenge to the multi-agency partnership. Contextual Safeguarding Services in the Adolescent and Family Service (Merton Council) and across CSC, are being embedded and evidence suggests effectiveness at articulating and refining risk during consultations, in meetings and in reports.

It has been acknowledged police officers are not always sharing information with CSC about a child being stopped and searched which, depending on the circumstances of each incident, could be a potential safeguarding issue. It seems not enough account was taken of concerns raised around Eddie associating with three high-risk individuals, possible drug dealing, carrying a knife, and having 'youngers' he could call on to hurt people, for example. Where this is based on information or 'intelligence' instead of hard evidence, workers need to be supported to explore the concerns and challenge behaviour especially with resistant young people.

There were four missing incidents between August 2016 and December 2018, each reported by Eddie's mother. These were seen as isolated incidents related to his peers and Eddie usually returned home within 24 hours. It would have been important to talk to Eddie about where he had been, explore the contextual risks and consider the return home information, if available, when reviewing the progress of the plan. It is important to note that although there is an independent provider for return home interviews consideration should always be given to the best person to complete this with a young person, preferably a trusted person.

5.4 Trauma informed practice

Adverse Childhood Experiences (ACEs) are significant childhood traumas that can result in actual changes in brain development. These changes may affect a child's learning ability and social skills,

and can result in long-term health problems. The traumas for Eddie include emotional and physical abuse, a parent treated violently, household substance abuse, household mental illness, parental separation and a household member in prison. In addition, Eddie has experienced loss and bereavement in the relationship with his father. It was noted there is a link between poverty, neglect, domestic abuse and trauma and a lack of hope for these families that indicates a need for a preventative approach with early and easy access.

In the Youth Justice Team it is not unusual to see a connection between ACES and young people's behaviour, whether offending, outbursts or self-harm, with the behaviour 'explained away' due to the young person's history and current chaotic environment. However, it is important for workers to continually review incidents and attempt to understand triggers and work with partner agencies to address these. This can be difficult for Youth Justice Practitioners who have a role and not a lead responsibility in safeguarding and who hold a time limited relationship where an order needs to be enforced if young people do not attend.

5.5 Self-harm and suicide prevention

Adolescents can turn to a number of potentially destructive behaviours in an effort to avoid or defuse the intense negative emotions that accompany traumatic stress, including self-harm. In understanding and responding to trauma, how do professional and family networks resist the pressure of a medical/individualised model to understand and assess the distress of young people? There is a need to keep the focus on the question 'What has happened to you?' rather than 'What is wrong with you?'. For Eddie the perception of medical conditions and labelling made it more difficult to manage the worries. This meant it was even more important, when wanting to resolve trauma experienced over years, to find the best agency to provide holistic support. It also may need to be accepted that these services do not currently exist and they need to be delivered in a way young people can use.

Any child or young person, who self-harms must be taken seriously as risky behaviour in response to distress can be serious, even accidentally. The worries for Eddie were that he could take another overdose impulsively when there is conflict with others and he might seriously hurt himself or kill himself. There appears to have been agreement he would need to be able to manage difficult feelings and conflict to a safe degree without hurting himself or anyone else, and, have a clear and safe plan around what he needs to do when things get difficult. There does not appear to have been a coherent plan in place to address this and it is not clear how much awareness non-health professionals have of suicide risk and prevention.

https://www.londoncp.co.uk/chapters/self_harm_suic_behv.html#intro

5.6 Planning

A plan to increase safety and reduce risk should be family and community based with the support of professionals, it can be led by CSC or any other TAC/TAF Lead. A clear safety plan would have underpinned the work with Eddie and his family, setting out the family's input and agreement, and designating people to do what and by when. TAC/TAF or CIN meetings, with clear and direct

overview, analysis of risk and safety, and the use of Signs of Safety/Wellbeing scaling would highlight both family and professionals view of risk and see the progress being made.

Eddie was supported to manage his distress with joint working by Youth Justice, Cressey College and - at times – CAMHS, who had a good understanding of what was working well for him. Eddie was supported by his family and linked to services where he was able to establish some working relationships, which was important to him. This young person presented with a number of needs and experiences of harm that could have resulted in him being exploited into very serious and extensive offending. However, to date, the protective factors within himself, his family and the network of professionals supporting him have managed to halt an escalation into a more complex situation. It will be important for all those working with young people presenting with similar needs to understand the positive impact of quality engagement.

Plans also need to be supported by regular summaries of current and historical factors and concerns. This information need to be considered when new information emerges and in the event there needs to be a more urgent review of risk and action required.

5.7 Stepping Down or Up and the TAC/TAF Lead

At times, there was a reliance on the interpretation of events and discounting of concerns by Eddie's mother and sister without the context of Eddie's views. There was also an over optimism about the ability of family care to meet his needs without a 'Think Family' approach that would have supported family members to address their own needs to increase their caring capacity.

When making a decision to end social care involvement, in the context of repeat referrals and concerns, CSC should have held and chaired a step-down Team Around the Family (TAF) meeting, including the family to find a TAC/TAF Lead who could continue to support Eddie and his family with the agreed plan. If the family were not in agreement with this it should have contributed to the risk assessment of stepping down and, if the decision remained, the rationale communicated to the family and professionals.

When there was no social worker involved and there was consideration of worries increasing for Eddie or re-referring to social care any of the involved agencies could have held a complex case discussion and reviewed the step down plan to consider the level of safety as well as risk. Had such a discussion taken place to share information across agencies it may have reduced the fractured approach to support for Eddie. Assessment and planning tools can be based on individual organisations, funding sources and KPIs. These could contribute to the understanding of risk and need through a TAF transition document supported by each agency's assessment.

If one of the worries were family members or Eddie not working with the plan, it would be important to understand why by asking them if they fully understood the worries, concerns and plan. This would have enabled the Team around the Child, particularly family, to consider if alternative action and input was required, what could be done differently to engage Eddie, reduce the risk of harm, or consider if safeguarding was needed. Strength based work needs to be utilised more in work done with young people who have experienced considerable trauma and/or have high levels of shame and

'hard to reach' young people (high risk, complex, entrenched and not conventionally help-seeking) need to be supported by a team around them who can build trust and understanding.

Any organisation working with Eddie should have informed the other agencies in writing it was ending the service or had decided not to be actively involved to reduce the risk of misunderstanding what the service provision is and what was in place. It is important in the face of non-engagement that all agencies, including CSC should maintain a level of perseverance so that all agencies remain committed to trying everything in the context of high demand on services.

6. Good Practice:

Youth Justice workers use a holistic assessment framework that includes a self-assessment by the young person to capture their views. The workers made efforts to develop a relationship with Eddie and his sister, who was often caring for him during his orders, and significant efforts were made so Eddie attended follow up appointments. The progress of the plan and consideration of risk issues was supported by good liaison with Sutton CAMHS, Education and Cressey College and referrals were made to the MARVE Panel for oversight of contextual factors and risk.

The Self-Assessment was completed by Eddie who was able express his ambitions and acknowledge family, friends, and behaviour issues including trying to hurt himself. The Youth Justice Team appropriately referred to MASH and challenged the closing of referrals, particularly if the YJ Team considered there was an expectation to address parental capacity to safeguard against significant harm.

The SMART centre kept an oversight of Eddie's education when in alternative education placements and tuition. The decision to undertake the Education Health and Care Plan was effective and the assessment well informed. The Education Psychology Report was referenced to the adverse childhood experiences, contextual trauma he had faced, built on 3 previous assessments and included the voice of Eddie, his mother and sister.

Any period of time out of school on one to tuition potentially increases risk. Interim part time education was provided while a placement was sought, taking account of mother's wishes. Although Eddie did not always take part in the tuition, the SMART centre worker kept an oversight and was flexible by moving the tuition to the grandmother's house.

General practice consultations are mostly time limited, however during the majority of the consultations, GP's discussed Eddie's other needs. For example, when attending with exacerbation of asthma, the consultation focussed on all of the needs of Eddie rather than just one symptom.

CAMHS provided an immediate response to crises; were receptive to mother's request for a new consultant; and provided a flexible response to family perceptions, agreeing to trial Concerta at the request of Eddie's mother. The CAMHS consultant asked for a full chronology from social care to inform CAMHS intervention and notified CSC when concerns escalated.

When Eddie was on remand his vulnerability indicated he would struggle to settle with strangers. There was good partnership working between CSC and Youth Justice to find a carer in the family network and not resort to foster care unless absolute necessary. The social work team tried to

understand Eddie's needs and encourage his engagement, including with safety-planning work; working with his mother and sister and all key agencies to deliver appropriate interventions.

Although there is limited opportunity for a 'think family' approach with Eddie police officers were able to engage with him and family members to establish circumstances including medication not being taken and mental health concerns at 3 different times which helped inform the action taken.

7. Missed opportunities

7.1 Eddie's voice

Eddie expressed a clear view he wanted to be in an education placement and it would have been an opportunity to build a trusted working relationship. Eddie's adverse childhood experiences affected his secondary education and the gap between him and his peers grew although he had been assessed as of average ability. It is clear from the Education Psychologist's report that being out of school was seen negatively by Eddie, added to his low sense of success and that low expectations became self-fulfilling. Given the few hours of occupation he had, it is understandable he struggled with his emotions and was vulnerable to criminal exploitation and activity.

The GP practice identified the importance of speaking children and young people on their own where appropriate; they should feel safe to speak and clinicians should explain how the information they disclose may be used. When completing the self-assessment as part of the work with Youth Justice Eddie positively expressed his ambitions however while his plan recognised this there were no steps or actions to support his growth towards those ambitions. Eddie when 9 years old expressed an opinion he was 'not listened too' – this would indicate that for him although we had heard and recorded his words it does not necessarily mean we listened.

Eddie was also clear that he wanted to talk to and work with adults with whom he had a trusted relationship. He said he did not talk to CAMHS workers even when he had the opportunity to do so as he did not trust them. After building relationships with Youth Justice workers this ended as Eddie was no longer on an order, this meant the adults in his life were no longer able to work with him in his version of his world and understand the motivation for his voice and views. While it was understood Eddie may have wanted to talk to someone outside of the family he trusted, it does seem that organisational structures and service limits meant his perspective was not always sought and an opportunity was missed to shift his negative view of himself.

7.2 Multi-Agency Assessment of risk

Assessments and interventions should have fully considered historical factors as part of a comprehensive assessment and were sometimes focused around single events. In CSC the rationale for decision-making does not appear to have included whether the views of immediate family members were accepted or how this was challenged if professionals had alternative views. It is also not clearly evidenced if CSC had considered legal proceedings when they believed the family were not fully able to support Eddie and manage his behaviour, for example, at the point of remand. Additionally, in responding to referrals family members appeared to discount the worries and

concerns on occasions and it would have been important to consider the potential of disguised compliance and resistance.

Eddie was a looked after child for 3 weeks in 2016 due to being remanded with bail conditions. When YOS and Social Care supported a placement with his grandmother instead of foster placement Eddie's mother was asked if he could remain in care so that interventions could happen however his mother did not agree and there was a need for parallel planning at this time. Systems thinking would suggest that moving a young person into local authority care removes the risk and this is not reassessed when they leave care, usually to go home. When Eddie's bail conditions were changed he returned to his mother's care, what was missing at this time is the assessment of risk including the parenting capacity of Eddie's mother and sister, stability of care and safety when he left the grandmothers home and the potential of risk recurring. There was an unmet education need at times for Eddie and there is no evidence of any single or multi-agency challenge.

In September 2016, the multi-agency plan was to progress to ICPC. The CAMHS consultant psychiatrist stated at a CIN meeting, in front of the family, it was not safe for Eddie to return to his mother's care from what was known then about risk, family function and the level of care provided. CAMHS considered Eddie was at risk of significant harm and a child protection plan would have been appropriate although it could not be known how effective it would have been. When the decision was taken by CSC to continue with a CiN Plan it would have been helpful for this to have been as part of a multi-agency meeting with the family and for the decision and rationale to be communicated to all partners. In retrospect CAMHS should have constructively challenged this decision and escalated if needed if the CAMHS view was safeguarding concerns and risk remained.

Youth Justice involvement and plans could have been more holistic about Eddie's wellbeing concerns from the time of his first low level offence aged 12 up to the most recent. There was clearly the motivation to deliver support for Eddie's ambition and the plan could have also addressed his substance misuse and potential exploitation.

ESTH missed opportunities during earlier attendances to make a referral to CSC. At times, professional curiosity, speaking directly to the child and seeking information from CSC would have supported a referral being made.

There were times when Eddie was involved with Police and tried to harm himself, this information did not reach CSC and may have been an opportunity for assessment and intervention, particularly if considered in the context of other events and behaviours at the time e.g. aged 12. While it is the responsibility of Met Detention to make sure the Merlin is complete it would be helpful to understand what role the custody nurse has in recording and sharing information about incidents of self-harm for child detainees.

From national clinical commissioning guidance, there is no direct communication between GP practices in one borough and Social Care in neighbouring boroughs. Consideration needs to be given to how that liaison can take place as there is an increased need for good communication between all the agencies involved.

When CSC are communicating with partner agencies to complete assessments or inform of outcomes, plans and meetings it is essential to confirm which borough or area the child's school or health team is located in. There are a number of Merton children who live near the borders of neighbouring boroughs and a child may not attend a Merton school even if they live in the borough.

8. Organisational safeguarding

The Lammy Review 2017 and research since shows although there are fewer young people offending and going into custody, the BAME proportion has risen. The review acknowledges many causes of and solutions to BAME over-representation in the criminal justice system lie outside the CJS itself. The Youth Justice Service first became involved with Eddie in 2016, this involvement was brief and required no further intervention due to it being low gravity and his first offence – he was aged 12. In 2017 Eddie (aged 13) received a Referral Order for Possession of Knife, the order was extended for two common assault matters. Before the Referral Order ended, in early 2018 (not yet 14), he received a 12 month Youth Rehabilitation Order.

In Youth Justice the first two overdoses should have been recorded as a significant incident and escalated to Head of Service for review. Consideration is needed as to how oversight of young people who are vulnerable and not yet presented to MARVE panel or do not meet threshold for CCE / Serious Youth Violence takes place. Embedding of the Trauma based approach in Youth Justice means Case formulation can be undertaken for high risk and/or high vulnerability young people and at an earlier stage. Strength based work needs to be utilised more in work done with young people who have experienced considerable trauma and/or have high levels of shame.

There is guidance as to when School Nurses should withdraw from involvement in safeguarding and there is an added layer of liaison with a safeguarding specialist nurse or the Named Nurse for Safeguarding Children. This is to ensure that learning for health partners from Serious Case Reviews considers all needs in any analysis before withdrawal from involvement. Decisions not to be involved in the child's network should be communicated to partner agencies

Practice has changed in ESTH since 2016 with an emphasis of obtaining the voice of the child, being curious and clearly documenting all information accurately. The Trust has a visible safeguarding team that ensures processes are embedded. This has been strengthened with the recruitment of a Liaison nurse who coordinates safeguarding processes in the Emergency Department and ensures appropriate referrals are completed in timescale

In relation to Education there are questions as to whether an earlier assessment for an EHCP would have been a protective factor given the level of trauma Eddie had experienced. There is a lack of evidence of therapeutic interventions available to school settings to prevent education breakdown and the seeking of a unique SEND placement meant Eddie was out of tuition for longer than was helpful.

This case highlights the importance of clinicians speaking to the children on their own especially in presenting for behavioural and mental health problems. GP's do need to speak to the children wherever possible on their own to record their wishes, their feelings and importantly, the child's

understanding, explanation and interpretation of events. This vital information will be valuable for further assessments and enable clinicians to signpost in the right directions for further management.

Documentation gaps identified at St Georges have been corrected with effective liaison between teams from St Georges Mental Health Trust and St Georges Hospital Trust. The CAMHS team now record their attendance and brief summary of assessment on the St Georges documentation with the in depth assessment being completed on the Mental Health Trust records.

In the latter part of 2019, Children's Social Care supervision policy was updated and implemented across services to improve management oversight and recording of decision-making that will help assessments to consistently demonstrate the in-depth links and evidence from exposure to domestic abuse or drug abuse and the impact for children. This is supported by more robust quality assurance that includes a strong audit cycle embedding management oversight, providing a level of scrutiny, and sampling cases around decision-making and quality of assessments via the audit process.

Where young people are missing this is now specifically recorded and brought to the attention of the Head of Service in CSC who chairs the weekly Missing meetings and MARVE panel. There is robust oversight and decisions agreed with a multi-agency approach. In addition, a leadership alert process has been implemented for the notification of serious or worrying events, which provides key and important information as and when events happen for leaders and are reflected in records for children.

9. The Parent and Carer's Views

Eddie's mother and sister were spoken to by a known professional and it was arranged to speak to them however this was unsuccessful. A further contact made in writing which was also unsuccessful.

10. The Practitioners' Views

An Appreciative Inquiry Meeting was held with practitioners directly involved with Eddie or representing agencies where practitioners had moved on. This sought to confirm whether the Panel and Review had appropriately identified what worked in and across organisations, to be able to learn from this and identify what may need to change to support the best of what was done. Safeguarding children is about living with high and unpredictable levels of risk and uncertainty. This can result in defensive practice which is driven by fear of making a mistake and an overreliance on 'doing things right' rather than 'doing the right thing.' (Munro, 2012).

Representatives from Education Services, Youth Justice and Epsom and St Helier Hospital (ESTH) took part and considered that, in the main what worked well had been capture through the review.

There were two areas that were clarified for emphasis in the worries about the response to Eddie:

Service fatigue - there was another dimension to this which for some workers was a helplessness created over time by the worry of not getting things right for Eddie's mother. Parents may have difficulty in consistently seeing good intent and be suspicious of the worker's motives or may not agree interventions are purposeful or making a difference. There was a sense of not knowing

whether the worker would be seen as part of the services who were failing Eddie and if there would be a negative reaction. This meant workers were unconsciously braced for this response while still keeping Eddie and his needs in mind.

Think Family – the family plan was for Eddie to be cared for by his older sister when he could not live at home with his mother and they did not want him to go to a foster placement. It would have been helpful to think explicitly about the older sister's capacity to parent, both in the context of Eddie's needs and her own unaddressed trauma, which Eddie had also witnessed. From a practical perspective this could have included consideration of how the sister could be supported to provide stability in sustaining a tenancy and access to education; and from an emotional perspective, how to sustain a parenting role when Eddie's mother was still very present in decision making and family life.

11. Appendices:

Appendix 1 Summary of agency involvement

Restricted Content

Appendix 2 Key Lines of Inquiry - Responses

Restricted Content

Appendix 3. Review Panel

The review is being undertaken on behalf of the safeguarding partnership by Debbie Eaton, Quality Assurance Manager, Audit and Practice Improvement, Children's Social Care and Youth Inclusion.

Panel Membership:

- London Borough of Merton, CSF – MASH & First Response; Safeguarding and Care planning
- London Borough of Merton, CSF – Head of Service, Adolescent Family Service (Youth Justice)
- Merton and Wandsworth CCGs NHS South West London Alliance Kingston, Richmond, Merton, Wandsworth & Sutton CCGs– Designated Nurse Looked After Children
- South West London and St George's Mental Health NHS Trust – Named Nurse for Safeguarding Children
- Central London Community Healthcare NHS Trust (Merton) - Named Nurse Safeguarding Children
- London Borough of Merton, CSF – Head of Service, Education Inclusion
- GP – Bishopsford Surgery – Supported By Sutton CCG
- London Met Police, BCU – Detective Chief Inspector
- Epsom and St Helier Hospitals (ESTH)
- St. Georges University Hospitals NHS Foundation Trust – Named Nurse
- Designated Doctor Merton CCG