Plymouth Safeguarding Children Partnership
Local Child Safeguarding Practice Review

Young Person A

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1.0 Young Person A

1.1 Young Person A is now 17 years old and being supported in the care of the local authority. They are looking forward to a future career in animal care. They have worked hard during the last 18 months to understand how their mental distress impacts upon them and have developed skills that enable them to manage this differently and seek support, where needed. They have a keen interest in understanding their world and have been developing their understanding of the diagnoses they have been given. Overall, Young Person A feels more settled, happy and relaxed and enjoys being be closer to their family members. In their spare time, they enjoy doing things like reading, playing games, baking and sewing.

**This report refers to Young Person A using the pronouns they/them/their.*

2.0 Serious incident leading to this review

2.1 The serious incident involved Young Person A, when they attempted to hang themselves in May 2020; they were 15 years of age at the time. Members of the public intervened and after hospitalisation, Young Person A made a full physical recovery.

2.2 Young Person A was discharged from Intensive Care following assessment and treatment for their physical wellbeing and needs. They were then assessed under the Mental Health Act and met the criteria for a section 2 voluntary in-patient admission for treatment. They then moved to the Plymbridge Unit and were supported by CAMHS and their father. Following a two-week initial voluntary admission to a psychiatric unit, Young Person A, supported by their father, withdrew consent and initially returned home supported by a safety plan that included support from several agencies.

3.0 The Rapid Review & Key Lines of Enquiry

3.1 In accordance with statutory guidance in Working Together to Safeguard Children 2018, a Rapid Review was convened on 15 June 2020 and the local authority, with partners, secured the following:

- An immediate and comprehensive multi-agency safety plan was put in place for Young Person A and their brother.
- Agreed together that there was potential for improving or further improving local arrangements for co-ordination of safeguarding and promoting children's welfare.

3.2 The rapid review examined the period January 2013 to May 2020 and identified the following Key Lines of Enquiry for the CSPR to consider:

- How well was Young Person A's voice heard and their lived experience taken into account by agencies?
- How did agencies recognise and respond to Young Person A's 'Adverse Childhood Experiences' (ACEs)?
- How effective were agencies' assessments, risk management and decision making?
- What was the significance and support of 'trusted relationships'?
- Was information sharing and communication between agencies effective?

- What was the impact, if any, of Covid-19 upon agency responses and support to Young Person A?

3.3 A decision was taken on 24 June 2020, by the Strategic Chair of the Plymouth Safeguarding Children Partnership that a Local CSPR should be undertaken and this was recommended to National Panel. There was a delay in identifying a suitable individual to undertake this review and then further delay in bringing this report to completion.

3.4 An independent lead reviewer, Fergus Smith, was commissioned and worked alongside the Clinical Commissioning Group (CCG)'s Designated Nurse for Safeguarding Children. Partners, independent of the practice at the time, within the CSPR Subgroup have then worked together to finalise this report and recommendations.

3.5 A review rooted in 'appreciative inquiry' and 'trauma-informed thinking' was intended to identify improvements in the local planning and delivery of services for safeguarding and promoting the welfare of children.

4.0 Process & contributing agencies

4.1 The review has sought information from the following agencies:

- Livewell Southwest, including Child and Adolescent Mental Health Service (CAMHS)
- Involved GP Practices
- Plymouth Children's Social Care
- Schools and complementary education that was attended
- Plymouth City Council's Targeted Support Services
- Plymouth's Inclusion & Attendance Service & Special Education Needs & Disability (SEND) Service
- Devon & Cornwall Police
- University Hospitals Plymouth NHS Trust
- Plymouth City Council's Youth Work Service

4.2 Consultation events were convened for practitioners and managers. These were virtual due to the ongoing Covid-19 restrictions in place, at that time. Participants were invited to reflect in advance and to identify what had worked well and to consider research, policies or procedures that had influenced their responses, as well as their ideas for improvements. Contributions were subsequently explored at the relevant events and reflected in this report, a brief summary of which, was shared and discussed at a 'feedback event' in early June 2021.

5.0 Family engagement with the review

5.1 Young Person A and their parents were invited to contribute to the CSPR. A virtual interview with their father was conducted jointly by the reviewers and the views of Young Person A's mother sought via her carers (given her ill-health). On advice from the current residential care providers and independent reviewing officer (IRO), Young Person A's views were obtained via their allocated social worker during the learning review.

5.2 Young Person A then met with their IRO in December 2021 and went through the draft report. They shared their views and these are reflected in this final report. Young Person A said that they appreciated the time that was taken to go through the report with them and they felt comfortable talking with their IRO. The IRO explained to Young Person A the process for the report to be agreed, shared with National Panel and then published on the

partnership website, with no plan to draw the media's attention but ensure the learning from their circumstances was available to practitioners.

5.3 The final report will be shared with Young Person A and their parents prior to publication.

6.0 Background history and professional involvement

6.1 Throughout Young Person A's early childhood, there had been concerns about the degree of inconsistent care they had received. Initially, this was the result of their mother's substance and alcohol use. This contributed to ongoing neglect of their basic needs at that time. During 2006, Children's Social Care undertook assessments in respect of these concerns and this resulted in a period of child protection planning. During this phase of Children's Social Care involvement, Young Person A went to live with their father who had separated from their mother in 2007.

6.2 Just prior to this, in 2006, Young Person A's mother was diagnosed with a life-limiting condition (Huntington's Disease) and she now requires supported accommodation, in light of the reality that this condition will not improve. This is of great significance to Young Person A for a number of reasons including the possible likelihood of them inheriting this condition. Young Person A has had access to this testing but has chosen not to pursue this yet. Health colleagues have advised that they would usually not recommend this testing prior to a young person reaching 18 years old, however there are exceptions and Young Person A could elect to have this sooner if they wished to pursue this.

6.3 Young Person A engaged with CAMHS in 2012, following a referral from school as a result of a self-harm incident. At this time, a number of support offers were made including art therapy and family support. These were not consistently accepted by Young Person A's father. When the family did engage, this support did have some positive impact.

6.4 Following a further referral to Children's Social Care in 2012, an assessment was undertaken. This clearly focused on the immediate issues of concern but did not take full account of Young Person A's lived experience. In addition, the assessment did not sufficiently build on what was known about the family history or take into account the cumulative impact of events and experiences on Young Person A and their family.

6.5 Health professionals from the acute hospital trust, primary health care, education, Children's Social Care and the police were consistently responding to crisis events, when they occurred. Young Person A required treatment and support following eight episodes of self-harm from 2012 to 2020, each episode escalating in terms of impact on them and treatments required.

6.6 In January 2013, CAMHS records indicate a concern about father's (unspecified) use of physical restraint and chastisement and in August 2013, Young Person A (aged 9) was seriously sexually assaulted by a family friend who was later jailed for this offence. A referral was made to '12's Company' (now called 'FirstLight') – a source of support and advocacy for victims of sexual abuse. A substantial number of art therapy sessions were provided. Records refer to a sense of Young Person A's residual guilt because by reporting the man who had assaulted them, they had disrupted their father's friendship with him. This service was the first to explore Young Person A's 'inner world'.

6.7 In 2018, the family accepted the involvement of a youth worker to work directly with Young Person A and this relationship did make a really purposeful impact for Young Person A. During their work together, self-harm episodes ceased for a significant period of time.

6.8 Family therapy was provided in 2018 as Young Person A's self-harm behaviours escalated. In addition, family mediation was also provided from 2019.

6.9 The single assessment undertaken by Children's Social Care in 2018, reflected Young Person A's feelings about being neglected by their father and that he had used physical chastisement; they described him as intimidating. This was refuted by Young Person A's father. It is possible that exploring this more robustly at the time could have led to statutory intervention by Children's Social Care.

6.10 Between 2018 and 2020, Young Person A's self-harm attempts and behaviours escalated in frequency and severity and were increasingly difficult for their family to manage. In 2018 they were found on a bridge and taken home by the police. In 2019 they overdosed with medication and were hospitalised and then discharged home. In 2020, they overdosed again with medication, which resulted in further hospitalisation. On this occasion, Young Person A's father discharged them from hospital. Agencies provided no challenge of the father's decision making and no consideration appears to have been given about the impact of the home environment on Young Person A's emotional well-being.

6.11 By early February 2019, tensions in the family home seem to have risen to the point which resulted in Young Person A staying away from the family home, with a neighbour and the prospect of returning home triggered thoughts of running away.

6.12 During early 2019, Young Person A's attendance at school had reduced and there was discussion about a possible transfer to an alternative school. Later, at an education meeting in September 2019, attendance had improved to 80%.

6.13 In February 2019, Young Person A, with their father's support, shared with education colleagues that they wished to be referred to by the male pronoun and shared a chosen name for everyone to use in addressing them. When Young Person A's gender identity was discussed with CAMHS in 2019, a referral was made to a 'Gender Identity Clinic'. Services were identified but it was not apparent how the Gender Identity Clinic referral and work would influence the support already in place. There is an apparent willingness to support Young Person A with this work but it is not clear how all agencies planned to ensure there would be a consistent approach from them all. A multi-agency approach could have supported the family and agencies to think about the necessary priorities and services that could support but not overwhelm the family at that time.

6.14 At this time, Young Person A was supported by their allocated youth worker to attend the 'Out Youth Group'. This group supports and connects LGBTQ+ young people with other young people who identify as LGBTQ+.

6.15 Family Mediation was arranged to support the relationship between Young Person A and their father. They both attended 3 months of mediation (a restorative facilitative process) from April 2019. This was apparently a helpful experience but was terminated at their father's request in July 2019. It is not clear if Young Person A agreed with this decision at that time.

6.16 There is evidence of Young Person A's father seeking professional support at times. He reported a deterioration when Young Person A's youth worker was no longer involved and subsequently contacted the Plymouth Gateway (the local 'Front Door' for accessing Early Help or Children's Social Care). In mid-November 2019, Young Person A cut themselves,

reportedly triggered by frustration about computer-based school work. The school alerted father, who in turn contacted CAMHS.

6.17 At other times, there was inconsistent engagement. For instance, CAMHS continued to be in regular contact with Young Person A's father and sent an appointment for a review with CAMHS for the 7th of February 2020, but that appointment was not attended. Young Person A's father said that he did not receive this appointment.

6.18 At this time, Young Person A's father said that he felt increasingly worried about Young Person A and that they were threatening to break into the medication box. There were ongoing discussions about possible options of support available at this time. The CAMHS worker discussed with the CAMHS team possible support from Neuro Crisis and Integrative Therapeutic Assessment & Support Clinic (I-TASC), which the family did not attend. I-TASC is a separate service from the Exeter 'Gender Identity Clinic' which is run by another provider and an outreach clinic for the Maudsley in London. CAMHS do not have specialists in gender reassignment; they provide local mental health support for those young people going through gender transition working closely with their specialist colleagues.

6.19 On the 15th February 2020, Young Person A attended the hospital stating they were feeling 'suicidal' and were transferred to Paediatrics. Young Person A said they had locked themselves in the bathroom with the intention of finding razors but had failed this time. They had burned their forearm which they said they 'did not regret' and were prepared to self-harm again, though had no active thoughts of suicide. Young Person A was noted to be under CAMHS and gender identity disorder was discussed. On the same day, CAMHS assessed Young Person A within 24hrs of presenting at hospital. This is standard practice for all admissions to hospital where self-harm is a concern. The CAMHS report discusses self-harm but the CAMHS assessment also refers to suicidal thoughts with no active self-harm. Young Person A was taken to hospital to keep them safe, as their father was unwell at this time too.

6.20 On the 25th February 2020 Young Person A's father took them to the Emergency Department again saying he was not managing Young Person A's behaviour. They had become increasingly distressed and locked themselves in the bathroom. Young Person A's father had ensured there were no sharp objects in the bathroom to prevent the likelihood of self-harm taking place.

6.21 An 'Intercom Trust' referral for the 'Gender Dysphoria Clinic' was completed. At the time, there was a 2 month waiting list. Young Person A was seen on the 27th February 2020 at home by CAMHS and the Outreach Team as a follow up appointment to the hospital attendance.

6.22 CAMHS undertook a school observation of Young Person A on 11th March 2020 and a home visit on the same day was completed by the CAMHS Outreach Team.

6.23 On the 18th March 2020 CAMHS provided telephone support for the family whilst the services were adjusting and implementing revised processes for Covid-19 working.

6.24 On the 6th April 2020 there was a conference call between CAMHS, Young Person A and their father with a newly allocated worker from CAMHS. They both engaged and Young Person A's care plan and safety plan was reviewed. Young Person A and their father reported that no self-harm had occurred in the past two months.

6.25 On the 14th April 2020, Young Person A's father rang the CAMHS telephone line and reported that Young Person A was stable in mood apart from one day since the last conversation and no self-harm. Young Person A was asleep on this occasion and their father did not want to wake them.

6.26 During a video therapy session held on the 23rd April 2020, Young Person A said they felt the impact of the Covid-19 restrictions in the session saying they felt the lack of social contact. A very in-depth session was undertaken and agreement secured from Young Person A to meet again and undertake further therapy. The risk assessment and care plan were reviewed.

6.27 Video therapy was undertaken between the CAMHS worker and Young Person A on the 30th April 2020. Young Person A remained engaged and stable and was collaborating on next therapeutic steps, this continued into May 2020.

6.28 On the 25th May 2020, when Young Person A had gone missing from home their father reported that they had been experiencing a low mood for a few days and had cut their wrist at the weekend but not needed medical treatment. He reported being unable to contact CAMHS Outreach. Young Person A's mood varied but they had become distressed screaming and shouting that they just wanted to die.

6.29 CAMHS clinicians report that they were assessing risk within every contact and had there been any worrying signs of lack of engagement or an increase in risk reported by the parent or young person, further assessment and a face to face appointment would have been offered.

6.30 Young Person A's father had spoken to CAMHS throughout May 2020 and was present and contributing whilst Young Person A was having appointments during this time. A 24 hour CAMHS crisis line had been implemented at the request of NHS England as a response to the impact of Covid-19 and the number provided to them. CAMHS report that this was answered 24 hours a day.

7.0 Contextual information and summary

7.1 Young Person A experienced several incidents of neglect, trauma and abuse during their childhood. Over time, these experiences have contributed significantly to their capacity/resilience to understand and cope with their evolving mental health challenges and gender dysphoria diagnosis.

7.2 The lack of consistency in Young Person A's care during their formative years would have impacted on their sense of self and emotional wellbeing.

7.3 Young Person A's maternal uncle died in late February 2019 as a result of the same condition as Young Person A's mother. His death was very upsetting for Young Person A.

7.4 Young Person A's relationship with their mother whilst in her care was challenging and their mothers use of substances and alcohol would have meant Young Person A's need for consistent care, emotional support and basic needs were not met consistently during their formative development stages.

7.5 The genetic condition of Young Person A's mother has meant she is currently managing in an adult supported care arrangement. This is likely to have a significant impact of Young

Person A's sense of self and their future plans. Young Person A has chosen not to be tested for this condition to date, but will be supported when they want to progress this as they move into adulthood.

7.6 The incident of being sexually abused in 2013, at aged 9, would have also significantly impacted upon Young Person A's emotional well-being.

7.7 Records of self-harm episodes provided by Young Person A's education setting refers to Young Person A's report of three precipitating factors: bullying at school, the probability of inheriting their mother's medical condition and frustration at being unable to recall things. Young Person A repeated these challenges on more than one occasion as their self-harm and challenging behaviours began to escalate.

7.8 The cumulative effect of unresolved and painful experiences that Young Person A was subjected to through their formative childhood years and subsequent developmental stages would all have contributed to their escalating behaviours and self-harm. Often this is the only way young people can express and manage the pain and trauma that sits within them every day.

8.0 The views of Young Person A

8.1 As outlined earlier in this report, Young Person A met with their allocated IRO and discussed the Child Safeguarding Practice Review process and offered them the opportunity to reflect on events. Young Person A understands the review taking place and the views they shared are summarised here. These reflections are triggered by events set out in the draft report seen by them. In general, Young Person A felt the proposed report was well put together and well written, highlighting what was not done in the right way and what was done in the wrong way.

8.2 Young Person A described their experience of interactions with the police negatively, using words such as 'scary' and' intimidating'. Young Person A stated they felt that they were treated like a criminal at times, and not a person in need of support. They feel that the police lack mental health understanding. Young Person A accepted that there were times when their behaviour posed a risk to their father, themselves, their home and other people; therefore accepted that actions were taken by police to protect themselves and others.

8.3 Young Person A felt that they received some professional support when they were harming themselves, but when they spoke of harming others no support was given and they could read in the body language of practitioners, that they were disgusted with Young Person A and didn't trust Young Person A.

8.4 Young Person A has stated that they felt listened to by their father and teachers but not by CAMHS or any of the services that were meant to listen. Young Person A reflected themselves that this may not have been the case at the time, they may have listened or may not have done, but this is how this felt to them. Young Person A gave an example. They picked up on a reference made at hospital that they (Young Person A) appeared 'dissociated'. On reflection, Young Person A said that it is interesting how statements like this were said about them, but then nothing happened to ask them of their opinion about that statement. Young Person A said that they can 'laugh about it now as I'm better in myself but I didn't feel like that then'.

8.5 Young Person A shared their awareness that their father had a dislike for Children's Social Care and CAMHS and the possible impact of this in getting consistent help. They said that they were not aware that their father had declined a number of assessments/support.

8.6 Young Person A advised that their father has admitted hitting them a number of times when younger. They reflected that they feel their father didn't really get the support to understand how to care/support them in the best way and feels this is something their dad still needs, although noted that dad would likely turn this down as he doesn't feel he needs the support. This is important learning to reflect on for the agencies involved as Young Person A clearly articulates, from their perspective, what could have been more helpful for them and their father at times of crisis**.**

8.7 Young Person A has noted 'it is just sad that there has to be a big event for people to recognise something is wrong'.

8.8 Young Person A wished to share a summary of how they view support services. They described feeling like they were in a big forest full of lots of trees, that they couldn't see which way to go and professionals should have been there to guide them out of this, help them to find the path again so they could lead themselves out. They said that sometimes professionals appeared when they really needed them at a point of crisis, when they didn't know which way to go. Young Person A lost sight of them because professionals were then not there to help anymore and they remained lost.

8.9 Young Person A feels it is the role of those professionals, those who have more understanding to help them get through the forest and find that path again, and this is what they felt they did not have for a long time.

9.0 The view of Young Person A's father

9.1 Young Person A's father was clearly endeavouring to look after Young Person A and tried to respond to their escalating self-harm and behaviours. It is not clear how agencies have worked together to support him to understand the cumulative impact of challenges that Young Person A was experiencing and expressing through their behaviours and self-harm.

9.2 He has said he did not feel well supported by CAMHS on some occasions and recalled the frustration and anxiety he felt sometimes, associated with delays and his perception of ongoing confusion in CAMHS responses.

9.3 Young Person A's father speaks positively about the art therapy offered, family mediation service and the period when a youth worker was allocated to Young Person A. Particularly as during this period self-harm episodes ceased.

9.4 Young Person A's father says he has a dislike of Children's Social Care intervention at any time or level. It is likely this negative view of Children's Social Care has prompted him to decline ongoing assessments on more than one occasion.

9.5 The possibility of assessments resulting in a diagnosis of 'ADHD' was, according to father, to have been further evaluated and this has remained unresolved in all agencies records.

10.0 Analysis

10.1 Prior to the serious incident that triggered this review, Young Person A was exposed to a significant number of adverse childhood experiences (ACEs). This included physical abuse, emotional abuse and neglect. They experienced the impact of parental mental and physical ill-health, the impact of their mother's substance and alcohol use, parental domestic abuse, parental separation, separation from sibling, sexual abuse and a developing and latterly chronic and constant anxiety about a possible future diagnosis of the condition their mother is experiencing (and from which a maternal uncle has died). All of this has contributed to this young person struggling with their emotional well-being and experiencing a number of challenges in the community and at home.

10.2 These experiences and exposure to them at different stages in their developmental journey through childhood to the present day would have impacted upon their resilience and sense of self and self-worth, as demonstrated through mental health and self-harming episodes outlined above.

10.3 Whilst several approaches such as art therapy, youth work, family mediation and un-specified forms of psychotherapy from CAMHS were provided, efforts were fragmented and most agencies knew only a proportion of Young Person A's experiences, particularly at times of significant crisis.

10.4 Young Person A's 'story' did not travel with them and Young Person A reports that only their father made the time and truly listened. Of an estimated 100 contacts with involved agencies, most were entirely or primarily influenced by Young Person A's father. Young Person A's mother has reported that their own (limited) re-involvement in Young Person A's life began only when Children's Social Care became involved in 2020.

10.5 Children's Social Care assessments should have been underpinned more robustly by the history of the family and events, to secure an evidence based view of Young Person A's lived experience including risks and needs that all required a response at different levels.

10.6 There was a single assessment undertaken between 26/05/2020 and 06/07/2020. This was undertaken to consider the impact of Young Person A's early life experiences upon her emotional wellbeing and to consider a safety and support plan following the serious incident where they had been found hanging by a tree. In discussion with the social worker, they acknowledged the previous assessments were brief and did not give due consideration to Young Person A's complex and lengthy history. In addition, previous assessments focussed on single incidents that had triggered the referral and were more parent focussed than child focussed.

10.7 The assessment outlines that little consideration is given to the impact of historical adversity on Young Person A, their emotional or behavioural development, and on the personal relationships between Young Person A and their father in particular. Children's Social Care assessments did not consider the cumulative effects of Young Person A's experiences of loss and trauma. They were too brief and limited and did not offer analysis or challenge of the reasons why their behaviour was manifesting in the way it was. In addition, there was little challenge or support to their father to overcome this and professionals were too ready to accept his view to not access support from Children's Social Care.

10.8 There was a strong focus on Young Person A's mental health and escalating self-harm episodes and behaviours. However, this focus led to agencies not prioritising some emerging safeguarding concerns.

10.9 Young Person A has expressed concerns about their relationship with their father on more than one occasion and has clearly stated they required help. They have not felt that services took account of this broadly enough, to actually help their father be able to respond to their presentation as effectively as possible. He has worked hard to help Young Person A be safe but we have to reflect back on what agencies provided and if understanding history, trauma and impact of ACEs could have enabled their father to access services and support that potentially would have made a greater difference to lived experience of Young Person A.

10.10 Of note, is the absence of Young Person A's younger and older siblings as the situation escalated, their voices are not heard in the records of agencies and the incidents would clearly have had an impact on them and Young Person A.

10.11 Extended family are also absent in the assessments and support packages, apart from more recently paternal grandfather, to whom Young Person A feels very close. There were opportunities to provide Young Person A and their father respite or time out to enable them space from each other, to work through some of the challenges in the household independently. This was never considered formally or integrated in any of the safety planning or interventions.

10.12 In addition there is a lack of attention, by all agencies, to the impact of Young Person A's relationship with their mother and what impact this potentially was having on their development and sense of self.

10.13 There were missed opportunities for multi-agency working to robustly assess, support and intervene collaboratively throughout the period particularly 2012 to 2020, where predominately single agency approaches were undertaken. These required a higher level of challenge to ensure issues of potential risk and harm were being assessed in context alongside the presenting behaviours and self-harm episodes.

10.14 Engaging Young Person A's father proved challenging and as a result the work only resulted in child in need recommendations by Children's Social Care, which facilitated Young Person A's father in his decision to not continue with Children's Social Care support and intervention.

10.15 Education colleagues and services, whilst supportive of the family and Young Person A, could not evidence completion of Young Person A's Education Health and Care Plan. There is no evidence of consideration of "missing school" due to physical or mental health guidelines being applied or considering if a more specialist resource was required to enable Young Person A to feel safer and better engaged in their education.

11.0 Response to the Rapid Review Key Lines of Enquiry

11.1 How well was Young Person A's voice and lived experience taken into account by involved agencies?

11.1.1 Records and reflection have identified some positive examples of Young Person A's 'voice' being heard and responded to:

- Ongoing and sensitive internal arrangements within their education setting, following a transfer there in Summer 2018, reflected their voice well in records.

- Young Person A had asked for the youth work to continue as it was helping them, this extension was agreed beyond the standard 12 week commitment that was in place, at the time.

- The successful negotiation by the hospital during the admission of May 2020, of prolonging their stay pending a pre-discharge assessment by the CAMHS consultant.

11.1.2 Those positive examples are out-numbered by other examples where Young Person A's father expressed views and/or conduct were accepted with little apparent challenge which could be seen as resulting effectively in the marginalisation of Young Person A's on these occasions:

- Young Person A's father, in 2013, declining the offer of 'family therapy' at the same time that Young Person A was reporting a continuation of physical punishment (his record of alleged domestic abuse of his ex-partner appears to have been overlooked or diminished); later withdrawal from mediation offers a further example.

- Young Person A's father's decline of a formal assessment during 2017 and ongoing decline to access child in need services or early help services, when offered. He reported his dislike of Children's Social Care.

- Young Person A's reports in summer 2018 of their father's aggression were not directly addressed (with agencies' attention seemingly diverted by the recently offered diagnoses of anxiety and depression, autistic spectrum condition and an attachment disorder). There was no professional challenge or evident curiosity about what impact this report might have on Young Person A.

- The insufficiency of agency capacity to further extend the valued relationship with the youth worker in summer 2019. Young Person A valued this relationship and incidents of self-harm were not reported during that time.

- Young Person A's voice was difficult to see, hear and feel through the agency records as decisions being made about their safety and well-being were continuously deferred to their father. This continued even on the occasions when Young Person A clearly reported that they felt angry with him,.

11.1.3 Young Person A's lived experience was not at the fore front of agency assessments and interventions, as noted above. Individual agencies were enabling access to services and support on an individual basis and, even when working together, their approaches are evidenced as singular in issue, with a lack of evidence that history, trauma and Young Person A's views were influencing factors regarding the decisions being made.

11.1.4 It is important to note in this context that Young Person A has reflected that at times, when younger, they didn't feel able to share their views so their father did this on their behalf and the response was that it needed to come from Young Person A and not their father.

11.1.5 Young Person A stated that "it shouldn't matter who it comes from", if they aren't comfortable sharing that, it should be accepted from their father. When this hasn't happened Young Person A has also felt invalidated and not listened too. Young Person A hopes that this report will change things for other people like themselves so this does not happen again.

11.2 How well did agencies recognise and respond to Young Person A's Adverse Childhood Experiences?

11.2.1 An important discovery that emerged from the practitioners' event was how partial each agency's knowledge and appreciation of Young Person A's experiences and needs were. Most of the involved agencies were dependent upon what Young Person A and/or their father felt able to say (and that attendance / engagement with them was always deemed to be voluntary), it was and remains of critical importance that all available information is contained within any referral form / subsequent assessment and that 'professional curiosity' is maintained.

11.2.2 Striving to understand a young person's lived experience and the impact it has had/is having on them, means we should "get in their shoes" and actively listen to what they are trying to communicate through language, behaviours, emotional, physical and mental health presentation.

11.2.3 Despite the many agencies offering support and intervention, at different times for Young Person A, it is apparent that they could have more robustly shared information with each other, particularly at times of crisis. This could have secured an earlier, more robust evidence based decision together, that could have addressed Young Person A's presenting needs more effectively. This should have included education, youth worker, specialist clinics, police, health, CAMHS and Children's Social Care.

11.3 How effective were agencies' assessments, risk management & decision-making?

11.3.1 In the view of the Educational Psychology Service, acknowledged difficulties within Young Person A's education setting, rendered it difficult to generate sufficiently clear detailed information for the use by the SEND 0-25 and s.19 teams. The s.19 process was also reported to have been frustrated by lack of timely CAMHS responses.

11.3.2 The lack of timely and reliable responses by CAMHS remains Young Person A's father's most significant criticism and it remains uncertain on what basis (a later rejected) diagnosis of ASD was formulated.

11.3.3 There is a clear diagnosis noted in the contextual information but as stated sharing information across all the agencies was less than satisfactory.

11.3.4 CAMHS have evidenced a robust approach to supporting Young Person A and it is acknowledged that Children's Social Care input remained at offers of child in need or early help, as Young Person A's father was not consenting to their involvement.

11.3.5 The education impact and outcomes remain challenging to evidence given the EHCP remained incomplete.

11.3.6 Children's Social Care assessments would have benefited from being explicit in terms of the neglect Young Person A felt they were experiencing from their father, they should have considered what this looked and felt like for them and what they felt needed to change in their lives.

11.3.7 It is clear that if workers in all agencies had considered and detailed a chronology and experiences of Young Person A, they would have enabled themselves to have a greater

understanding of their father's reluctance to engage with Children's Social Care. This should have supported agencies to be more persistent in terms of advocating the need for a co-ordinated multi-agency plan or even consideration of child protection planning as concerns regarding parenting started to emerge.

11.3.8 Police colleagues were supporting Young Person A through a number of traumatic events and whilst securing Young Person A in safe places together with their father, hospital or family friends, it would be helpful to understand how they de-brief from these challenging circumstances and share reflections and learning with other agencies that might be offering or able to offer support to the family.

11.3.9 Police appropriately submitted their concerns on a ViST Vulnerability identification Screening Tool), however when no further action was decided by Children's Social Care, partner agencies seemed to accept this was the position and there is a lack of evidence of this being challenged by any organisation.

11.3.10 Education colleagues were supportive of the family and Young Person A, however their intervention and assessments appear to be incomplete and take too long. Resulting in Young Person A's being missing from education for prolonged periods with no plan identified or shared for supporting their access to education.

11.3.11 An incomplete EHCP remains unresolved and therefore education opportunities that may have assisted Young Person A in managing more effectively the escalation of their behaviours and self-harm episodes were not identified.

11.3.12 CAMHS intervention support and assessment was comprehensive, in the main timely and several periods of therapy and access to additional resources were extended.

11.3.13 On reflection, engaging more colleagues from partner agencies, at an earlier time of Young Person A presenting self-harm and unregulated behaviours, could have resulted in a de-escalation sooner for them. Had all agencies involved robustly challenged the parenting and considered the impact of cumulative life experiences, there was potential to collaborate and work together from a stronger evidence based position to address Young Person A's needs.

11.3.14 In isolation, each agency dealt with the presenting issue, which meant their responses were singular and not collaborative, so not providing a safety net across them and the community. As Young Person A's presentation became increasingly challenging for all involved including Young Person A and their family, agencies did not understand their lived experience fully enough to be able to address the underlying causes of their distress being displayed in different ways.

11.3.15 A multi-agency approach was needed much earlier for Young Person A and their family to offer Young Person A and their family a clear understanding of what their needs were and how best they could be met, potentially utilising the wider family support network.

11.3.16 Young Person A's brother was also exposed to the challenges and it remains unclear what impact it had on him and his relationship with Young Person A.

11.4 What was the significance & support of 'trusted relationships'?

11.4.1 It is true that during the period of engagement with their allocated youth worker, Young Person A initiated no self-harm or suicide attempts. Not since the provision of ongoing art

therapy by 'FirstLight' years earlier, had Young Person A benefitted from such a prolonged relationship with an individual professional.

11.4.2 The description of the arrangements and flexibilities at the education provision suggests that they also gained a good deal from the sensitivity, insight and commitment that is apparent in its account of service provision (a perception reinforced by Young Person A's father's contemporary comments).

11.4.3 Agencies did not demonstrate an appreciation of this factor during their interventions and made some assumptions about who Young Person A's trusted people were.

11.4.4 Young Person A has a close relationship with their grandfather but this review could find no records of attempts to bring extended family together to consider safety plans and interventions from them that could have supported Young Person A to feel safer themselves. Young Person A had stayed with him when younger so already had identified him as one of their trusted persons.

11.4.5 The evidence reflected that for Young Person A the positive impact of a key and trusted worker who can remain a point of consistency when other areas of life are uncertain was important in helping them manage their emotional well being

11.4.6 The value of a trusted and consistently available person (in this case exemplified by the allocated youth worker and the team of staff and its sensitive deployment within Young Person A's education provision) demonstrated good practice and the benefit of relationship building being a key support for Young Person A.

11.4.7 The inconsistent approach across the agencies did not facilitate the ability for a core group of workers to be able to build these trusted relationships alongside Young Person A or fully utilise the trusted relationship in place, to effect change.

11.5 Was information sharing & communication effective between agencies?

11.5.1 There are examples where agencies had opportunities to meet together and share their expertise about the family and compliment this understanding by working through their specialist lens and enabling a holistic picture to be secured.

11.5.2 There were missed opportunities on more than one occasion when the lead agency at the time of crisis presentation did not always seek support, advice or guidance from their safeguarding partners. There was a lack of timely referrals into services that could have supported Young Person A and their family.

11.5.3 There was a lack of appropriate referring into Children's Social Care during some crisis episodes and it reflected a lack of confidence perhaps in the response that might be received in terms of recognising and responding to safeguarding matters for Young Person A and their sibling.

11.5.4 In addition, when Young Person A was subject to Children's Social Care assessment, there was a lack of engagement of all relevant partners and their father's refusal to engage in working with Children's Social Care was not challenged effectively, often resulting in Children's Social Care stepping away, as he requested.

11.5.5 This resulted in other agencies considering a new referral to Children's Social Care as something Young Person A's father would not respond well to or accept.

11.5.6 This resulted in a lack of attention to the chronology of events known about Young Person A's family and home life. Negating the likelihood of analysis and understanding about the impact of inconsistent parenting and its impact on Young Person A's presentation.

11.5.7 The focus on Young Person A's mental health and self-harm episodes resulted in responses and interventions being single-issue outcomes.

11.5.8 It is likely that a multi-agency safeguarding plan, could have managed and offered a breadth of services and interventions including sensitive challenge and support for Young Person A's father and mother in understanding the potential impact of their well-being and parenting approaches in influencing Young Person A's sense of self and emotional well-being.

11.5.9 Sharing information within health provisions was also not consistent, reducing the likelihood of a consistent response to Young Person A's escalating emotional challenges.

11.5.10 Young Person A's 'pupil passport' was not supplied ahead of their transfer resulting in their education provision not having timely access to significant information. As a result, their planning for education and social support would not have been as well informed as you would expect, particularly for a young person with such challenges in their formative years.

11.6 What is the impact, if any, of Covid-19 upon agencies' responses and support to Young Person A?

11.6.1 Complying with regulatory restrictions and recommended professional approaches inevitably impacted upon agencies' ability to support Young Person A. It seems probable that for many individuals denied the opportunity to socialise at school or work, the psychological pressures may have increased throughout 2020. The restrictions will also have meant further complexity of task and more anxiety to those professionals operating from home or in circumstances that were more isolated.

11.6.2 All services that Young Person A was accessing had individual risk management and assessment plans to respond to young people and family's needs particularly during lockdowns and always maintained a high level of contact with them and their family.

11.6.3 Covid- 19 restrictions resulted in Young Person A no longer being able to attend their education provision. During April 2020, a CAMHS I-TASC (therapeutic) clinician twice contacted Young Person A and their father via video calls. Young Person A was 'unavailable' for two further calls, thus diminishing the potential for early indicators of self-harming thoughts / intent to be detected.

11.6.4 Without direct contact with the individual, it remains impossible to conclude how 'Young Person A' experienced the Covid-19 constraints. Young Person A has subsequently shared they found the lack of social contact difficult.

11.6.5 Reflective feedback from participating agencies indicates that with the loss of individual or group work face-to-face, some developed or refined their use of text, WhatsApp, Zoom calls with/without cameras, as well as 'doorstep' exchanges. It is thought that this increasing diversity in the means of communication may be here to stay and/or be accompanied by what have been described as 'blended' approaches.

11.6.6 There was evidence to suggest that whilst face-to-face visits had to reduce during some periods, particularly lockdowns, all agencies endeavoured to retain a high level of contact by other means ensuring there was an ongoing level of contact and access for Young Person A and their father.

12.0 Conclusions & recommendations

12.1 Conclusions

12.1.1 All partners have actively engaged in this review and committed to understanding how their safeguarding approaches and interventions could be strengthened and improved for young people presenting with complex needs, trauma experiences, mental health and self-harm presentation and exploration of gender identity.

12.1.2 There were some valuable and effective responses to Young Person A's emotional needs especially from the local voluntary sector therapeutic service providers, youth worker and the education provision.

12.1.3 Trauma-informed practices could not be evidenced as consistently embedded across the partnership, agencies did not consider the accumulative impact of Young Person A's experiences and how they may have been affecting their presentation, including emotional distress and self-harm.

12.1.4 It is positive that Young Person A has been able to give their view about their circumstances and their insight and candour about the experiences they recounted is appreciated. The partnership should take them on board as an opportunity for partners to learn and improve experiences for children and young people in the future.

12.2 Recommendations

12.2.1 The child or young person's voice should always be heard and central to work undertaken with them. Agencies should review their policies and procedures internally to assure themselves this is in place throughout and that practitioners and supervisors are expected to demonstrate this is clearly recorded and considered.

12.2.2 The Partnership (PSCP) should ensure that it outlines clearly how children and young people's voices will/or do influence the work of the Partnership.

12.2.3 All agencies should consider how chronologies are used in their work with children and young people, particularly where there is a level of complexity. They should ensure they are able to identify Adverse Childhood Experiences and traumatic events and consider the potential impact on the child or young person. They should be confident they have a clear overview of the child/young person's lived experience, including the cumulative impact of events, as well as processes in place to work with other agencies to combine chronologies, where appropriate, to allow agencies to work together to fully understand the lived experience of children and young people and then work with them to achieve the changes needed.

12.2.4 The Partnership (PSCP) needs to be assured that all agencies are confident that practitioners have an appropriate understanding of Adverse Childhood experiences (ACEs) and Trauma-informed practice.

12.2.5 Multi-agency risk assessments and subsequent interventions should include all relevant professionals and take account of relevant specialisms, such as mental health and exploration of gender identify.

12.2.6 All children and young people should have clear genograms (family tree) and ecomaps (support network) on their records that also identify friends and trusted persons. This supports their inclusion (with the appropriate consent), in any safety or support plans for the child or young person at that time.

12.2.7 This learning review serves as a reminder to agencies to seek and share all relevant information with each other when assessing a child or young person with complex needs, including self-harm. This supports effective support and safety planning.

12.2.8 Parental consent for intervention should be balanced against the needs and risks of children and young people. Where consent is refused, this should be understood, explicitly considered with other agencies that are directly involved, and recorded. Alongside efforts made to encourage and support parents to work with the proposed assessment/ intervention. The voice of children/young people needs to remain heard within this.

12.2.9 Education settings should be clear on the pathways available for young people presenting with this level of complex need and review at what point they should seek additional guidance to ensure they are offering the appropriate support and if necessary ensuring the right multi-disciplinary approach to meeting the young person's needs.

12.2.10 The Partnership (PSCP) to review the processes, procedures and strategic commitment to support children and young people with significant self-harm presentation. Any identified gaps should be addressed.

12.3 System developments already in place

12.3.1 Triggered by reflections on the actual delivery of services and what might be the optimal arrangements for young people in Young Person A's situation, the following changes have already been implemented by the partnership:

- The 'Targeted Support' part of Plymouth City Council was reviewed immediately and staff merged to create an 'Early Help Advice and Support Team' with youth and family support workers offering advice and support to settings as well as a key worker on a 1:1 basis or via group work. They had been delivering support during the Covid-19 pandemic via MS Teams, WhatsApp and phone, the offer in 2021 has evolved into a 'blended' offer of face to face or virtual contact, dependent upon individual need.

- The historically distinct and complex functions within CAMHS have been re-modelled. Rather than first-line therapy for an individual, the approach has become 'externally' (rooted in trauma-informed and holistic appreciation of presenting symptoms) to support the efforts of the family and professional network and - 'internally', to co-ordinate by means of multidisciplinary 'core meetings', the specialities within the wider CAMHS.

- The hospital now has the benefit of a 'Mental Health Care Pathway' which can call upon the assistance of an 'enhanced care observation team' for 1:1 care of children and young people.

- All children who present to the Hospital's Emergency Department following deliberate self-harm or concerns for emotional health are communicated to 'Children's Gateway' and considered as a potential referral for Children's Social Care intervention. This needs to be considered further as a Partnership to ensure there is a shared understanding of when these situations should 'automatically' result in a referral or result in a conversation about what might be appropriate.

- The Police have adjusted their approach in recent years to one that is more child and family centred.