SERIOUS CASE REVIEW
CHILD W

Independent Reviewer:

Dr Kenny Ross - Consultant Adolescent Forensic Psychiatrist

CONTENTS

SECTION 1: BACKGROUND

1. Child W was found deceased by a member of the public on 19 September 2018 and his death was thought to have been caused by suspension by a ligature around his neck. A Rapid Review took place within fifteen days. The decision was made to progress to Serious Case Review and an Independent Reviewer was commissioned.

2. His brother described Child W as being "*cynical*" and as having "*a dark sense of humour*". He also described him as being "*very loving*" but as being "*very, very blunt*". Child W had been "*more of a best friend than a brother to me*". However, his brother also described Child W "*used to just switch from looking normal to going glazed with his head down and looking like he was going to go for my throat*". There was no obvious trigger described for this.

3. Child W's mother and stepfather described him as being "*a joker*" and "*very happy*" but also as being "*very stubborn*". They stated that he was looking forward to becoming 18 and having a pint in the pub. His mother described him as being "*happy go lucky*" and a character although sometimes he would become "*stressed*".

4. Practitioners attending the Practitioner Event were asked to describe Child W in a few words. He was described by them as follows:

   - "*Child W was slim-built, quiet, but engaged with his peers at times".*
   - *"He was bright articulate, driven and well-read, quick witted with a dark/dry/good sense of humour".*
   - *"He was suspicious and wary but engaged when he wanted to".*
   - *"He knew what he wanted and could be stubborn".*
   - *"Child W was determined to get out of the system and could not wait to turn 18".*
   - *"He occasionally gave hope to staff but then could change quickly and shut down again".*
   - *"Child W was described as an anxious little boy at the age of 5 who seemed to be the same aged 17".*
   - *"He had low self-esteem and thought of himself as a fat little boy, he was anxious, impulsive and struggled to cope in large groups*".

5. Information provided states that school reported that Child W had no established relationships within schools and was described as being anxiety-driven and sensitive to rejection.

6. In his Pathway Plan Child W is described as being "*a very articulate young person who is good company with his good sense of humour and observations. Child W can challenge others when required and can express his wishes and feelings in the majority of situations however he can struggle when emotionally overloaded*".

7. A Record of Consultation dated 25.11.2009 by County Psychological Service states "*Overall, Child W* presents *as a boy of high average general ability, with a particular strength in verbal reasoning and a noticeable weakness in auditory working memory*".

8. A chronology received states:

- Between 2005 and 2006 Child W was placed with Local Authority foster carers, initially under Section 20 of The Children Act but this was replaced by an Interim Care Order. During this placement Child W was cared for on a temporary basis by other foster carers on three occasions due to holiday plans made by the foster carers.
- Between 2006 and 2009 Child W was made subject of a Freeing Order and placed with potential adopters along with his two younger siblings.
- Between 2009 and 2013 Child W was placed with foster carers following the breakdown of his adoptive placement although his siblings remained there. Child W was moved to out of borough foster carers in Carlisle through Family Foster Care.
- During 2013 and 2014 Child W was placed in a residential placement, in the Carlisle area.
- Child W was placed with foster carers in the Carlisle area from April to October 2014
- Between 2014 and 2016 Child W was placed at a Children's Home in Wigan (an internal provision).
- In early 2016 Child W was placed with Local Authority foster carers.
- In mid-2016 Child W was placed at a residential children's home in the Wigan area.
- Between 2016 and 2017 Child W was placed in another residential children's home in the Wigan area.
- From August 2017 until March 2018 Child W was placed in a semi-independent accommodation in the Wigan area.
- During 2018 Child W was placed within a residential children's home in the Wigan area.
- In mid-2018 Child W was placed in semi-independent accommodation in the Wigan area.
- Autumn 2018 Child W was admitted to Ancora House, a Tier 4 Child and Adolescent Psychiatry inpatient unit.
- Upon discharge from Ancora House Child W was placed in semi-independent accommodation in the Wigan area.

9. Child W had a total of ten Social Workers between July 2003 and September 2018. This works out as an average of just over 18 months per Social Worker. However, it should be noted that Child W had two long periods where the Social Worker remained consistent, these were: September 2012 to January 2015 and, January 2015 to July 2017.

SECTION 2: PARALLEL PROCEEDINGS: CORONIAL, NHS AND CRIMINAL

Coronial

10. The coroner requested that the WSCB Serious Case Review took place before the Inquest.

11. The Independent Reviewer acknowledges that at the time of writing the Coronial process had not concluded and this may have inhibited the way in which the professionals felt they could contribute to this process.

NHS

12. The case met the criteria for investigation under the NHS Serious Incident (SI) Framework.

13. Cheshire and Wirral Partnership NHS Trust (CWPT) added the incident to the NHS Strategic Executive Information System (StEIS). An SI investigation was then carried out by CWPT and submitted to NHS Wigan Borough Clinical Commissioning Group (WBCCG) for review and closure.

14. North West Boroughs Healthcare NHS Foundation Trust (NWBH) were also providing care to Child W therefore they conducted a 72-hour Concise Review under the NHS SI Framework. This Concise Review was considered by their Patient Safety Panel where it was agreed that a Comprehensive SI Investigation was not required. This decision was endorsed by WBCCG.

15. Wrightington, Wigan, and Leigh NHS Foundation Trust (WWL) and Bridgewater Community Healthcare NHS Foundation Trust (BWCH) reviewed the care and treatment provided and did not feel that a SI Investigation was required.

16. An SI Comprehensive Investigation Report was provided by CWPT and reviewed by WBCCG Serious Incident and Never Event (SINE) Panel. The Business Manager from Wigan Safeguarding Children Board was invited to take part in the SINE Panel. The SI Investigation Report; comments from the SINE Panel; and correspondence between WBCCG and CWPT in relation to the report has been shared with WSCB for consideration as part of the Serious Case Review process.

Police

17. The Independent Office for Police Conduct (IOPC) conducted an investigation because Child W was Missing from Home.

18. There are no criminal or civil proceedings known to the Independent Reviewer.

SECTION 3: TERMS OF REFERENCE

19. The Serious Case Review Panel Members agreed six Key Lines of Enquiry (KLOE) as outlined below:

KLOE 1	To develop an understanding of Child W's developmental history of attachment and consider the impact of life events on him
KLOE 2	To consider and review the various risk assessments undertaken by all agencies involved with Child W
KLOE 3	To review the content and chronology of interagency communication in Child W's care and the multi-agency care planning in relation to his mental health and placement history.
KLOE 4	Review the care planning afforded to Child W in the context of his being a child with Looked After status, including the potential impact of location on Child W's access to services
KLOE 5	Explore the interventions Child W experienced in the later part of his life.
KLOE 6	Establish learning from critical episodes which are identified through the SCR process.

SECTION 4: SOURCES OF INFORMATION

20. This Serious Case Review report is based on the following sources of information:

Date	Meeting
16 July 2019	Initial Panel Meeting held
03 December 2019	Second Panel Meeting held
05 February 2020	Third Panel Meeting
03 April 2020	Fourth Panel Meeting held
03 September 2020	Meeting with CWP representatives
02 November 2020	Fifth Panel Meeting held
11 February 2020	Practitioner Learning Review Event held. This included a session solely for Practitioners in order to facilitate a full and frank discussion by Practitioners about how Child W's death was communicated to them and about the support offered to them by their organisation thereafter without their managers being present.
28 February 2020	Meeting with Child W's mother and stepfather and their legal representatives
06 March 2020	Attendance at Coroner's Court
20 March 2020	Telephone interview with Child W's brother

21. I have been provided with large amounts of information from involved agencies although some information remains missing (CAMHS records from Cumbria and Yorkshire; Mental Health records from Lancashire (Blackpool); and some General Practice (GP) records.

SECTION 5: SERIOUS CASE REVIEW PANEL MEMBERS

22. The Serious Case Review (SCR) Panel was comprised of:

The Independent Reviewer	
Business Manager	Wigan Safeguarding Children Board (WSCB)
Learning and Improvement Officer	WSCB
Named Nurse for Safeguarding Children	Cheshire and Wirral Partnership NHS Foundation Trust (CWPT)
Named Nurse for Safeguarding Children and Children in Care	Wrightington, Wigan, and Leigh NHS Foundation Trust (WWL) – Acute and Community Services Community Services were provided by Bridgewater Community Healthcare NHS Foundation Trust (BWCH) which transferred to WWL in April 2019
Specialist Nurse for Safeguarding Children	WWL
Named Nurse for Safeguarding Children	North West Boroughs Healthcare NHS Foundation Trust (NWBH)
Service Lead, Children's Social Care	Wigan Council
Assistant Director/Designated Nurse for Safeguarding Children & Looked After Children	NHS Wigan Borough Clinical Commissioning Group (WBCCG)
Associate Named Nurse for Children in Care	CWPT
Advanced Nurse Practitioner for Safeguarding Children	NWBH
A Representative from Cheshire Police	Cheshire Police
Secure and Specialised Case Manager for Cheshire, Merseyside, and Lancashire	NHS England - Cheshire, Merseyside, and Lancashire

23. The following people were subsequently added to the SCR Panel:

Detective Sergeant	Greater Manchester Police (GMP) Serious Case Review Team
A representative from Pathways and Inspire	Pathways and Inspire (Placement Providers)
Lead for Children in Care	Children's Social Care, Wigan Council
Virtual School Head	Wigan Council
Strategic Lead Practice and Quality and Assurance Team	Children's Social Care, Wigan Council.

24. The SCR Panel Members created a detailed multi-agency chronology that was compiled as part of the Serious Case Review Process.

SECTION 6: KEY LINES OF ENQUIRY (KLOE)

KLOE 1: To develop an understanding of Child W's developmental history of attachment and consider the impact of life events on him

25. Life events had a significant impact on Child W and there are several mentions of major changes adversely impacting on him (change of Social Worker; change of placement; moving to the Leaving Care Team etc.). However, throughout the documentation provided there seems relatively little in the way of understanding of his difficulties or indeed seeing his behaviour through the prism of attachment difficulties. Rather the responsibility for his not engaging with professionals is laid fully with him and this is reflected in the language used e.g., you failed to engage in… There seems little ownership by professionals i.e., it is their role to facilitate his engaging with them.

26. QQ described that Child W struggled with "*the constant change*" of both Social Worker and placement.

27. On two occasions documents contain reports and/or statements that strongly suggest that a professional did have more understanding:

- In the Pathway Plan Part 1 – Assessment – completed December 2017 by his Social Worker states "*Child W feels let down by professionals and adults throughout his childhood, alongside his attachment difficulties, which has had a detrimental effect on his ability to manage present working relationships which is a significant barrier to him accessing support to ensure his needs are met. Therefore, there is a risk of unmet needs*".

- An Educational Psychology Service Report from June 2015 states that the hypotheses developed by the Educational Psychology Service which included Child W struggling to form relationships, replicating relationship patterns to those of his parents, the need to be in control, struggling to adapt his strategies and with routine and change. He also is reluctant to engage but can respond positively; and seems to do better in smaller settings with firm boundaries and behaviour management strategies.

KLOE 1 - Independent Reviewer Concluding Comments:

28. It is very likely that given Child W's early history of not being provided with safe and appropriate care; multiple placements, with many failing (compounded by his siblings being successfully adopted); changes of professionals allocated to his case; geographical moves; and changes of school that he had attachment difficulties or possibly an attachment disorder.

29. The diagnosis made in Ancora House of F92.9 – Mixed Disorder of Conduct and Emotions, Unspecified can be seen as being one of the end points of earlier attachment difficulties.

30. The overall feeling of the Independent Reviewer was that professionals did have an awareness that Child W had difficulties with attachment as a result of his life experiences but that this rarely seems to have translated into written documentation or impacted on their interactions with Child W.

31. **Independent Reviewer Recommendation 1:** WSCB should seek assurance that all agencies work with children and young people in a way that considers the consequences of attachment difficulties This includes the long-term effects on behaviours, relationships, and engagement with professionals. Language used in agency records should reflect that the responsibility for engaging children and young people sits with the professional. The ethos should be included in the following:

- Workforce development and training
- Agency assessment and planning documentation
- Trauma-informed practice
- The use of professional language
- How professionals engage children and young people

KLOE 2: To consider and review the various risk assessments undertaken by all agencies involved with Child W

Referral to Wigan CAMHS - 28/02/18

32. A referral to CAMHS was made by Child W's Social Worker on 28/02/18. The referral included a detailed list of Child W's risk factors, protective factors, unmet needs, and other issues such as him presenting as unkempt, not sleeping, damaging property, being missing from home and disengaging from the staff.

33. In this referral the Social Worker documented that Child W had said he would "*hang himself*" if he had to stay at his residential placement and there was concern that he may do this.

Looked After Child (LAC) Review Health Assessment - 13/03/18

34. A statutory Review Health Assessment (RHA) was completed by a Specialist Nurse for Children in Care and Child W's Support Worker. Child W gave his consent for this to occur with his Support Worker's involvement but opted not to take part himself.

35. The RHA documentation outlined that Child W was not reported to be self-harming. He was described as accessing social media, but it is not known what sites he accesses. It states "*It is thought he may be accessing inappropriate material on-line. He will not engage in meaningful discussions around Internet safety. It is not thought he is being exploited, however, this could not be discussed with him*".

Strategy Discussion - 31/08/18

36. A document entitled 'Record of Strategy Discussion' from a telephone Strategy Discussion held on 31/08/18 states the professionals involved were from Children's Social Care and the Police. Child W was reported missing from home on 30/08/18 and subsequently located in Blackpool.

37. Child W is described as having stated to a Police professional and the staff at the care home in Blackpool that he cannot return to Wigan "*as his family are going to kill him*". There were concerns expressed by him about how a family argument.

38. Child W is described as being extremely anxious and professionals are described as being concerned he was experiencing psychosis. The Police Officer in Blackpool felt that Child W may try and run away should he be made to come back to Wigan. The Police Officer was advised that if there were concerns for Child W's mental health he needed to be taken to hospital or Paramedics called to review him. Child W declined to go to A&E and was taken back to his placement and ran away on return.

39. Child W was placed in a staff car to return to Wigan and the Police followed this onto the motorway because of concerns he would jump out of the car. Child W later accused

staff of being liars and that he was going to be put into a Secure Unit. He also reiterated that he was "*in danger*" and was "*a dead man*". He asked to go to A&E but stated he wanted to go to A&E in Blackpool. Staff believed that he would abscond if he was taken to hospital in Blackpool so offered to take him to Wigan A&E, but he refused. Shortly after returning to the unit Child W absconded again.

40. Information from the Police states that Child W has a Section 39 Assault, criminal damage, and threats to cause damage in 2018 that have not been pursued with the Police and have occurred in placement. Mother and stepfather are described as having a forensic history.

41. Child W was assessed by the Police as being medium risk missing but the Deputy Practice Manager from Children's Social Care thought that he should be high risk.

42. Plans from the Strategy Discussion held on 31 August 2018 included that Police should inform Social Care and Child W's brother when Child was located. Then assess his mental health and support access to mental health assessment if appropriate. If this was not required Child W would be returned to his placement. The grading of risk should then be collectively reassessed. The Police agreed to consider any risk in relation to where Child W was staying and his family and if concerns identified contact Social Care.

Letter from Wigan RAID/CAMHS - 02/09/18

43. A letter from Rapid Assessment and Interface Discharge (RAID) Team/Child and Adolescent Mental Health Services (CAMHS) Wigan follows an assessment of Child W. This included a review of Child W's:

- Risk to Self within which he denied having any current thoughts of self-harm or suicide as he reported feeling safe in hospital.
- Risk of Self-Neglect as it was reported that Child W had not been maintaining his personal care and restricting his dietary intake.
- Risk to Others which included reports that Child W had assaulted staff.
- Risk of Vulnerability, Child W was seen as vulnerable due to his mental state and risk of absconding. He was also reported to smoke cannabis daily to reduce auditory hallucinations.
- Risk of Eating Disorder as he had been restricting his dietary intake as a means of self-harm.

44. The formulation from the RAID assessment was:

> "*Child W is presenting with psychotic symptoms where the present auditory hallucinations are causing Child W distress*".

"*Child W's risk to self has increased due to his presentation where his delusional and paranoid beliefs are enhancing the auditory hallucinations which are increasing his vulnerability and risk factors*".

45. The plan was for a further assessment with the CAMHS psychiatrist with a request for a Tier 4 (a child and adolescent psychiatry inpatient) bed. Fairhaven (the local Child and Adolescent Psychiatry inpatient unit in Warrington) were aware of this.

Street Triage from Knowsley Adult Mental Illness Services - 03/09/18

46. On the 03/09/18 the Street Triage from Knowsley Adult Mental Illness Services completed a comprehensive Risk Screening Tool.

47. This Risk Screening Tool completed by Street Triage does list the presence or absence of many potential risk factors but does not lead to any formal assessment of risk e.g., the risk of self-harm is currently high and related to the patient's mental state. The use of alcohol and/or illicit substances that have a disinhibiting effect may be associated with an increased risk.

Referral for Access Assessment into Inpatient Services for Children and Young People - 04/09/18

48. A Referral for Access Assessment into Inpatient Services for Children and Young People form dated 04/09/18 was completed by Clinical Lead at RAID services in Wigan contains the following information.

49. The risk factors section of the report is completed including his history of self-harm and suicidal ideation; he has absconded from the ward; his assault on care staff; the risk of self-neglect; risk of exploitation. The referral form does not ask for an assessment of risk as such but asks for one to be attached.

Mental Health Act (MHA) Assessment Form - 06/09/18

50. A Mental Health Act (MHA) Assessment Form dated 06/09/18 follows Child W being assessed whilst he was under Section 136. Under risk to others, this assessment states that "*Child W can present as agitated and aggressive to others especially when trying to act on his voices' commands to get away*". Under risk to self, it states "*Child W is at risk of self-harm and suicide. He has attempted to hang himself on two occasions in the last 48 hours. He continues to have suicidal ideology and is stressing he will act on this and the voices telling him to kill himself*".

51. Child W was detained under Section 2 of The MHA (1983) due to:

- An evident mental disorder (hearing voices and persecutory thoughts) of a nature and degree that warrants hospital detention.

- Risk to own health and safety due to lack of insight into mental state, persecutory thoughts and inability to risk assess.
- Lacks capacity regarding voluntary admission and consent to assessment.
- DoLS not appropriate as admission only for assessment/treatment of mental disorder.

52. Community alternatives were deemed inappropriate given him being actively at risk of self-harm or suicide.

AMP Outline Report – 06/09/18

53. This follows Child W undergoing a Mental Health Act Assessment. The reasons for this as stated on the form were: "*actively suicidal, attempted hanging, hearing voices and numerous attempts to abscond. Absconded from the ward and detained by Police on Section 136 MHA 83*".

54. The assessment is summarised as "*Child W is hearing voices, responding to outside stimuli which is telling him to commit suicide. He has attempted to hang himself on two occasions over the past 48 hours and continues to express suicidal thoughts. He used cannabis approximately 4 days ago. He continues to be a risk to himself if not admitted to hospital under the MHA. Child W has absconded from the general health ward at Wigan Hospital and returned on Section 136*."

55. He was felt to lack capacity to agree to informal admission and an alternative care plan was not deemed appropriate as his risks could not be managed in the community.

Mental Health Act Assessment Form – 06/09/18

56. A MHA Assessment Form follows him being assessed whilst he was under Section 136. This states that Child W was unknown to CAMHS prior to these presenting concerns. It describes him hearing persecutory voices telling him to kill himself and states that he had attempted to ligature himself and had cut himself with plastic. A history of cutting his arms is noted. He is described as hearing voices encouraging him to kill himself and has been actively suicidal.

57. The history is noted. He was described as being happy to engage in the MHA assessment although he remained in bed and presented as tired and lethargic. He described hearing voices that were "*always there*" and told him to kill himself and called him "*a nonce*". There were in internal space and intrusive to his thoughts. They had been present for a month. The voices were of his "dad", QQ, his girlfriend, and a cousin. The voices said that his "dad" wanted to kill him, and he should kill himself. He had attempted to hang himself by tying his hospital gown to the roof. He explained that he absconded because the voices told him that his "*dad*" was coming to get him to kill him. The voices said "*run*" so he got on a train. The next stop was Preston

where he tried to self-harm in the station toilets. Child W stated he was unsure whether the voices were real or not.

Clinical Assessment of Risk to Self and Others (CARSO) Summarised View of Risk - 06/09/18

58. The opening statement to this document states: What is the nature & degree of risk? Who is at risk? Can you state how likely it is to occur? Is risk escalating or decreasing? Under what circumstances might it occur? Relationship between risk and mental disorder, social circumstances, or their contextual factors? Factors increasing risk and protective factors which reduce risk. What benefits to the user may arise from taking considered risks? What would be in the best interests of the service user? Are there any gaps in the information or areas which require further assessment?

59. This risk assessment included 'Risk to self', 'Risk to others', Risk from others and a 'Summarised view of risk '.

60. I think it is fair to say that this is not a risk assessment in that there is no view expressed about risk in terms of either severity or imminence. No mention is made of any potential risk factors that were not present. There is no attempt to formulate risk, or any plan developed to manage risk, in the short, middle, or longer terms. The CARSO process does not of itself lead to a weighted score for risk e.g., high or low risk.

Baseline Summary by Mental Health Practitioner Ancora House - 06/09/18

61. A document entitled Baseline Summary (undated but appears likely to be 06/09/18) contains the recent history. The "Risks" heading is followed by:

62. Risk to Self:
Risk to self through self-injurious behaviour, he cuts superficially and scratches as a method of coping with derogatory voices that he hears. Child W also reports voices telling him to harm himself and end his life. He believes that the only way to stop what he is experiencing is to end his life. Child W has been restricting his diet as he described the discomfort caused by hunger helps to distract him from the voices and focus his mind, this can cause a risk to his physical health.

63. Risk to Others:
The document states: "*There are reports of historical violence and aggression that has caused* breakdown *of foster placement and residential care placements. However, there are no clear details of these incidents and Child W denies any risk to others*." Child W does report paranoid beliefs about others wanting to hurt him and feeling that he is being watched/recorded and "*bugged*", this may cause some increase in agitation and risk towards others.

64. Indirect Risk to Self:

Child W reports smoking large amounts of cannabis. He states that he does this to reduce the voices and distressing thoughts that he has, this may cause an indirect risk towards his physical health and may alter his sense of perception and awareness of danger plus allowing him to place himself in vulnerable situations.

65. From Others:
Child W reports being at risk from others as he believes people are trying to kill him. There is no evidence he has been targeted by others; however, he presents as a vulnerable young man who may be easily influenced by others, particularly due to the large amount of cannabis he consumes on a daily basis.

66. There is some attempt here to link risk factors with actual assessment of risk. There is recognition of the need for further information to inform the assessment of risk e.g., in relation to the reported history of assaultive behaviour towards residential staff "there are no clear details of these incidents and Child W denies any risk to others".

67. There is a heading stating Forensic followed by "*none identified*". It is not clear how much detail was pursued in this area.

68. In the formulation Child W's presentation was described as being "consistent with an expected presentation where a young person has experienced significant trauma and neglect". It goes on to describe Child W reporting auditory hallucinations and paranoid beliefs; hears voices telling him to end his life and harm himself and he believes that people are trying to harm him as they believe he is a paedophile. Child W reports that these symptoms have begun in the past few months and a full assessment of his mental state is required to ascertain the nature of these thoughts.

69. Under the heading of "Likely impact of hospital admission" the following is mentioned:

    1. Positive – admission will allow a full assessment of mental state and allow risk to be assessed in a safe environment. A psychological formulation can be completed to allow an understanding of Child W's difficulties and inform future CAMHS work.

    2. Negative – Child W may become dependent on the inpatient unit due to the provision of a structured and safe environment that meets his needs.

Minutes Care Planning Meeting - 07/09/18

70. Minutes from a Children's Social Care Care Planning Meeting state that Child W had been detained under Section 2 of The Mental Health Act (MHA) and is in Ancora House. Professionals involved will be led by Mental Health in addressing care planning for his future. It makes note of "*numerous missing from home episodes, suicide attempts*" since the last meeting.

71. The plan describes that a package of support around Child W once discharged from hospital would be put into place and Wigan CAMHS would become involved with him ASAP.

72. I note that this plan is incomplete with remaining areas not completed. Under 'Risks identified and mitigation' it states "*currently Child W is presenting with paranoia, psychosis (possibly drug-induced). He has made several attempts to commit suicide. Child W is described as being "a very poorly young man*".

CARSO Summarised View of Risk – 11/09/18

73. CARSO Summarised View of Risk was completed by a Staff Nurse. It has been explained to the Independent Reviewer that after an initial CARSO document is completed that information contained in it is automatically prepopulated in subsequent CARSOs. This did lead the Independent Reviewer to incorrectly believe that this had been the result of cutting and pasting information. It is important to note this in the final version of the report.

74. This second CARSO contains no additional information under the headings "Risk to Self" and "Risk from Others."

75. However, under the heading "Risk to Others" three new items which included verbal and physical aggression against staff and patients.

76. The additional information has been added into the prepopulated subsequent CARSO. Again, this summarised view of risk does not contain any assessment of risk. It also does not mention any missing factors. Again, there is no statement about degree or imminence of risk. There is no formulation of risk or any plan to reduce risk.

CARSO Summarised View of Risk - 14/09/18

77. CARSO Summarised View of Risk was completed by Staff Nurse. This CARSO also has additional information under the heading "*Risk to Others*" which includes verbal and physical aggression and assault. Child W is reported to have "*Exposed himself to female staff on a number of occasions*" and set off the fire alarms off causing Fire Service to attend the ward. The 'Risk from Others' section was updated to acknowledge that Child W "*Could be a target due to disinhibited and provocative behaviour*".

78. Again, there is no statement about degree or imminence of risk. There is no formulation of risk or any plan to reduce risk.

Risk Review prior to discharge – 18/09/18

79. The following sentences are included within this section: "*No thoughts to harm others or self-expressed* and *no reports of any voices. No evidence of any psychotic symptoms*."

80. What this entry does not make clear is whether or not Child W was asked questions in order to elucidate any symptoms of psychosis or thoughts of self-harm or suicide. The statement that he did not express thoughts of self-harm or thoughts to harm others could be seen as meaning that he was not asked. The fact he did not express these thoughts is not evidence that he did not have them. There is a need to ensure that case note entries are very clear i.e., Child W denied having thoughts of self-harm or suicide. This makes it clear that the question was asked of him (the veracity of the answer is of course never certain).

Electronic Discharge Summary - 18/09/18

81. The Electronic Discharge Summary includes the following information:

- Child W was "*reluctant to state where he obtains his cannabis but stated that he gets it for free*".
- He stated that he has a history of superficial self-harm by cutting and scratching himself as a coping strategy as the pain caused by self-harm results in "*the voices stopping*". He also stated that he sometimes harms himself because the voices tell him to.
- Child W appears preoccupied at times by thoughts that he is evil and a paedophile, he is unable to state why he believes this is the case, but he expresses thoughts that he believes people, particularly his father, will try and kill him as they know he is a paedophile.

82. The electronic discharge summary includes reference to the CARSO.

83. Language is used to incorrectly describe this young man, i.e., he never exposed himself. He was wearing ill-fitting hospital pyjamas resulting in his genitals being visible. This is not the same as indecent exposure. Again, he is described as "*does not engage*" with professionals but this puts all the responsibility on him.

84. The Risk Assessment contained here really is risk factors rather than a risk assessment although to be fair it is called Risk Identified.

Section 136 Assessment at Arrowe Park A&E - 18/09/18

85. The Risk Assessment states:

"*Risk to Self – Child W would not elaborate fully when exploring suicidal thoughts, however, he is asking for help, he said that he would want an inpatient admission and*

therefore, strong indicators of future planning and help seeking. He has self-harmed in the past and also on the ward. He can contact staff at his accommodation should he have thoughts of harming himself or contact RAID Team. Risk to Others: the ward Discharge Summary stated that he can be verbally aggressive to staff and peers and has a low tolerance of peers. Risk of self-neglect – he was unkempt today. This will be monitored by supported accommodation."

86. There is consideration here of factors that could impact on risk – both increasing and decreasing risk. However, there is no formulation of risks and no risk management plan.

KLOE 2 - Independent Reviewer Concluding Comments

87. There are very few actual assessments of risk documented. The majority of documents are simply lists of risk factors that are present in Child W's case (and rarely the risk factors that are absent). In general, there seems to be no attempt to describe any risk, certainly in terms of imminence or degree (low, medium, or high). Generally, there are no formal risk management plans, albeit that his being detained under The Mental Health Act and admitted to a Tier 4 CAMHS inpatient unit and his being placed on Level 3 ('enhanced' i.e. line of sight observations) and then Level 2 (at a frequency between 5 and 15 minutes i.e. the frequency required to maintain safety) observations could be seen as contributing to a plan to manage risk. I understand that there is a daily risk review process whereby the observation levels are reviewed and can be raised or lowered as appropriate. Risk levels, and therefore observations levels, are reviewed at the weekly Case Planning Meeting.

88. The three CARSOs provided are incomplete. The opening statement to this document states: What is the nature & degree of risk? Who is at risk? Can you state how likely it is to occur? Is risk escalating or decreasing? Under what circumstances might it occur? Relationship between risk and mental disorder, social circumstances or their contextual factors? Factors increasing risk and protective factors which reduce risk. What benefits to the user may arise from taking considered risks? What would be in the best interests of the service user? Are there any gaps in the information or areas which require further assessment? The next section is entitled "Summarised view of risk" and contains the following prompts: Can you identify previously helpful interventions; are there any lessons to learn about what to do and what not to do in the future? There is a text box to "Detail any reasons for inability to consider or collect information on any of the above."

89. None of the three CARSOs have any statements in relation to the above three paragraphs.

90. It is difficult to state whether or not better-quality risk assessments; risk formulations; and risk management plans would have led to a different outcome. It is likely that better risk assessments would lead to better risk management plans.

91. A further factor that impeded risk assessment was that information was not always shared between agencies. Information concerning Child W's statements about being in a pornographic video with someone underage was not shared with Ancora House. Information about his being "the victim of childhood sexual abuse" seems not to have been shared with a number of agencies.

92. **Independent Reviewer Recommendation 2**: Agencies involved should explore the issues raised in this report regarding Risk Assessment; Risk Formulation; and Risk Management. They should consider the need for further workforce development and strengthening of existing policies and processes.

KLOE 3: To review the content and chronology of interagency communication in Child W's care and the multi-agency care planning in relation to his mental health and placement history

Language used to describe Child W and his difficulties with engagement with professionals

93. Across documentation from agencies involved in Child W's care there is a pattern of language use that places the responsibility for his engaging with professionals with him as opposed to the professionals. Phrases such as "refused to engage;" "chose not to engage;" "has not engaged with any appointments;" and "has always refused to attend any appointments;" are used.

94. The language used places all of the responsibility for any failure to form a therapeutic alliance on Child W and absolves professionals of any responsibility. Engagement skills should be a core facet of any professional who works with children and young people and it should be seen as the responsibility of professionals to facilitate the engagement of children and young people. Children and young people have often had adverse experiences with adults who have let them down, abused and/or abandoned them and it should not be surprising that many children and young people who come into contact with services find it extremely difficult to form trusting relationships or engage with professionals. Professionals need to work in a flexible manner, including not expecting children and young people to necessarily attend a clinic in order that they can be seen.

95. There is a distinct issue about the use of language used both to describe Child W and to communicate with him. There is minimal acknowledgement that he may have found it difficult to trust people. In the Pathway Plan Part 1 – Assessment – completed 5 December 2017 the Analysis section states "*Child W's significant difficulties with adults and his lack of engagement has resulted in a number of his needs being unmet as this barrier prevents Child W assessing support available to him*". It also states however, "*Child W feels let down by professionals and adults throughout his childhood, alongside his attachment difficulties, which has had a detrimental effect on his ability to manage present working relationships which is a significant barrier to him accessing support to ensure his needs are met. Therefore, there is a risk of unmet needs*". This shows insight into Child W's likely difficulties.

96. Child W is described as being "*a very articulate young person who is good company with his good sense of humour and observations. Child W can challenge others when required and can express his wishes and feelings in the majority of situations however he can struggle when emotionally overloaded*".

97. **Independent Reviewer Recommendation 3:** WSCB should seek assurance that agencies are working with children and young people in a way that places the responsibility for engaging children and young people and their families with professionals and that professionals use appropriate language in records which reflects this responsibility.

Communication with and to Child W

98. It appears that when Child W moved placement that professionals involved in his care changed: not only those providing care but Looked After Children Nurse professionals; and CAMHS professionals and this must have had an adverse impact on their ability to engage him and his ability to trust in them. Child W was described as having a good relationship with his Social Worker who was consistently in his life from the ages of 12 to 16 but then he had to change to the Leaving Care Team and was allocated a new Social Worker. The Independent Reviewer understands that this no longer is the case.

99. The appointment letter from Wigan CAMHS sent out on 03/04/18 enclosed questionnaires to be completed by the child/parent. It must be borne in mind that Child W was a Looked After Child and this potentially could be seen as being insensitive or inappropriate. He did not attend the appointment and was discharged following contact with Social Care.

100. A Pathway Plan Review held on 20/06/18 states that the review report was completed on 21 May 2018. Again, language is again emotionally laden such as "Child W refused to engage in his health assessment". The Young Person's Review of Pathway Plans – dated 24 June 2018 uses language such as "*Child W was present in placement but refused to give his views*". Statements such as "*I chaired your CLA Review today, although you was present in your placement you refused to attend your review or give your views*".

101. The language used in communications to Child W is often 'professional' and emotionally laden such as "*refused to give his views*"; "*refused to attend*" as opposed to "*chose not to attend*" or "*you decided not to attend*". There are some positive statements but others are quite negative such as "*unfortunately you are not motivated to explore further educational opportunities*". Later on, it states "*Child W we heard how you refused to attend to your health needs*". This type of language was unlikely to have made it any easier for Child W to engage and, indeed, may have made it even more difficult.

Ancora House and Child W "exposing" himself

102. The Electronic Discharge Summary dated 18/09/18 includes the following information "*Exposed himself to female staff on a number of occasions*". A Discharge Planning CPA Review took place on 18/09/18 Child W was described as demonstrating some disinhibited behaviour on the ward towards female staff at times and this is explained as "*has been known to expose himself to female staff*".

103. Child W had inappropriate and inadequate clothing. He had hospital pyjama trousers that were too big for him and he had no underwear on as he did not have any. His genitals were then visible at times. The issues here are:

- Child W did not have appropriate clothing in Ancora House. This does not seem to have been provided for him, at least for a period of time.
- The impact of language used – "*exposing oneself*" has certain connotations of a criminal/deviant nature and this seems to have led to a change in the discharge placement.
- There was a request for additional support following the Discharge Meeting which may not have been related to discussion about Child W "*exposing himself*".

104. It is apparent that this issue was a clear misunderstanding of the term 'indecent exposure' and that there was absolutely no intent to cause difficulty for Child W or to be malicious towards him. The use of this phrase led to Child W's community placement changing but it does not seem that there was any questioning of Ancora House staff as to exactly what had transpired. Professionals could have sought clarity and this would probably have meant that the original placement plan could have progressed.

Meetings at Ancora House

105. The CPA Meetings and the Discharge Planning Meetings at Ancora House were integral to Child W's care, both as an inpatient and after he was discharged. There was confusion, in particular when inpatient staff stated that the plan was to discharge Child W the following day. However, after concerns were raised the discharge was deferred and two further meetings took place. This was seen as Ancora House adopting a pragmatic approach to the situation and allowed for local services to put plans and services in place.

106. The Wigan CAMHS Care Co-Ordinator reported having little knowledge or notice of the Discharge Planning Meeting. He met Child W on that day and arranged to meet him again on the Thursday (the day Child W died). Wigan CAMHS were aware that Child W was an inpatient for the whole of his admission.

107. There was an issue as to whether a junior member of staff from one service would feel able to challenge a manager of another service in a meeting.

108. When NWBH were concerned about Child W's potential discharge from Ancora House being unsafe this was escalated through the Business Manager at WSCB but not to the Designated Nurse for Safeguarding Children and Looked After Children in WBCCG. The concerns were subsequently escalated to the Designated Nurse by a Senior Manager from Wigan Children's Social Care. The Senior Manager was not aware of the exact time, date, or venue for the planned Discharge Meeting and the Designated Nurse for Safeguarding Children and Looked After Children in WBCCG tried unsuccessfully to find out these details. Following the meeting the Designated Nurse for Safeguarding Children and Looked After Children in WBCCG was informed that Child W had not been discharged and that an agreed discharge plan was put in place and therefore there was no further need for her to be involved.

109. If the Designated Nurse for Safeguarding Children and Looked After Children in WBCCG had been aware from the outset of the concerns about a possible unsafe discharge, then she could have been involved i.e., attended the Discharge Meetings.

110. **Independent Reviewer Recommendation 4:** Wigan Safeguarding Children Board should ensure that escalations made regarding unsafe discharge are shared with the Designated Nurse at WBCCG in line with the agreed escalation policy.

111. Did the CAMHS Duty Practitioner (a Tier 2 practitioner) from Wigan CAMHS have enough knowledge of the case to challenge the decision to discharge? Should a more experienced Practitioner have attended?

112. A Children's Social Care note dated 17/09/18 relates to Child W's discharge from Ancora House. It states "*It is not within our remit to challenge the discharge decision*" but surely as he is subject to a Care Order and, therefore, the Local Authority is his corporate parent then it is within their remit to do this.

113. It appears that Ancora House staff were not aware of some of the statements that Child W had made prior to admission e.g., that his family were going to kill him because he was "*a nonce*."

114. The SI Concise Investigation by North West Boroughs NHS Foundation Trust report includes in the conclusions "*It is evident that the agreed multi-agency discharge plan was not fully implemented and that there were a lack of clear lines and timely communications between agencies. There is poor evidence of collaborative decision making and cohesive working across agencies and no formal agreement/procedure with external safeguarding teams/providers as to timeframes and communication pathways*."

115. The author of the SI Concise Investigation found little evidence of the voice of the child in Child W's discharge planning and through the limited involvement of NWBH.

116. The Recommendations/Lesson Learned for NWBH included lack of clear lines and timely communication between agencies and escalation processes.

117. The Independent Reviewer concurs with these recommendations. Communication between agencies could have been clearer and there is evidence that significant information was not shared e.g., regarding Child W's statements that he was at risk from his family. Clear processes for the escalation of concerns between different agencies involved in complex cases, including those young people admitted to hospitals or placed in residential and/or educational settings out of borough, must be in place. This should include expectations as to the timescale for a response.

118. There is a piece of work that is required to help professionals working with young people who are admitted to mental health units, either detained or informally, to help them understand what The Mental Health Act does, and indeed does not, allow. Professionals must feel confident to challenge decisions to admit and indeed to discharge young people from a mental health unit, in particular those who are Children

Looked After/subject to Care Orders as the Local Authority is acting in loco parentis and who they have Parental Responsibility for.

Safeguarding Communication

119. In Ancora House a Clinical Support Worker made a Safeguarding Children note in the electronic case notes detailing the conversation and emailed CWP Safeguarding with the details requesting advice. A response was sent the same day but the Clinical Support Worker did not see this prior to them taking a period of leave. The advice was to contact Child W's Social Worker and make them aware of the information. It does not appear that this was actioned.

120. In Ancora House a Nurse made a Safeguarding Children note in the electronic case notes detailing the conversation and emailed CWP Safeguarding team. A response to the email was sent on 10/09/18 with the advice being told make Child W's Social Worker aware of the information and "*If factual, may indicate child sexual exploitation in relation to the older women*." It also asked if the names of the sexual partners were known. The Nurse did not note the response until they were back on shift, but this was after Child W's death. It does not appear that this information was passed on the Child W's Social Worker. The CARSO was not updated.

121. Both professionals at Ancora House took the expected actions when informed of information that raised safeguarding children concerns. Notes were entered in the electronic case record as soon as was possible (in the same shift) and CWP Safeguarding Team was informed (again in a timely manner). CWP Safeguarding Team responded in a timely manner.

122. The issues were that neither staff member received/accessed the email response prior to a period of them not being in work. This meant that the advice from CWP Safeguarding Team was not acted on.

123. The Comprehensive SI Investigation performed by CWP makes recommendations about developing specific advice and reiterating staff members' responsibilities regarding safeguarding.

124. Recommendations/Lesson Learned for NWBH from their internal review included that there should be clearer guidance in relation to the Trust communication channels with agreed time responses with external providers for safeguarding children.

125. It is essential that communication pathways and protocols between professionals and designated Safeguarding Leads are robust, and this clearly was not the case whilst Child W was an inpatient at Ancora House. CWP and NWB drew up action plans to address the issues raised.

126. **Independent Reviewer Recommendation 5**: Wigan Safeguarding Children Board should seek assurance that the actions from the NHS SI Investigations have been completed.

127. It is apparent that Child W made a number of statements that relate to his potentially being at risk from others and a risk to others. Interagency communication and communication with the relevant Safeguarding Children Teams are addressed in Paragraph 163 onwards.

Other Issues Communication

128. There seems to be a great deal of confusion about Child W's biological parents. His biological mother is known, and his father's name is not known to the Reviewer. His stepfather is not Child W's biological father although he does appear to have been his "Dad".

KLOE 4: Review the care planning afforded to Child W in the context of his being a child with Looked After status, including the potential impact of location on Child W's access to services

Pathway Plan Part 1: Assessment – Completed 05/12/17

129. This is a comprehensive Needs Assessment. The Analysis section states "*Child W's significant difficulties with adults and his lack of engagement has resulted in a number of his needs being* unmet *as this barrier prevents Child W assessing support available to him*". It also states however, "*Child W feels let down by professionals and adults throughout his childhood, alongside his attachment difficulties, which has had a detrimental effect on his ability to manage present working relationships which is a significant barrier to him accessing support to ensure his needs are met. Therefore, there is a risk of unmet needs*".

130. There is acknowledgement here that Child W's difficulties accessing support are not merely his being difficult or awkward but are related to his previous life experiences. This should lead to Child W being seen as not solely responsible for these difficulties. It is the role of professionals to engage with young people and sometimes this can be difficult and different professionals (with different approaches) can and will have different levels of success in forging therapeutic/working relationships with a particular young person.

Statutory Review Health Assessment - 13/03/18

131. The statutory Review Health Assessment documentation dated 13/03/18 states plans/actions are required in the areas of dental health; vision; diet; sleep routine; immunisations; cannabis use; generalised anxiety/High SDQ score; and independence skills. All issues were to be reviewed by his Social Worker and IRO/Reviewing Officer at Looked After Young Person Reviews.

132. The Care Plan (Part 2) dated 21/05/18. This covers the following areas of need: Physical Health; Education, Training, and Employment; Emotional and Behavioural Development; Identity; Family and Friends; Independent Living; Accommodation; and additional needs - personal care and navigating his way around the local area.

133. The document includes details on how his needs in these areas would be supported, monitored, and reviewed. Under the heading of Support Child W's view was that he did not need support from staff, but the Worker's view was for staff in placement to continue to engage Child W and continue to support him in regards to his independence, education and health appointments.

134. Actions identified as follows:
- Child W to have his basic needs met.
- Child W needs age-appropriate stimulation so he can meet his full potential.

135. This was to have a detailed support plan which the Social Worker would monitor. This was to be delivered by the carers and Social Worker.

136. The plan is incomplete (in particular around "How will we know if things have worked or not worked?") and also contradictory in that it states in some places that Child W does not wish contact with his mother and stepfather and other that he is having this. It is however a comprehensive assessment of needs. It uses a comprehensive structure and allows the whole range of needs to be assessed and then addressed if needs be. However, the assessment is incomplete as stated above. This assessment does not seem to have been shared with other agencies e.g., mental health and this may have been helpful.

Minutes Care Planning Meeting - 07/09/18

137. Minutes from a Children's Social Care Care Planning Meeting that took place on 7 September 2018 state that Child W had been detained under Section 2 of The Mental Health Act (MHA) and is in Ancora House. Professionals involved will be led by Mental Health in addressing care planning for his future. It makes note of "*numerous missing from home episodes, suicide attempts*" since the last meeting. Of course, the assessment could be that Child W's mental health difficulties were not of a degree that would mean that it was appropriate for mental health services to adopt the lead role.

138. The plan describes that a package of support around Child W once discharged from hospital would be put into place and Wigan CAMHS would become involved with him ASAP.

139. I note that this Care Plan is incomplete with remaining areas not completed. Under 'Risks identified and mitigation' it states "*currently Child W is presenting with paranoia, psychosis (possibly drug-induced). He has made several attempts to commit suicide". Child W is described as being "a very poorly young man*".

140. The care plan is a comprehensive document that should have had information in the 'How will we know if things have worked or not worked?' sections.

141. Child W appears to have potentially had access to services. However, services did not have access to all the information held in various agencies about Child W, including incomplete records in General Practice and, importantly, CAMHS. It appears that when Child W moved across geographical boundaries that the relevant information did not necessarily follow him.

142. The lack of complete records must be seen as potentially compromising Child W's care; the assessment of his needs; and the assessment of his risks. Gaps in information may have meant that he had unidentified needs or that interventions that had been unsuccessful in the past were tried again. It is essential that information about a patient/service user is complete and accurate. Otherwise, care is compromised.

143. When a person is subject to a Care Order and the Local Authority has Parental Responsibility then it should be a core part of corporate parenting that the information held about that person is complete and accurate as well as being shared appropriately with other agencies/services in order to meet needs and manage risks.

KLOE 5: Explore the interventions Child W experienced in the later part of his life

Educational Psychology Service Report - June 2015

144. An Educational Psychology Service Report from June 2015 states that Child W had been referred to CAMHS for intervention and he "*engaged well but his difficulties continued*". An overview of the hypotheses developed by the Educational Psychology Service are outlined in paragraph 27.

145. These seem to be eminently sensible and helpful suggestions and would have been helpful to the professionals working with Child W both in terms of enhancing their understanding of Child W and his behaviour and making management plans to meet his needs. However, the Independent Reviewer is not certain if these were shared with the professional network or not.

Letter from NWBGM Control Room Triage to GP record – 01/09/18

146. In the chronology from WBCCG dated 1 September 2018 there is mention of a letter from NWBGM Control Room Triage to GP record. It states that Child W was in A&E awaiting treatment and assessment awaiting outcome of meeting from MASH Team. A history of deliberate self-harm noted, and the Police reported history of criminal damage, minor assault and anger related issues and then states, "*this in response to CSA as the victim*".

147. This does not appear anywhere else. What happened to this information? There does not seem to have been a referral made to Safeguarding.

Mental Health

148. Information in the chronology from Children's Social Care 2001 – 2005 suggests that Child W's behaviour was "extreme" and that CAMHS could have been involved. CAMHS involvement in Leeds and Carlisle during 2013 information is missing. In 2014 when Child W moved back to Wigan there does not seem to have been a transfer of care to Wigan CAMHS.

149. Child W was assessed in both Blackburn and Blackpool in August 2018 because of concerns about his mental health. The Independent Reviewer has not had sight of the assessment report from Blackpool, and it seems that the assessment report from Blackburn was not shared with all of the professionals involved in Child W's care in that the letter following the assessment was sent to Child W's GP but not copied to his Social Worker or to local Mental Health Services in Wigan.

150. QQ stated that Child W never got an appointment; that a referral never went through; and that local services did not know that Child W had been in contact with mental health services in East Lancashire.

151. A document from WBCCG dated 28/02/19 entitled SCR Information Request Report states that not all GP records were available at that time and that those available dated from 11 September 2016 to 19 September 2018.

152. A report entitled Timeline of Agency Involvement for WBCCG GP services provided to the SCR suggests that there may have been missing GP records that have not been shared possibly as a result of Child W being registered at a number of different GPs throughout his life.

153. What appears clear is that the detail was not available, merely the GP coding for the contacts.

154. In 2012 there were mentions of low mood (on two occasions) and Separation Anxiety Disorder of Childhood. Again, these are coding entries and may relate to information being received elsewhere.

155. Similarly, in 2014 there is GP coding for "anger management counselling".

156. Information in chronologies and in documentation often describes that Child W did not attend appointments but that the whole DNA area has been re-thought and current practice would deem a child to be Was Not Brought rather than Did Not Attend. I am assured that this is reflected in current policies and procedures.

157. A note on the chronology dated 31/12/14 (covering that calendar year) states that Wigan CAMHS reported that Child W was not in a stable enough placement for CAMHS involvement. Whilst this may be the case for some interventions e.g., psychodynamic psychotherapy there would have been interventions that were possible, despite the placement not being stable including:

- CAMHS being part of the professional network in order to provide advice to the non-CAMHS professionals involved.
- “Here-and-now” interventions – such as anger management or medication (if indicated)
- Risk and/or Needs Assessment.
- Advice on the type of placement that may have benefited Child W if the current placement was not stable.

158. There seems to be significant amounts of information that is not present in Child W’s records as a result of his repeated moves. Significant information could be contained within these records e.g., what types of therapeutic input had been offered previously; what approaches had worked or not worked; what Child W’s experience of therapeutic input had been like (including were there any specific reasons why he found it so hard to trust adults); had he felt that his trust been breached leading to issues with trust; what the context for his previous referrals and difficulties has been etc.

159. Child W does not seem to have been offered non-verbal therapy. Professionals found it difficult to engage him in verbal therapies and this could have been tried. The Independent Reviewer is not aware however if such therapy is available in Wigan.

160. There does not seem to be a single document and/or agency that has all the information about Child W. This must have an impact on the ability of agencies involved in his care to effectively plan for his care and to assess his risks and needs.

161. There clearly is a need for further knowledge for professionals about other professionals' roles and responsibilities and the frameworks need work within. This should include when to consider Secure Accommodation and when to seek legal advice.

162. According to Child W's brother QQ there was a lack of communication between Blackburn and Wigan Mental Health Services.

Sexual Behaviour and concerns regarding threats to life

163. This next section will explore agencies responses to Child W's statements that he was a paedophile; that he had been involved in inappropriate sexual behaviour; that his family/his father were going to kill him; and that he had been filmed engaging in sexual activity.

17/08/18	A disclosure is made by Child W about appearing in a pornographic video but this does not appear to have followed-up or actioned in any way whatsoever.
29/08/18	Entry in chronology from CSC that Child W had returned to his placement extremely upset as there was "a price on his head". He "would not" disclose any further information.
31/08/18	Entry in the chronology by CSC stating that Child W had disclosed to the Police that he had been in a sexual video with somebody underage and that this had been shared with his family. He stated that he was "a dead man". When missing in Blackpool he had also told another adult about the video.
31/08/18	Entry in chronology by CSC states that there was a Strategy Discussion held in part as a result of Child W's disclosure. Information was shared that "his family had found out that he was gay and had seen a pornographic video of him and that his family were going to kill him".

164. Child W's Social Worker was not aware of any pornographic video. They were aware that Child W had a couple of girlfriends, but they were deemed age appropriate. There does not seem to have been a Strategy Meeting or a referral to Safeguarding.

165. A document entitled Record of Strategy Discussion from a Strategy Discussion held on 31/08/18 states that this was held by telephone. Child W was reported missing from home on 30/08/18 and subsequently located in Blackpool. Child W is described as having stated to a Police professional and the staff at the care home in Blackpool that he cannot return to Wigan "as his family are going to kill him". When asked why he stated, "*they have found out that he is gay as they have seen him in a porn video*".

166. Child W is described as being extremely anxious and professionals are described as being concerned he was experiencing psychosis. The Police Officer in Blackpool felt

that Child W may try and run away should he be made to come back to Wigan. The Police Officer was advised that if there were concerns for Child W's mental health he needed to be taken to hospital or Paramedics called to review him. Child W declined to go to A&E and was taken back to his placement and ran away on return.

167. Child W was placed in a staff car to return to Wigan and the Police followed this onto the motorway because of concerns he would jump out of the car. Child W later accused staff of being liars and that he was going to be put into a Secure Unit. He also reiterated that he was "*in danger*" and was "*a dead man*". He asked to go to A&E but stated he wanted to go to A&E in Blackpool. Staff believed that he would abscond if he was taken to hospital in Blackpool so offered to take him to Wigan A&E but he refused.

168. In the chronology from WBCCG dated 01/09/18 there is mention of a letter from NWBGM Control Room Triage to GP record. It states that Child W was in A&E awaiting treatment and assessment awaiting outcome of meeting from MASH Team. A history of deliberate self-harm noted and the Police reported history of criminal damage, minor assault and anger related issues and then states "*this in response to CSA as the victim*". The Independent Reviewer has not been able to find out more information about this.

169. In the letter from RAID/CAMHS Wigan dated 02/09/18 it states that Child W had a Mental State Examination. In this he reported low mood and he made reference throughout the assessment to "*others being aware that he was a nonce and a paedophile*". He did not make eye contact, rarely lifting his head other than when he was distressed by the auditory hallucinations where he was observed to sit up and cover his ears in a distressed state.

170. Child W presented as paranoid, reporting that his father was trying to kill him. He was paranoid about care staff at the first residential setting he was residing in that he reported them being able to intercept his text messages that were sent to his phone. He had smashed up his phone as a result.

171. Child W spoke about staff on the ward and stated that he was aware that when staff look at him that he is aware they are not believing him and telling the doctor that he is not telling the truth so they can discharge him to be killed.

172. In NWBH note dated 02/09/18 Initial Assessment by Rapid Assessment & Interface Discharge Team (RAID) it states that Child W stated that he was not feeling safe at his then placement as he "*has a fear that his family are looking for him and are attempting to kill him*".

173. Child W stated that he does not feel safe in the community as he will take his own life as he has been followed by his family who want to kill him. He reported that he felt safe in the hospital as he had thrown all his clothes away so could not be traced. The boots and all of his clothing were in the ward sluice where he had asked for them to be incinerated.

174. A Referral for Access Assessment into Inpatient Services for Children and Young People form dated 04/09/18 was completed by Clinical Lead at RAID services in Wigan states: "*A full history is given including his fears that "he is going to be killed by his father or he needs to kill himself as he is a nonce". Child W reported that people are now aware that he is a paedophile although he was unable to explain why others think of him in this way.*"

175. A Mental Health Act Assessment Form dated 06/09/18 follows him being assessed whilst he was under Section 136. This states that Child W was unknown to CAMHS prior to these presenting concerns (which is not correct as he had been seen by a number of CAMHS services in other areas and had been referred to and discussed with Wigan CAMHS). It describes him hearing persecutory voices telling him to kill himself and states that he had attempted to ligature himself and had cut himself with plastic. A history of cutting his arms is noted. He is described as hearing voices encouraging him to kill himself and has been actively suicidal.

176. The history is noted. He was described as being happy to engage in the MHA assessment although he remained in bed and presented as tired and lethargic. He described hearing voices that were "*always there*" and told him to kill himself and called him "*a nonce*". There were in internal space and intrusive to his thoughts. They had been present for a month. The voices were of his "*dad*", QQ, his girlfriend, and a cousin. The voices said that his "*dad*" wanted to kill him and he should kill himself. He had attempted to hang himself by tying his hospital gown to the roof. He explained that he absconded because the voices told him that his "*dad*" was coming to get him to kill him. The voices said "run" so he got on a train. The next stop was Preston where he tried to self-harm in the station toilets.

177. Child W stated he was unsure whether the voices were real or not.

178. A document entitled Baseline Summary (undated but appears likely to be 06/09/18) written by a Mental Health Practitioner from Ancora House contains the recent history. This document states that Child W reports that he gets his cannabis "for free" and there does not seem to be any effort to understand why this might be. This should have been explored further and Child W should have been seen as potentially vulnerable as a result of this.

179. This document states "*Child W appears preoccupied at times with thoughts that he is evil and a paedophile, he is unable to state why he believes this is the case but expresses thoughts that he believes people, particularly his father will try and kill him as they know he is a paedophile*".

180. The Mental State Examination on admission states that Child W was dressed in hospital pyjama bottoms and a t-shirt and states that he does not have clothes or toiletries yet. He was disinhibited on occasions and was not aware of it (no detail).

181. He was responding to unseen stimuli and stating that he could hear me say he is evil. He was distracted at times. He sat with his head down with his hair covering his face.

He reported that this was due to his thoughts that people think his eyes showed he was evil.

182. In the formulation Child W's presentation was described as being "*consistent with an expected presentation where a young person has experienced significant trauma and neglect*". It goes on to described Child W reporting auditory hallucinations and paranoid beliefs; hears voices telling him to end his life and harm himself and he believes that people are trying to harm him as they believe he is a paedophile. Child W reports that these symptoms have begun in the past view months and a full assessment of his mental state is required to ascertain the nature of these thoughts.

Ancora House Case Notes

183. 06/09/18: Child W tells admitting doctor that he hears voices telling him that "*his father is going to kill him*". He also tells the admitting doctor that he had been told that he had been abused as a child but that he did not have memories of that himself.

184. 06/09/18: The admitting doctor's case note entry includes a risk assessment which considers Risk to self; Risk to others; and Risk from others. Child W was worried that "*his father wants to kill him but couldn't say why, otherwise wasn't concerned about any specific individuals*".

185. 06/09/18: Child W was seen by his Responsible Clinician. He described voices telling him that he is "*evil*" and "*a nonce*" and that he needed to be dead. The voices commanded him to harm himself by either hanging or slitting his wrists. He reported that he had tried to hang himself as a result. He admitted to suicidal ideation.

186. 07/09/18: case note entry – Child W stated that he did not want to return to the Wigan area because "*his dad wants to kill him*".

187. 07/09/18: Child W spoke to a Clinical Support Worker about his belief that he was "*a nonce*". He stated that he had told people this for over a year but could not remember why he thought this. He believed that it may be something to do with his 13-year-old sister but was unsure. Child W stated that he told his brother that while he was at his care home that a staff member looked through his mobile phone and found a video on there. Child W would not state what this depicted.

188. The Clinical Support Worker made a Safeguarding Children note in the electronic case notes detailing the conversation and emailed the CWP Safeguarding Team with the details requesting advice. A response was sent the same day, but the Clinical Support Worker did not see this prior to them taking a period of leave. The advice was to contact Child W's Social Worker and make them aware of the information. It does not appear that this was actioned.

189. 07/09/18: Child W spoke to a nurse and indicated that at the age of 15 he had sex with a 25-year-old woman and again when he was 16. He added that he had had sex with ten females most of whom were older than him (and implied as being significantly older

in the context of the conversation). Child W also stated that when he was aged 14 that he had sex with a 13-year-old girl. He showed the nurse his back which had "*numerous stretch/growth marks*" and stated "*she put all these scratches on my back and scarred me."*

190. The Nurse made a Safeguarding Children note in the electronic case notes detailing the conversation and emailed the CWP Safeguarding Team. A response to the email was sent on 10/09/18 with the advice being told make Child W's Social Worker aware of the information and "*If factual, may indicate child sexual exploitation in relation to the older women*." It also asked if the names of the sexual partners were known. The Nurse did not note the response until they were back on shift, but this was after Child W's death. It does not appear that this information was passed on the Child W's Social Worker. The CARSO was not updated.

191. A Datix (an electronic incident form) was completed but the CARSO was not updated. There does not seem to have been any liaison with Safeguarding about his statement about just finding out that he had been abused as a child. This was a missed opportunity to further explore this with Child W, at least to ascertain where he had learned this and what form the abuse had taken. Potentially the opportunity to have therapeutic input was missed.

The Initial Care Programme Approach (CPA) Review - 12/09/18

192. The Initial CPA Review took place. Apologies were received from Child W's Social Worker; the Manager of Wigan CAMHS; and staff from the care home. The Duty Social Worker Wigan attended as did a member of staff from Wigan CAMHS. Apologies were also received from Fairhaven bed management team who indicated that they were not aware of the meeting.

193. Minutes initially state that since admission there has been no evidence of psychosis in Child W's presentation. However, it goes on to state "*on admission he was guarded at times, over-familiar at times, some disinhibition, excessive showering; preoccupied with thoughts that he is evil and a paedophile and preoccupied with thought he had been rejected by his family"*. Yesterday Child W reported that voices have diminished, showed no remorse about assault to peer and threats to assault staff. Some preoccupation about being evil/not of a delusional intensity; some over-familiarity (with his Responsible Clinician) at times. There does not seem to have been any challenge or comment from other professionals about Child W's presentation.

Electronic Discharge Summary - 18/09/18

194. The Electronic Discharge Summary includes the following information: "Child W appears to experience intrusive thoughts about being evil; other people believing he is evil and being a paedophile. It is unclear how long he has been experiencing these

difficulties but Child W states that this has been gradually getting worse over the past few months."

KLOE 5 - Independent Reviewer Concluding Comments

195. In the information provided Child W is reported to make a number of statements that raise concern – that he is a "*nonce*" or a paedophile; that he is "*evil*"; that his family or his 'father' are going to kill him; that there is a video in circulation of him being involved in sexual activity with someone underage; that he is gay; and that he had been involved in sexual activity with older females (at least one of whom is 26). Additionally, there is a statement about his being the victim of Childhood Sexual Abuse.

196. These statements are generally not acted on. On two occasions in Ancora House members of staff (a Clinical Support Worker and a Staff Nurse) sent emails to the Safeguarding Team seeking advice. The advice was sent by email but both clinicians were either on leave or rostered off duty when the replies came through and did not access these emails until after Child W had died.

197. These disclosures were made to a range of agencies – Children's Social Care; the Police; Wigan CAMHS/RAID; and CWP inpatient staff.

198. It appears that professionals in general made assumptions that these statements were part of Child W's mental health difficulties and not based in reality. No professional other than those mentioned above in Paragraph 7.217 referred this information on to Safeguarding. No professional seems to have undertaken (or at least attempted to undertake) a psychosexual history with Child W. This was not a part of any assessment documentation provided, including the inpatient clerking. This should have included information about his sexuality, thus possibly clarifying the statements about his being gay, and about his being a paedophile.

199. If Child W was sexually attracted to children this potentially placed other residents in his placements as well as other inpatients at Ancora House at risk. This does not appear in any risk assessment documents provided to the Independent Reviewer.

200. Likewise, Child W reported that he had been sexually active with older females. This was reported to the CWP Safeguarding Team but the advice received was only accessed after his death.

201. The statements that his family/his father were going to kill him do not appear to have been explored.

202. The Independent Reviewer has no way of ascertaining whether Child W's statements were based in reality or were part of his symptomatology. However, what is clear is that he made these statements between 17/08/18 and 12/09/18 and they are mentioned in the Discharge Letter of 18/09/18.

203. There were potentially missed opportunities to understand Child W's presentation and to keep him safe by the lack of professional curiosity about the range of statements that Child W made. He could have been involved in sexual activity with underage children and/or adult females; he could have been struggling with his sexuality; he could have been the victim of exploitation (pornographic video; free cannabis; sexual exploitation etc); and there may have been a risk from his extended family. These were not explored by the professionals involved.

204. When QQ was asked about Child W's statement of being "*a nonce*" QQ described he had an inkling what this was about. He described that their mother had a girl called MM living there who was aged 13 and that she had tried to set Child W up with her.

205. QQ was not sure whether anything had happened with MM or not. However, he described MM as being "*very upset*" when Child W died and described that she has his name tattooed on her body. When asked about the statements about under-age sex and being gay QQ stated that he had only heard these at the Inquest. QQ stated that he asked Child W's friends who did not believe that Child W had been gay. QQ described him as being more of a "*ladies' man*".

206. When asked about whether Child W had expressed any concerns about his sexuality Child W's mother and stepfather reported that they were not aware of any issues around his sexuality and that he talked about girls. They were clear that if Child W had not been heterosexual that they would not have had a problem with this.

207. There appears to be no formal psychosexual history or any detailed forensic history in any of the records provided. It is unclear how his forensic history was explored i.e., was Child W asked about previous convictions/Cautions etc or was he asked about involvement in criminal behaviours such as fighting aggression, stealing, fire setting etc. Making assumptions that a young person who has no convictions or Cautions has not been involved in high-risk behaviours such as interpersonal violence or fire setting can lead to significantly impaired assessments of risk and needs. Similarly, not taking an appropriate psychosexual history can lead to important information not being gained e.g., worries about sexuality, being the victim of sexual abuse etc.

208. Issues about communication and safeguarding are included elsewhere in this report.

Standard of Care Ancora House

209. The CWP SI Comprehensive Investigation Report states: "*With regards to the overall quality of care provided this was deemed "good*". *The Psychiatrist on the Panel concurred with the initial impression of First Episode Psychosis and the change to Acute Intoxication of Cannabinoids and Mixed Disorder of Conduct & Emotions*."

210. The treatment offered to Child W was in general within expected standards. The medication regime (PRN) was as expected. He has regular contact with his Responsible Clinician. His wishes about not having contact with his family were respected.

211. The CWP Investigation Report highlights some issues about Child W's care:

- Ancora House staff to be provided with additional support in the identification and response to challenging behaviour.
- Ancora House Management to ensure compliance with the process and documentation of Section 17 leave.
- Further development of the psychology team (an increase in the numbers in post) was discussed. Internal standards for psychology input were to be explored with the CAMHS Clinical Director.

Wigan CAMHS/RAID

212. Child W seems to have engaged with the CAMHS/RAID Worker well. The assessment is thorough and appropriate advice was sought and acted upon. Communication between professionals (both within agencies and between agencies) was good. The risk assessment did contain a formulation of risk although there were areas that could have been included. It did not seem that a formal risk assessment tool was used.

213. **Independent Reviewer Recommendation 6:** Agencies should review their risk assessment procedures and develop urgent action plans to improve practice. Consideration could be given to using a formal tool e.g., STAR to aid in the assessment of risk.

WWL Inpatient Stay

214. During his admission to WWL in Wigan Child W attempted to hang himself. From the information provided it is unclear how he did this. If he managed to attach a ligature to part of the fixtures and fittings of his hospital accommodation, then it is essential that a Ligature Point survey be undertaken to ascertain if there is a need for modifications to prevent other patients from doing the same thing.

215. **Independent Reviewer Recommendation 7**: WSCB should seek assurance from WWL that Ligature Point surveys have been completed and that patients are safe.

Good Practice

216. There were areas of good practice noted as follows:

- The CWP Safeguarding Practitioner received an email from the Named Nurse in NWB Healthcare on 14 September 2018 to thank her for her input into the meeting.
- Two members of staff from Ancora House made referrals to the CWP Safeguarding Team when Child W discussed issues that raised safeguarding concerns. One of

these concerned Child W stating that he had engaged in sexual activity with adult females.

- Multiple staff from the unit were noted to have offered support to both Child W and the Support Worker following his discharge on 18 September 2018, including two Clinical Support Workers; his Responsible Clinician; and the Unit Manager.
- There is evidence of good practice by the Police in terms of Operation Madison on 17 July 2015 – this took the form of monthly meetings between the Police and residential staff following concerns about the vulnerability of the residents
- QQ stated that some professionals had been supportive to him naming "JJ, KK, and LL". He was asked if he wanted his brother's possessions and asked about funeral arrangements. However, he stated that nobody had checked if he wanted support and stated "they hid from Mum" i.e., professionals.

Support Provided After Child W's Death

Family

217. QQ stated that some professionals had been supportive to him naming professionals "*JJ, KK, and LL*". He was asked if he wanted his brother's possessions and asked about funeral arrangements. However, he stated that nobody had checked if he wanted support and stated "*they hid from Mum*" i.e., professionals. QQ stated that he asked if the person who had found Child W after he had died had received support. The Independent Reviewer was assured that this person was offered support from agencies involved but declined this. QQ described that he saw his own GP and was referred to 'Minds Matter' but this was not helpful. He felt that he would benefit from more longer-term input in terms of therapy.

218. Child W's mother described that they were told about Child W's death by the Police who had been "*really nice*" and explained more than Social Services had. His mother stated, "*Social Services didn't want to tell us anything*". Child W's mother did acknowledge that support was offered to the family.

219. RR (younger sister) had six months of support from Rainbow at school in terms of bereavement work, but Child W's mother stated that she had had to ask for this.

Professionals

220. As part of the Practitioner Learning Event frontline staff were asked about the provision of support in light of Child W's death from their agencies to them. A number of professionals from a number of agencies reported that they were either informed of Child W's death by email or heard by chance from other professionals. Details of funeral arrangements etc. were not circulated. In contrast other agencies very clearly offered their staff support, either in-house or by signposting them to appropriate agencies.

221. Of note, professionals who had previously been involved with Child W (including those with significant amounts of involvement with him) were not necessarily informed as at the time of Child W's death they were not actively involved in his care/case.

222. It was not felt by practitioners that it would have been difficult to find out who had worked or was working with Child W and consideration must be given to how staff are informed and supported through difficult situations, including the death of a person who they have worked with professionally.

223. The Independent Reviewer has concerns about both how the sad news of Child W's death was communicated (or not) in some agencies and the lack of support offered to some professionals.

224. **Independent Reviewer Recommendation 8**: Wigan Safeguarding Children Board should seek assurance that agencies have reviewed their procedures for both informing staff about the death of a patient/service user that they are/did work with and what procedures are in place to offer appropriate support to affected professionals.

KLOE 6: Establish learning from critical episodes which are identified through the SCR process.

225. The Independent Reviewer is of the view that the following represent areas where lessons need to be learned and Wigan Safeguarding Children Board should wish to be assured that agencies have put Action Plans in place to do so.

Risk Assessment

226. The vast majority of documents that are denoted “Risk Assessment” that the Independent Reviewer has seen have been lists of risk factors. There is rarely any attempt to formulate or describe risk (including factors that will potentially increase or decrease risk) or to generate a risk management plan.

227. This is true across all health and social care agencies involved. Therefore, these agencies should review their risk assessment procedures and develop urgent action plans to improve practice.

228. For example, if the risk of self-harm is related to a diagnosis of depression and more likely when the patient uses alcohol and seems related to a history of childhood sexual abuse then the risk assessment should include factors in the formulation such as:

a) The risk is increased when the patient’s mood is low

b) The risk is reduced when the patient’s mood is normal or good

c) The risk is increased when the patient is non-compliant with their medication

d) The risk is increased when alcohol has been taken

e) Input to help the patient overcome the adverse effects of being the victim of childhood sexual abuse may reduce the risk of self-harm in the longer-term but may actually increase the risk in the short-term.

229. The risk assessment will lead to a statement about the imminence and/or severity of the risk (e.g. the risk is high when the patient does not take her medication and does consume alcohol).

230. The risk management plan could include elements such as:

a) The prescription of an antidepressant that is both effective but safer if taken in overdose.

b) Providing verbal therapy sessions on a regular basis.

c) Regular monitoring of mood, including for thoughts, plans, and acts of self-harm/suicide.

d) Increased support around the start of therapy sessions.

e) A plan on how to manage distress and thoughts of self-harm.

Safeguarding

231. There are several issues that are seen as crucial in this area. It appears that although Child W made a number of statements to a range of professionals that fall under the safeguarding umbrella that his voice was not truly heard.

232. In general, there was a lack of professional curiosity about several statements made by Child W relating to his sexuality, sexual activity with underage people and an older female, pornographic material, threats to his life, obtaining cannabis for free and that he was a victim of childhood sexual abuse.

233. The Independent Reviewer does not know if any of these statements were factually correct or if they represent his mental illness. Child W certainly stated them over a period of several weeks to a range of professionals.

234. Only two referrals were made to designated Safeguarding Leads/Teams (both to the CWP Safeguarding Team whilst Child W was an inpatient in Ancora House) but the advice provided was not accessed due to the professional being either on leave or not rostered for duty.

235. It appears that assumptions were made that these statements were made by Child W as part of his mental illness. There were few efforts made to discuss any of these in more depth. It is possible that had this happened that professionals' understanding of Child W and his presentation may have been more accurate and care plans and risk assessments more accurate and relevant.

236. **Independent Reviewer Recommendation 9:** Agencies should review safeguarding policies and training to ensure that staff don't discount safeguarding disclosures when they are made by children and young people with mental health presentations. Staff should seek support and advice from their Safeguarding Team.

Responsibility for engagement

237. Another recurring theme throughout the documents provided is the language used to describe Child W and his difficulties accessing the support offered. The responsibility for him engaging with professionals is almost always placed with him. Statements such as "*you failed to engage*" occur liberally throughout the documents received.

238. The Independent Reviewer's view is that the responsibility for engaging children and young people lies with the professionals. The language used about Child W was highly unlikely to promote his engaging with professionals. Additionally, the gaps in information, particularly about input from CAMHS Services in a range of geographical locations, may mean that professionals are not aware of a particular issue that arose leading to Child W struggling to trust professionals thus increasing their difficulty engaging him.

239. The Independent Reviewer Recommendation in response to this has been outlined in KLOE 1.

Action Plans

240. Independent Reviewer Recommendation 4 (outlined in paragraph 110) suggests that Wigan Safeguarding Children Board should seek assurance the Action Plans related to the NHS Serious Incident Investigations submitted by both CWP and NWB have been completed.

Support after the death of a child or young person

241. It was clear that Child W's family had been offered some support, but it seemed as though they were still struggling to come to terms with their sad loss.

242. Professionals described a range of experiences in relation to how they found out about his death and what support was available to them afterwards.

243. Independent Reviewer Recommendation 7 (outlined in paragraph 217) suggests that Wigan Safeguarding Children Board should seek assurance that agencies have reviewed their procedures for both informing staff about the death of a patient/service user that they are/did work with and what procedures are in place to offer appropriate support to affected professionals. This should ensure that staff are told such sad news in a personal as opposed to an impersonal manner and that appropriate support is offered (and this may include referral to external agencies).

Assessment

244. There appears to be no formal psychosexual history and no detailed forensic history in the records of any agency. It is unclear how his forensic history was explored i.e., was Child W asked about previous convictions/Cautions etc or was he asked about involvement in criminal behaviours such as fighting, aggression, stealing, fire setting etc. Making assumptions that a young person who has no convictions or Cautions has not been involved in high-risk behaviours such as interpersonal violence or fire setting can lead to significantly impaired assessments of risk and needs. Similarly, not taking an appropriate psychosexual history can lead to important information not being gained e.g., worries about sexuality, being the victim of sexual abuse etc.

245. **Independent Reviewer Recommendation 10:** The Independent Reviewer recommends that agencies should review their training and ensure that professionals take appropriate forensic and psychosexual histories to inform assessment of risk and needs and to manage the safety of others. The level of detail required will depend on the age of the patient/service user along with their history.

Accurate recording in case records

246. It is crucial that records contain information that is accurate, clear, and easily understood. This is especially important when it relates to risk (to both self and others). Entries must make it clear whether or not a person has been asked e.g., about thoughts of self-harm or not. An entry that states "*He denied any thoughts of self-harm*" makes it clear that the person was asked and denied having such thoughts. A statement such as "No thoughts of self-harm were reported" is much less clear – were they asked? Did they merely not say anything to the professional about this issue? Similarly issues around experiencing symptoms of mental illness or thoughts to harm others need to be written in a manner that is only open to one interpretation and makes it clear that the person was asked and denied having (or reported having) the symptom/thought.

247. The Independent Reviewer has a longstanding issue with how important issues such as the presence of thoughts of suicide/self-harm or the presence/absence of psychotic symptoms are recorded. It is crucial that records contain information that is accurate, clear, and easily understood. This is especially important when it relates to risk (to both self and others). Entries must make it clear whether or not a person has been asked e.g., about thoughts of self-harm or not.

248. Of course, it must be borne in mind that even if a patient/service user denies the presence of a symptom that this may not be the truth.

CAMHS Procedures

249. A note dated 31 December 2014 states that Wigan CAMHS reported that Child W was not in a stable enough placement for CAMHS involvement. Whilst this may be the case for some interventions e.g., psychodynamic psychotherapy there would have been interventions that were possible, despite the placement not being stable including:

- CAMHS being part of the professional network in order to provide advice to the non-CAMHS professionals involved.
- "Here-and-now" interventions – such as anger management or medication (if indicated)
- Risk and/or Needs Assessment.
- Advice on the type of placement that may have benefited Child W if the current placement was not stable.

250. **Independent Reviewer Recommendation 11:** Wigan Safeguarding Children Board will wish to seek assurance that CAMHS can and do provide appropriate input to young people, even when their placement is not stable.

251. Information in chronologies and in documentation often describes that Child W did not attend appointments. More recently health services have reflected on the use of the term "Did Not Attend" when children miss appointments. The term "Was Not Brought"

is now accepted as more appropriate as this reflects that children are brought to appointments by adults. This change in terminology ensures that there is a safeguarding focus when a child "Was Not Brought" to an appointment. I am assured that this is reflected in current policies and procedures and have been provided with the relevant algorithm.

Corporate Parenting

252. The Independent Reviewer feels that there are a number of issues for the Corporate Parenting Board to review/assess/address as follows:

- Automatic change of Social Worker at 16 with the move to the Leaving Care Team (the Independent Reviewer understands that this no longer happens).
- Issues of challenging discharge decisions.
- Understanding of the roles of other agencies and professions.
- Managing the needs of a young person who is an inpatient. There needs to be a clear procedure for what happens when a young person/child who is subject to a Care Order or whom Social Care have Parental Responsibility for is admitted to any hospital e.g. who will visit; what will be provided in terms of basic necessities and when; who will be the lead contact in Children's Social Care for the professionals to liaise with; and how will the professionals know who to contact?
- Risk and needs assessment.
- Meeting basic needs.
- Interagency working.
- Secure Accommodation Orders – when and how to use them and what they permit professionals to do.
- The other issues highlighted in this report for all agencies e.g., the language used to describe Child W and the impact of his experiences on his attachment abilities.

253. During his time at Ancora House Child W had insufficient attire and none was provided to him, certainly not in a timely manner. He was subject to a Care Order. If he was in the care of his biological parents and they failed to provide adequate clothing, then this would probably have raised safeguarding concerns, but this did not seem to happen in this case.

254. **Independent Reviewer Recommendation 12:** Wigan Safeguarding Children Board should seek assurance from Children's Social Care that the issues identified (see paragraph 252) in relation consistency in Social Worker, challenging discharge decisions, risk and assessment, meeting basic needs of LAC in hospital, and trauma informed practice have been addressed. This recommendation from this review should also be shared with the Corporate Board and added to the workplan.

Interagency Working

255. **Independent Reviewer Recommendation 13:** Wigan Safeguarding Children Board and individual agencies should explore opportunities to enhance existing training to include information about the roles, responsibilities, and remits of agencies working with children and young people. This would enhance understanding of other professionals' roles and lead to fewer misunderstandings and misperceptions.

Information Sharing

256. Child W moved to at least three different regions of England during his life (Wigan to Leeds to Cumbria and back to Wigan. He had input from a range of services including universal services, Children's Social Care, and CAMHS.

257. However, services did not have access to all the information held in various agencies about Child W, including incomplete records in GP and, importantly, CAMHS. It appears that when Child W moved across geographical boundaries that the relevant information did not necessarily follow him. Additionally, information was not shared between agencies e.g., Ancora House reported that they were not aware of some issues relevant to risk.

258. There seems to be gaps in Child W's records as a result of his repeated moves. Significant information could be contained within these records e.g., what types of therapeutic input had been offered previously; what approaches had worked or not worked; what Child W's experience of therapeutic input had been like (including were there any specific reasons why he found it so hard to trust adults); had he felt that his trust been breached leading to issues with trust; what the context for his previous referrals and difficulties has been etc.

259. Although universal services' (School Nurse, Health Visitor, and GP) records follow a child/young person other records seem not to (such as CAMHS, Health). This can lead to vital information not being shared with or even known about by those professionals charged with caring for and/or providing therapeutic input to that child/young person. Information that could inform risk assessments; needs assessments; therapeutic input; and choice of therapist amongst others is potentially missing.

260. Although WSCB may not be able to effect change on its own in relation to effective sharing of health records, this could be escalated centrally.

261. There does not seem to be a single document and/or agency that has all the information about Child W. This must have an impact on the ability of agencies involved in his care to effectively plan for his care and to assess his risks.

262. **Independent Reviewer Recommendation 14**: WSCB should seek assurance that agencies have reviewed their information sharing procedures and made amendments if necessary.

Secure Accommodation Orders

263. Was there consideration given to Child W being made subject to a Secure Accommodation Order given concerns about the risks he presented i.e. that he has a history of self-harm; history of absconding; and presents a risk to himself and others? If not why not? The Independent Reviewer has not seen any documentation to say that a Secure Accommodation Order was considered and discounted or even that it was considered. Would this have been the same if Child W were female?

264. **Independent Reviewer Recommendation 15:** Wigan Safeguarding Children Board should seek assurance that agencies make detailed notes when significant issues are considered, including an analysis of the potential positive and negative outcomes as well as what the alternative solutions could be.

265. **Independent Reviewer Recommendation 16:** Children's Social Care need to ensure that Social Workers understand when to consider Secure Accommodation and when to seek legal advice. Training or guidance should include information about Secure Accommodation Orders, including how to apply for one; when their use is appropriate; and what a Secure Accommodation Order permits professionals to do (and what it does not permit them to do).

Forensic Child and Adolescent Mental Health (FCAMHS) Assessments

266. In view of Child W's history of potentially having contact with the criminal justice system as a result of his behaviours (Section 39 Assault, criminal damage, and threats to cause damage), in combination with his mental health needs was there consideration of Child W being referred to the Forensic CAMHS Service in Manchester for a consultation and/or assessment?

267. **Independent Reviewer Recommendation 17:** WSCB should seek assurance that agencies are aware of Forensic CAMHS North West and how to access their services (including which young people are appropriate to refer and what services FCAMHS North West offer)

OVERVIEW OF INDEPENDENT REVIEWER RECOMMENDATIONS

KLOE and Number	Recommendation	Theme
KLOE 1		
Recommendation 1	WSCB should seek assurance that all agencies work with children and young people in a way that considers the consequences of attachment difficulties. This ethos should be included in the following: • Workforce development and training • Agency assessment and planning documentation • Trauma-informed practice • The use of professional language • How professionals engage children and young people.	**Trauma Informed Practice**
KLOE 2		
Recommendation 2	Agencies involved should explore the issues raised in this report regarding Risk Assessment; Risk Formulation; and Risk Management. They should consider the need for further workforce development and strengthening of existing policies and processes.	**Risk Assessment**
KLOE 3		
Recommendation 3	WSCB should seek assurance that agencies are working with children and young people in a way that places the responsibility for engaging children and young people and their families with professionals and that professionals use appropriate language in records which reflects this responsibility.	
Recommendation 4	WSCB should ensure that escalations made regarding unsafe discharge are shared with the Designated Nurse at WBCCG in line with the agreed escalation policy.	**Escalation**
Recommendation 5	WSCB should seek assurance that the actions from the NHS SI Investigations have been completed.	**Assurance RE: NHS SI Processes**
KLOE 5		
Recommendation 6	Agencies should review their risk assessment procedures and develop urgent action plans to improve practice. Consideration could be given to using a formal tool e.g. STAR to aid in the assessment of risk.	**Risk Assessment**
Recommendation 7	WSCB should seek assurance from WWL that Ligature Point surveys have been completed and that patients are safe.	**Assurance RE: NHS SI Processes**

Recommendation 8	WSCB should seek assurance that agencies have reviewed their procedures for both informing staff about the death of a patient/service user that they are/did work with and what procedures are in place to offer appropriate support to affected professionals.	**Policy/Procedure**
KLOE 6		
Recommendation 9	Agencies should review safeguarding policies and training to ensure that staff don't discount safeguarding disclosures when they are made by children and young people with mental health presentations. Staff should seek support and advice from their Safeguarding Team.	**Safeguarding**
Recommendation 10	Agencies should review their training and ensure that professionals take appropriate forensic and psychosexual histories to inform assessment of risk and needs and to manage the safety of others. The level of detail required will depend on the age of the patient/service user along with their history.	**Assessment**
Recommendation 11	WSCB should seek assurance that CAMHS can and do provide appropriate input to young people, even when their placement is not stable.	**Service Provision - CAMHS**
Recommendation 12	WSCB should seek assurance from Children's Social Care that the issues identified (see paragraph 252) in relation consistency in Social Worker, challenging discharge decisions, risk and assessment, meeting basic needs of LAC in hospital, and trauma informed practice have been addressed. This recommendation from this review should also be shared with the Corporate Board and added to the workplan.	**Children's Social Care and Corporate Parenting**
Recommendation 13	WSCB and individual agencies should explore opportunities to enhance existing training to include information about the roles, responsibilities, and remits of agencies working with children and young people.	**Workforce Development**
Recommendation 14	WSCB should seek assurance that agencies have reviewed their information sharing procedures and made amendments if necessary.	**Policy/Procedures**
Recommendation 15	WSCB should seek assurance that agencies make detailed notes when significant issues are considered, including an analysis of the potential positive and negative outcomes as well as what the alternative solutions could be.	**Record Keeping**
Recommendation 16	Children's Social Care need to ensure that Social Workers understand when to consider Secure Accommodation and when to seek legal advice. Training or guidance should include information about Secure Accommodation Orders, including how to apply for one; when their use is appropriate; and what a Secure Accommodation Order permits professionals to do (and what it does not permit them to so).	**Workforce Development – CSC**
Recommendation 17	WSCB should seek assurance that agencies are aware of Forensic CAMHS North West and how to access their services (including which young people are appropriate to refer and what services FCAMHS North West offer).	**Awareness of Service Provision**

APPENDIX 1: GLOSSARY OF TERMS USED

1. WSCB: Wigan Safeguarding Children Board (now Wigan Safeguarding Partnership (WSP))
2. WBCCG: Wigan Borough NHS Clinical Commissioning Group
3. CWP/CWPT: Cheshire and Wirral Partnership NHS Trust
4. NWB/NWBH: North West Boroughs Healthcare NHS Trust
5. WWL: Wrightington, Wigan, and Leigh NHS Foundation Trust
6. BWCH: Bridgewater Community Healthcare NHS Foundation Trust
7. CAMHS: Child and Adolescent Mental Health Services

8 Tier 4: Child and Adolescent Mental Health Inpatient Services/Units

9. RAID: Rapid Assessment and Interface Discharge
10. Datix: an electronic incident recording system used in some NHS Trusts
11. CSC: Children's Social Care
12. TAC Meeting: Team Around the Child Meeting
13. CiN: Child/ren in Need
14. IOPC: Independent Office for Police Conduct
15. SI: Serious Incident / SINE Panel: Serious Incident and Never Event Panel
16. RHA: Review Health Assessment
17. MHA: Mental Health Act
18. DoLS: Deprivation of Liberty Safeguards
19. CPA: Care Programme Approach
20. CLA Review: Child Looked After Review
21. CARSO: Clinical Assessment of Risk to Self and Others
22. CSA: Childhood Sexual Abuse
23. MASH Team: Multi-Agency Safeguarding Hub
24. PRN: pro re nata i.e. as required

APPENDIX 2: ANONYMISATION USED

1. Child W – the young person that this report is about

2. QQ – his older brother who was interviewed as part of the process

3. RR – one of Child W's younger siblings

4. MM – a teenager living with Child W's mother and stepfather

5. JJ – a professional mentioned by QQ

6. KK – A professional mentioned by QQ and in the admission records from Ancora House

7. LL - a professional mentioned by QQ

Appendix 3: CARSO:

Harm to Others Factors

1. Concern has been expressed about others about risk of harm to others.
2. Current violent or threatening or impulsive or abusive behaviour.
3. Past violent or threatening or impulsive or abusive behaviour.
4. Violent or abusive thoughts or fantasies.
5. Misuse of drugs/alcohol
6. Possession of weapons with possible intent to use
7. Has access to potential or threatened victim
8. Being victimised/bullied/harassed
9. Has problems controlling temper
10. Witnessed or a victim of violence or sexual or emotional abuse in childhood
11. Living alone (or will do so after discharge)
12. Has symptoms which increase risk of this person harming others
13. Malnutrition (consider malnutrition risk screening tool)
14. Incontinence
15. Risk of accidents
16. Self or others
17. Driving risk
18. Is physical health affected by current mental state (has physical health check been completed)
19. Problem/compliance with prescribed/non-prescribed medication
20. Condition of skill/tissue viability (consider tissue viability screening tool)

Harm to Self

1. Any previous suicide attempts, deliberate self-harm, and/or unintentional self-harm.
2. Family history of suicide
3. Major mental illness
4. Intent to end life
5. Social isolation
6. Feelings of hopelessness or lack of control
7. Disengagement from services or non-compliance
8. Loss or threat of loss
9. Physical illness or disability
10. Learning disability or intellectual disability
11. Concern expressed by significant others
12. Recent discharge from hospital
13. At risk of absconding or going missing
14. Threats to privacy and dignity
15. Disinhibited behaviour
16. Impulsivity
17. Is the main carer for a child(ren) – Child Protection issues.
18. Is the main carer for a (potentially) vulnerable adult
19. Problems with mobility ? risk of falling (consider falls assessment screening tool)

Harm from Others (particular relevance for CAMHS)

1. Physical abuse
2. Sexual abuse
3. Emotional abuse
4. Neglect/Lack of supervision

5. Exposure to domestic violence (may or may not be directed at patient)
6. Parental mental illness
7. Bullying/victimisation – including on-line
8. Exposure to war or torture
9. Exposure to gang crime
10. Risk of sexual exploitation
11. Child in Need
12. Parental substance misuse
13. On Child Protection Register

Appendix 4: Independent Reviewer: Dr Kenny Ross, Consultant Adolescent Forensic Psychiatrist

I am Dr Kenny Ross. I qualified in 1985 from the University of Dundee. I then completed General Practice Training before entering into Psychiatry in 1992. I completed Senior House Officer and Registrar Training in Psychiatry in Glasgow, gaining membership of the Royal College of Psychiatrists in 1996. I completed Higher Training in Child and Adolescent Psychiatry in 1999 and undertook a further year of training in Adult Forensic Psychiatry in order to be recognised to work in the field of Adolescent Forensic Psychiatry. I have been working in the Adolescent Forensic Service, Greater Manchester Mental Health NHS Foundation Trust since 1997 and took up a Consultant post in 2000. I have completed dual training in Forensic and Child and Adolescent Psychiatry. I am approved under Section 12(2) of the Mental Health Act 1983.

I was the Named Doctor for Safeguarding Children for Greater Manchester Mental Health NHS Foundation Trust for many years until 2018 when I reduced my hours. Since October 2018 I have provided an in-reach session to Barton Moss Secure Children's Centre weekly and continued my role as Guardian of Safe Working Hours for the Trust.

As Named Doctor I was a member of both Bolton Safeguarding Children Board and the local Child Death Overview Panel.

I have completed two previous Serious Case Reviews and one Serious Adult Review.

Dr Kenny Ross,
Consultant Adolescent Forensic Psychiatrist.

13 November 2020