Oxfordshire

Safeguarding Children Board

Serious Case Review

Child R

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Foreword

This is the first time that a foreword has been written by an Independent Chair of the Oxfordshire Safeguarding Children Board for a Serious Case Review as the time taken and circumstances are very unusual, I wanted to provide some background to those who read it.

This review is written for a young girl, who died eight years ago. She was 13 years old and in the care of the local authority. Family was really important for her and she felt a huge sense of responsibility for her younger siblings. The review will explain that she suffered great distress and mental health problems. However, there were also happier times when she felt settled and was able to enjoy her foster family and after leaving hospital, her residential home. She enjoyed school (and was far better at it than she thought she was) and especially liked reading, creative writing and drawing. She enjoyed playing cards, helping to cook meals and trips to the cinema. There were a lot of happy everyday activities as well as harder times when her experiences felt overwhelming for her.

Due to factors beyond the control of the OSCB, we have not been able to produce and publish a report, the type of report that she deserved in a timely manner. We know that she was much-loved by her family and friends. We know that those professionals in Oxfordshire, who supported her, also cared for her as they have remained in touch wanting to know the outcome of the review. We know that her loss is felt by many and that it has been very painful to have to wait such a long time for a review to be written.

The Serious Case Review has been held up by criminal investigations in two police forces and a Health and Safety prosecution. The OSCB knew that the outcome from these processes could potentially lead to some sense of justice for her family. In order to preserve the integrity of those investigations, we put on hold the review work until they were complete. This meant that there could be no contact between the independent reviewer and the professionals who were caring for her at the time of her death. We did however contact repeatedly the investigating police forces and the council leading the Health & Safety prosecution to check progress. Concerned about the length of time it was all taking, we explored other options and sought advice from the Department for Education as to what action we might take, but this did not lead to an earlier conclusion. The Health & Safety investigation did lead eventually to an outcome in Court. After seven and a half years the residential home where she was staying was convicted of breaches of health and safety legislation whilst she was in their care. The sentencing took place in November 2020 and the residential care provider was fined.

At the point of publication of the Serious Case Review, it is our understanding that the Senior Coroner has determined that there will not be an inquest.

Jane Wonnacott, the independent reviewer, has thoroughly considered these aspects of professional practice across all the relevant organisations. This includes looking at children receiving services more recently, to test whether improvements are real. Her report

provides the local safeguarding system with a constructive overview of learning that has been identified so far, as well as making recommendations for further action.

In conclusion, this Serious Case Review highlights the learning that has been achieved by agencies after examining their actions in this child's early life and exposes in sharp relief the work that is still needed at both national and local level to ensure the future safety and care of such vulnerable children.

It is my role and duty now to ensure the organisations in Oxfordshire continue to effectively address these challenges.

Derek Benson, OSCB Independent Chair on behalf of the Multi-agency Safeguarding Arrangements in Oxfordshire.

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1 INTRODUCTION

1.1 Child R was 13 years and seven months old when she died in February 2013 having taken her own life in an out of county residential placement over three hours travel time away from home. She had previously been in foster care and had been treated in an Oxfordshire in-patient psychiatric unit prior to moving to the residential home. The foreword to this review highlights the impact that Child R's death had on many people, not least her own family.

1.2 The primary reason for serious case reviews is to improve the safeguarding system and reduce the likelihood of similar events in the future. However, it is important that this report also gives Child R's family the fullest possible information about her contact with agencies in Oxfordshire and the area where the residential home was situated.

1.3 Due to the nature and circumstances of Child R's death, Oxfordshire Safeguarding Children Board had commissioned a serious case review in 2013 and the terms of reference for the review included consideration of events during the time Child R was in the residential establishment. However, due to concurrent inquiries by the Police and the Health and Safety Executive it was not possible to complete and publish a serious case review at that time.

1.4 Police inquiries in the area where the home was situated focused on whether a charge should be brought against the home for corporate manslaughter and in July 2018 these investigations concluded that would be no charges. There were also protracted Health and Safety inquiries, and it was not until September 2020 that the residential home pleaded guilty to a breach of health and safety legislation and two months later received a fine.

1.5 The inquest into Child R's death had been adjourned to allow criminal proceedings to take place. The coroner then considered whether there was sufficient reason to resume the inquest and reached the decision that the information presented to the Crown Court for the Health and Safety prosecution covered all the necessary statutory determinations and therefore it would not be necessary for it to resume.

1.6 In June 2021, further details became available from the coroner which pointed to the potential for important learning from Child R's time in the residential home.

Background to this report

1.7 Child R's death deeply affected many people, and from 2013 onwards, there has been a wish to understand what happened, why it happened and any lessons for future work with young people in similar circumstances. As a result, there have been a series of actions aimed at learning for the safeguarding system.

1.8 The serious case review that could not be completed in 2013 resulted in a 2014 summary report with recommendations for practice improvement which informed an action plan. The learning from the report was used anonymously in learning events

with practitioners to make sure that immediate learning was not lost, and practice improvements were implemented.

1.9 The intention in 2014 was to complete and publish the serious case review, after the conclusion of all criminal and health and safety investigations. This was to have included learning from Child R's time in the residential home and a new lead reviewer was commissioned. Taking the findings of the 2014 report as a starting point, the intention was not to re-review all original detailed material but to build on these findings when further information regarding the placement became available.

1.10 As it was increasingly unclear when the Health and Safety inquiries and out of county police investigations into the residential home would be completed, the decision was made by Oxfordshire Case Review and Governance Group (CRAG)[1] to undertake a 'systems test' in the form of a progress report which could test the Oxfordshire safeguarding system against the recommendations made by the original background summary report. This has been completed and the findings have been used in this report to identify where services in Oxfordshire have changed and developed.

1.11 When the Health and Safety proceedings finished, a serious case review was prepared for publication. This still did not include a full analysis of Chid R's time in residential care as all relevant information had not been made available to Oxfordshire Safeguarding Children Board. Then, in June 2021, when further information became available via the coroner, it was decided that there should be further consideration of all the available information and this report was commissioned.

1.12 The following three sections of the report set out a summary of Child R's contact with agencies. The intention is to help explain to those who knew and cared about her, what happened and where things could have been done differently. Since Child R's death there have been many changes in the way help is given to children and families and these were explored within the system check carried out by Oxfordshire Safeguarding Children Board. These are noted in this report, with a view to making sure that any recommendations from this review are focused on gaps that still exist and need addressing.

2 AGENCY INVOLVEMENT WITH CHILD R FROM BIRTH UNTIL SHE WAS ADMITTED TO HOSPITAL AT THE AGE OF 13

2.1 Child R and her siblings had been known to agencies in Oxfordshire all their lives due to concerns about physical, sexual, and emotional abuse and neglect. During the early part of their lives there were opportunities for all professionals to work better together to provide a comprehensive package of help and support, and to monitor whether this was meeting the needs of the children.

[1] Now known as Oxfordshire Child Safeguarding Practice Review Subgroup

The overall finding from the system test that concluded in 2020 is that it is now much more likely that there would have been a coordinated approach at an early stage when the difficulties in Child R's family came to light. There is a remaining challenge in developing confidence amongst all relevant practitioners to carry out early help assessments and ask the questions that will help understand the child's needs within their family context. This is acknowledged within Oxfordshire and actively being worked on to make sure that children with complex needs are identified early enough and the right help is given. Schools and health practitioners are recognised as an essential part of this system in relation to identification of need and intervention at this early help stage.

2.2 When the risks to the children's physical and emotional development were recognised, all the children became subject to child protection plans and subsequently Children's Social Care instigated care proceedings. Interim Care Orders were made in March 2005 and the children placed in foster care. The two youngest siblings were then returned to their parent's care, followed a month later by Child R and her sisters. Child R's return home was because of a recommendation by the Children's Guardian that all children should be returned home with a support package. In May 2005 care proceedings continued, the parents were no longer accepting the support package and there were escalating concerns about the care of the children. The Final Hearing took place in May 2006 and the court agreed with the recommendation of the Children's Guardian for a Supervision Order with directions for the parents to engage with support services.

2.3 By the end of the Supervision Order, concerns about the children in the family continued and the children remained on child protection plans until July 2008.

2.4 By 2010 Child R's school was describing concerns about her behaviour which was described as chaotic, unsettled, destructive, secretive, with limited concentration skills and a tendency to be bullied and marginalised by her peers. She was noted to be severely distressed, suicidal, frequently running to the school fence next to a railway line. She was referred to CAMHS for an assessment, the outcome of which was that she did not show signs of depression and self-harm, she did not have a diagnosable mental health problem and did not have ADHD. She was not taken to a follow up appointment in October 2010.

2.5 In June 2010 Child R's school reported that she had been tying a ligature around her neck and care proceedings started once again in respect of Child R and her siblings. At this stage Child R was living with her father and spending alternate weekends with her mother. In November 2010 the Judge did not agree to hear the case for Interim Care Orders and the Children's Guardian also did not support this approach. Instead, Interim Supervision orders were granted, and social workers continued to work with the family.

2.6 When Child R was age 10 (Autumn 2010) she alleged regular sexual abuse by a member of her family. She had told family members then who called uniformed police and Child R repeated her allegations. Child R was interviewed twice on video by

specialist police officers, but it was view of the police that it was not possible to pursue a prosecution due to insufficient evidence to give a realistic prospect of conviction. Child R told her social worker that she was worried that the family member would go to prison.

2.7 The episode left Child R feeling that she had not been believed and worried that she had not been able to protect her siblings. Children's Social Care decided that although criminal proceedings were not possible, they could pursue Child R's allegations through a Finding of Fact[2] in the family court.

2.8 Child R was seen by a CAMHS consultant in April 2011. There was still insufficient evidence to diagnose ADHD and she did not have a diagnosable mental health disorder. However, in view of the concerns about sexual abuse it was recommended that counselling should be provided by the early intervention team. At that time in Oxfordshire there were limited specialist counselling services for a child who had been sexually abused.

2.9 It was not until May 2011 that Interim Care Orders were granted by the court and Child R was placed with experienced foster carers. At this stage she had a place at a special school and a comprehensive care package was put in place to support the placement.

2.10 The Finding of Fact hearing in June 2011 concluded that Child R had been sexually abused by the family member and had experienced neglect and emotional abuse. As a response to concerns expressed in court CAMHS agreed to become involved again.

2.11 Child R was diagnosed and given medication for ADHD from August 2011, and this helped to calm some of her behaviour. Oxfordshire CAMHS considered carefully when might be the best time to offer psychotherapeutic help and regular sessions with a psychotherapist started in November 2011. CAMHS also provided support to the social worker, school and foster carer as her self-harming behaviours and suicidal thoughts were a continual concern.

2.12 Full Care Orders were finally granted in February 2012 when Child R was age 12.

During this period Children's Social Care had been working hard to try and keep children in the family safe but the Family Court had not been convinced that there was sufficient evidence to remove the children from their parents. The second set of care proceedings were very protracted, taking seventeen months to reach a conclusion and during this time it was difficult to make long term plans for the children. Practice in legal proceedings has changed greatly since 2010 with the new Public Law Outline, improved assessment frameworks for Children's Guardians within Cafcass, and greater scrutiny of the time taken for legal proceedings to be concluded. Oxfordshire have also developed a tool for assessing neglect. This supports a more focused approach to understanding whether the help

[2] If one party makes allegations during family law proceedings and the other party denies the allegations, the judge will consider whether there should be a fact-finding hearing. This is a special hearing which is arranged just to decide whether or not the allegations are true.

given to families is making sufficient difference to children as well as assist the presentation of evidence in court.

The response to Child R when she spoke of being sexually abused by a family member fell short of the standards that would be expected today. The uniformed officer who first spoke to Child R was not sufficiently experienced, there was no contact that evening with Children's Social Care, and there was also no consideration given as to whether an intermediary might have supported Child R to give a full account. The result was she felt guilty and disbelieved.

A more recent investigation into another allegation made by a child within the family has provided an opportunity to understand where practice challenges remain and where improvements can still be made. This more recent investigation avoided the pitfalls of the first with only properly trained specialist detectives carrying out interviews with children. Now, although uniformed officers may have contact with children during the initial response, all new officers in Oxfordshire now spend time with the child abuse investigation team to make sure they fully understand the team's role and the sensitive nature of the investigation process. The way in which strategy meetings are arranged has been changed to facilitate full multi-agency involvement via conference call facilities. The conclusion of the recent investigation was also that no criminal charges could be brought but mindful of past lessons, the police team made sure that the young people concerned received letters assuring them that they had been believed. This is a recent example of good creative practice.

2.13 Child R lived with her foster carers from May 2011 through to September 2012. Throughout this time, she developed a strong attachment to her foster mother who is described as becoming skilled at managing Child R's behaviour. This behaviour included aggression, frequent episodes of self-harm, tying ligatures and needing restraint. The plan was for her carers to go forward to the Permanency Panel to be approved as her long-term carers.

2.14 During the summer of 2012 Child R's foster mother reported that Child R's behaviour had deteriorated, and social workers were aware that although the plan was that she should remain with the foster carers, this might not be possible, and she may need residential care.

2.15 On 9th July 2012 the social worker e-mailed CAMHS expressing concerns about Child R's "relentless" self-harm and frequent need for restraint. The social worker requested a multi-agency risk assessment.

2.16 Child R first come to the notice of the Placement Duty Team in Oxfordshire Children's Services when she was discussed at a meeting in August 2012. Those that knew her were worried that her foster placement and school placement were fragile and could come under increasing pressure as she got older. There was then a professionals meeting on 10th September 2012 where it was agreed that although her placement was currently stable there should be a "Plan B". The placement team agreed to investigate alternatives such as alternative foster carers or a therapeutic community.

2.17 The next day Child R took an overdose and was admitted to the paediatric ward at the general hospital for observation and assessment. During this admission she tried to abscond, she attempted to strangle herself with a scarf and cut herself with a broken ring. She was described as agitated and aggressive towards staff who tried to stop her self-harming. There were discussions as to whether she should be admitted to a psychiatric unit.

2.18 These discussions between practitioners following Child R's overdose show some disquiet from mental health professionals as to whether admission to a psychiatric unit was the best option. The Consultant at the local unit was reluctant to admit her due to her self-harming behaviour being assessed as behavioural rather than from a mental health disorder and there was a concern that she was too young to be on the unit. However, following discussions with Child R's CAMHS Care Coordinator it was decided that the unit was the most appropriate setting, and she was admitted on 12th September with a view to her being there for 4-6 weeks. She was age 13.

The picture during Child R's time in foster care is of carers who were committed to her and a Local Authority who provided a great deal of support aimed at helping Child R to settle within a family placement.

However, although there was CAMHS involvement, there was a delay in Child R being able to access counselling partly because of difficulties in identifying the most appropriate service to provide counselling to children who have experienced sexual abuse. At that time there were few specialist services available but since 2012 there has been considerable work within Oxfordshire developing services for young people who have been sexually abused. The annual review of one therapeutic service noted (in 2017) that statistical analysis had revealed that young people who have completed a course of treatment through their service experienced significantly fewer mental health difficulties, higher levels of protective factors, and there was a better understanding of risks and vulnerability within the system.

3 CHILD R'S TIME IN HOSPITAL AND PLANNING FOR HER RESIDENTIAL PLACEMENT

3.1 It became clear that Child R could not return to her foster carers unless, and until, her mental health improved, and her behaviour was stabilised.

3.2 Throughout the six weeks that Child R spent on the unit she made repeated attempts to self-harm, tie ligatures and needed to be restrained on numerous occasions for her own safety. When she refused to take her medication, this would be administered via injection. She was on level 3 (within eyesight) observations. The policy requires that *patients subject to level 3 observations are kept within sight at all times by day and by night and any tools or instruments that could be used to harm self or others should*

be removed. It may be necessary to search the patient and their belongings whilst having due regard to their legal rights.

3.3 Child R was sectioned under the Mental Health Act Section 2 for her own safety.

3.4 Her social worker referred her to the Complex Case Panel, and she was then discussed at the Placement and Commissioning Panel - a multi-agency panel which was chaired by a Health representative. The view of Child R's medical team was that for Child R to re integrate back into family life she *needed a period of therapeutic intervention to help her rebuild trusting relationships and make sense of her abusive relationships.*[3] The original intention was to find a placement as close to home as possible and various options began to be explored.

3.5 Records show that from the start, the opinion of all professionals was that Child R should not remain in the psychiatric unit for too long.

3.6 By 3rd October 2012, social work records show that of the residential homes being considered, Provider X, that ran the out of county home where Child R eventually was placed was the preferred option. Reasons for this included:

- The option closest to home used a therapeutic group work model which was not suitable for Child R.
- Another option specialising in young people with mental health difficulties had not been used by Oxfordshire health or social care before and was therefore untested as a provider.
- The preferred provider was known to both the treating psychiatrist and Children's Social Care who had another young person placed with them.

3.7 On 3rd October Child R's social worker forwarded a referral to Provider X with various documents giving details of Child R's background. Following receipt of this referral Provider X had internal discussions about Child R's needs and how these might best be met within their group of homes. Initial thoughts were that if an immediate placement with 2:1 care was needed, placement at their crisis and emergency home might be the best option whilst other plans were put in place. Another option, which took account of other young people already in the homes, was the home where Child R was placed.

3.8 The referral information was also forwarded to three of Provider X's therapists for consideration and one therapist expressed an interest in working with Child R. This therapist noted that in Oxfordshire Child R was working with Child and Adolescent Psychotherapist like herself so that she could offer continuity of approach. There were some changing views at this stage of what therapy Child R might need as the notes of the CPA meeting held on 8th October (see below) refer to psychotherapy being discontinued as it caused Child R distress and she could not manage it. The provider's therapist suggested that she could offer Child R Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing for Child R's

[3] Oxford Health NHS Trust Individual Management Review.

suspected PTSD. The provider's individual management review notes that within the paperwork there was lack of clarity as to whether PTSD had been diagnosed with the discharge summary suggesting a diagnosis and another document saying that Child R had PTSD "type symptoms" but this could not be formally diagnosed.

3.9 At a professionals meeting on 8th October attended by representatives from the psychiatric unit, Children's Social Care, Child R's school and foster carer five possible placements were discussed, and Provider X was confirmed as the preferred provider. At this stage it was not known exactly where Child R would be placed as there were various homes run by the provider concerned. The Oxford Health notes record that Child R should not be told of the plans until an exact assessment date had been agreed

3.10 However, at a CPA review held on the ward later the same day which included Child R, the plan was explained to Child R including the intention that she would have contact with her family and the foster carer. It was also explained that Child R's social worker would arrange for staff from the residential provider to visit Child R in hospital.

3.11 The records show that at this stage funding for the placement had not been finally agreed and there were some tense e-mails between Children's Services and Health colleagues as well as subsequent challenge from Education about whether Provider X was the best option. There was also considerable pressure from the ward to arrange a move as soon as possible as it was recognised that a psychiatric unit was not an appropriate placement for her.

3.12 A continuing health care assessment was carried out by Oxford Health on 10th October 2012. This assessment is required in situations where Health will be contributing to the costs of a placement to determine whether the criteria for a high intervention therapeutic provision are met. The assessment was based on the nursing assessment at the psychiatric unit as well as further information provided by Child R's social worker and school. The assessment had a point scoring system which gave Child R 261 points indicating a high level of health need. Consequently, Oxford Health agreed to meet 50% of the costs of a "therapeutic placement". Consent was therefore given for the placement with Provider X to be pursued.

3.13 Following further discussions about Child R's likely discharge date, Provider X concluded that direct admission to one of their long-term homes would be most appropriate.

3.14 The final decision on the placement was deferred until the Placement and Commissioning meeting on 23rd October. One of the reasons for the delay was the need for an outstanding report on Child R's therapeutic needs. Education had also not given their final consent to the placement. Provider X agreed to keep the placement open and to attend a planning meeting on 24th October if required.

3.15 On 23rd October the Placement and Commissioning Panel agreed funding for Child R at Provider X. Their records are unclear whether a formal report outlining Child R's therapeutic needs was received from the treating consultant. It is also not clear

whether there was discussion about the decision to offer Child R a place at the out of county home. The Statement of Purpose does sit in Child R's records in Oxfordshire but there is nothing in the notes to suggest that the extent to which this specific home was appropriate for her needs was discussed. Risk assessments within the home relevant to young people who self-harm are also not referred to. This issue is discussed further below.

3.16 A planning and Child in Care review meeting took place at the psychiatric unit on 24th October 2012. This included the manager of the out of county home and provided an opportunity to discuss Child R's specific needs. It was noted that Child R found restraint by male staff difficult, and the proposed home had predominantly male staff. The plan was to seek to build up safe and secure relationships with a consistent staff base. This issue is discussed further in Finding Three. Child R's use of ligatures was described by her psychiatrist as 90% behavioural and 10% what she is experiencing at the time and was a way in which she could communicate how she was feeling.

3.17 Provider X asked for additional funding to support 2:1 care and the social work team manager undertook to request this. Issues relating to the various interpretations of 2:1 care are explored in Finding 2.

3.18 The Placement Plan that followed from this meeting noted that the aim was for Child R to move to family-based placement within 9-12 months. The plan discussed therapy and other outcomes, such as engagement in education, in general terms but did not:

- Specify expectations regarding the input from the therapist and how this would be monitored by CAMHS within the context of an overall plan to meet Child R's mental health needs.
- Specify expectations regarding 2:1 care and night-time supervision.

3.19 The discharge summary from the psychiatric unit included an expectation that Child R would be seen by an Oxfordshire consultant from Community CAMHS within seven days and a telephone call took place between the psychiatrist and the manager at the out of county home on the day that Child R was discharged from hospital.

From the time Child R was admitted to hospital it became clear that she would not be able to return to a family setting until her mental health improved. Staff felt that her behaviours were consistent with Post Traumatic Stress Disorder (PTSD) because of the abuse she experienced. It is also significant that her self-harming behaviours were described as 10% linked to dissociative behaviours resulting from past trauma and 90% linked to help seeking behaviour. It seems that the plans for Child R going forward into residential care were based on the 90% with little attention given to risks of harm including completed suicide associated with the 10%.

Her foster carers remained involved in planning for her, and the hope was she would eventually be able to return to their care. There is evidence of good joint work between the whole professional team in considering her needs and there were detailed discussions about which residential placement should be chosen for Child R.

Several placements were considered, careful consideration was given to her needs and initially the aim had been to keep her as close to Oxfordshire as possible, but placement choice is limited and due to the complexity of her needs, it became clear that a move further away from Oxfordshire would be needed. The process of agreement for joint funding and specific issues relating to placement commissioning and monitoring are explored in Finding Two, but the eventual decision to choose Provider X seems to have been driven by a positive experience of the company by her treating psychiatrist, as well as Children's Social Care also working successfully with them in the recent past. The decision as to which specific home was used was driven by the provider rather than practitioners working with Child R. The Statement of Purpose for both the overall company and the specific home are within Children's Services records. These show that although generally offering a therapeutic approach, the out of county residential home where Child R lived specialised in young people with psychosexual problems and sexually harmful behaviour. There is no mention of work with self-harm, suicidal ideation or mental health issues. In fact, the Statement of Purpose specifically *excludes* accepting referrals for young people with a diagnosed mental illness. This should have given commissioners an idea of the skill set of the staff and prompted further discussion as to whether this was a suitable fit for Child R. Whilst it could be argued that Child R did not have a diagnosed mental illness, she had been detained in hospital under a mental health section and part of her treatment had included taking antipsychotic medication.

An additional issue was that the chosen home had predominantly male staff and it was known that Child R found restraint by male staff difficult. There was insufficient in-depth exploration of this issue with it too readily being agreed that developing positive trusting relationships would be sufficient.

There was careful consideration, and discussion with Child R about contact arrangements when she moved, and planning included a visit from the home's manager to the hospital. However, the placement plan was not specific about important elements of her care including expected input from her therapist and expectations about waking night cover.

It was positive that Oxfordshire CAMHS agreed to maintain responsibility for Child R's care but exactly how this was to work, lines of accountability regarding therapy and the interface with local CAMHS provision at times of crisis should have been clearly specified from the start. At Child R's last CPA meeting in hospital medication was noted to be working well but although the home was clear that they would not force Child R to take medication (as had been the case in hospital) there is nothing in the discharge or placement plan describing the potential consequences of her not taking medication and whether CAMHS advice should be sought in this instance.

4 CHILD R'S TIME IN THE OUT OF COUNTY RESIDENTIAL HOME

4.1 Child R moved to the out of county children's home on 26th October 2012 and the residential home pre-admission risk assessment identified Child R's history of risk-taking behaviour including self-harm cutting and ligatures.

4.2 The bedroom risk assessment and ligature risk assessment prepared the day before admission (25th October 2012), included:

- Child R's bedroom to be kept very basic until after the initial assessment period.
- Nightwear to be handed to her at bedtime and day clothes removed. No clothing with ties and bandages to be used.
- The door to be left open when using the room before bedtime and staff to assess the need for regular checks through the night due to Child R's mood or behaviour.

4.3 The Care Planning, Placement and Case Review statutory guidance and the associated regulations[4], place a duty on local authorities to notify other local authorities if they place a child in care within their area. It also requires children's homes to notify their host local authority when a child is placed with them by another authority. In respect of Child R, Oxfordshire sent the appropriate notification to the local authority in the area where the home was situated, and the home notified local organisations on 26th October. They also made sure that Child R registered with the local GP on 29th October.

4.4 There had been no prior notification to the local health team for Children in Care. They would have ensured that the child's health file followed, and any outstanding health needs could be identified. The first time that the local team were aware was on 9th November 2012 when they received a request from Oxfordshire health for completion of a Child in Care Review health assessment by 14th December 2012. This assessment did take place but there is no evidence in the Oxfordshire health records as to who was taking responsibility for coordinating Child R's health plan.

4.5 The Oxfordshire CAMHS consultant visited Child R in the home a week after her admission and had weekly conversations with the care home manager. However, initial liaison between Oxfordshire CAMHS and the local CAMHS was not smooth. The first contact was by phone call from Oxfordshire, who were then asked to submit a written referral. This was sent on 12th November, but it had the wrong date of birth which made Child R an adult. The local CAMHS planned to send the referral to adult mental health services but did not do so. This meant that when Child R first needed to be seen by the local CAMHS team at a point of crisis, they had no background information.

4.6 The records indicate that staff at the home were quick to establish a set routine for Child R and staff used firm and clear statements to direct her away from certain types of behaviour and that more often than not she respected those boundaries. Daily reports from the home show that she enjoyed a range of activities, shopping trips, cinema visits, trips to the beach, art and craft activities and activities and learning provided at school.

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4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000549/The_Children_Act_1989_guidance_and_regulations_Volume_2_care_planning__placement_and_case_review.pdf

4.7 However, Child R remained a very troubled young person and volatile behaviour, self-harm, tying ligatures and refusal to take medication were frequent occurrences. For example, between 28th October and 11th December 2012 the records show the following incidents.

Date	Incident
28.10.12	Scratches/ligature with pyjamas
30.10.12	Refused medication
31.10.12	Scratches/ligature with cardigan/ligature with pillowcase/ligature with shower pipe/ligature with tea towel. Restraint
1.11.12	Scratching/ligature with jumper
6.11.12	Escalating behaviour including attempted ligature with jumper. Restraint.
9.11.12	Refusing medication (medication found in her bedroom drawers/escalating behaviour/Restraint x2
10.11.12	Hiding medication/Clothing bedding and furniture as ligatures. Restraint.
12.11.12	Hiding medication
19.11.12	Self-harm through scratching
30.11.12	Self-harm through scratching
3.12.12	Self-harm through cutting
5.12.12	Self-harm through headbanging and punching glass door
7.12.12	Hitting kitchen cupboards and microwave
9.12.12	Self-harm though cutting and ligature with pyjama bottoms
10.12.12	Self-harm through scratching and ligature with jacket and shower in her bathroom
11.12.12	Self-harm through scratching and ligature with hoover cable.

4.8 On each occasion the appropriate documents were completed, and the Oxfordshire social worker was made aware. What is less clear is whether this level of detail was available to the CAMHS consultant in Oxfordshire who maintained responsibility for her care. There is evidence of regular telephone discussions between the home and the consultant which focused generally on her behaviour and any changes needed to her medication, but there was no formal process for notifying CAMHS of specific incidents.

4.9 Throughout this period Child R had yet to meet her local therapist. The reason cited at the Child in Care review in November 2012 was that therapy was not possible due to her behaviours and the therapist was to liaise with the therapist at Oxfordshire CAMHS. There is then evidence of a meeting between the two therapists on 19th November 2012. A therapy session planned for 9th December was then postponed and the first session took place on 14th January 2013.

4.10 The November Child in Care review noted that Child R would need continued 2:1 staffing. This was agreed by Health and Social Care but a senior manager within Children's Social Care asked the Independent Reviewing Officer to explain what steps were being taken to reduce Child R's behaviours and requiring that any additional staff members were female.

4.11 On 12th December 2012, Child R was taken to the local hospital having swallowed glass. The Oxfordshire Children's Social Care records note that this episode was precipitated by an arrangement for Child R to have contact with her siblings and her mother. Due to the subsequent events, Child R was deemed too vulnerable for the visit to take place.

4.12 A Child in Need referral was made to the local Children's Services by the Emergency Department. She was admitted to the paediatric ward, discharged the next day but readmitted four hours after discharged having swallowed a further glass fragment. She was seen by the local CAMHS team on the paediatric ward and a further CAMHS assessment and review took place on the ward on 17th December. The Oxfordshire social worker joined the review later. The probability of self-harm was recorded as high and 2:1 supervision was noted to be a risk reducing factor.[5]

4.13 Child R's social worker returned with her to the residential home and her bedroom had been cleared as agreed and only contained a mattress. Child R told her social worker that she had wanted to see her family but liked it at the residential home and she would "shoot her" if she tried to move her.

4.14 There was then a discussion between CAMHS consultants locally and in Oxfordshire and a further self-harm review by the local clinical psychologist on 20th December. It was now clearly agreed that serious incidents should be referred to the local CAMHS, but ongoing care would be Oxfordshire CAMHS.

4.15 A further hospital stay took place on 29th December after Child R was taken to the Emergency Department having cut herself on the elbow. The Emergency Department decision was that a full mental health assessment should take place and she was admitted to the paediatric ward. She was assessed by the local CAMHS clinical psychologist and in discussion with staff from the home the risk assessment was updated and agreed. This included reinstating daily searches of her bedroom. This risk assessment was faxed to Oxfordshire CAMHS by the clinical psychologist. There was a telephone discussion between the two CAMHS teams and it was agreed that Child R's records should be "red flagged" to avoid any further admissions to the paediatric ward following another episode of self-harm.

4.16 The next day there was a further telephone conversation between the local and Oxfordshire CAMHS consultants to clarify that the residential home should first contact Oxfordshire CAMHS for advice about Child R and the role of the local CAMHS would be confined to emergency assessments. There was also a telephone

[5] The Wales Applied Risk Research – WARRN- network risk formulation was used and the Pierce Suicide Intent Score Scale

conversation between the clinical psychologist and Child R's social worker to explain the red flag agreement, as the last admission to the ward was not necessary or helpful. The social worker asked whether someone from the local CAMHS could attend the Child in care review on 29th January. The local CAMHS decision was to ask for minutes of this meeting.

4.17 There continued to be incidents during the early part of January with a more settled period during the latter half of the month although it is notable that on the 26thJanuary Child R told staff that she was "going mad" and was "hearing voices". There is no indication within the records that this was discussed further within the staff team, including whether advice should be sought from mental health professional. Incidents during January and the first week of February include:

1.1.13	Escalating behaviour self-harm though head banging and punching. Restraint.
4.1.13	Found with piece of glass
7.1.13	Attempted to break window with toilet cistern.
8.1.13	Escalating behaviour and tied jeans around her neck.
9.1.13	Found with small piece of glass.
1.2.13	Self-harm with glass
5.2.13	Punched wall
6.2.13	Escalating behaviour/self-harm. Restrained 9 times.
7.2.13	Punching window to break glass. Restraint.

4.18 On 21st February, the residential home manager notified the social worker via e-mail that a young person had died in a fire in another of their units. It is not clear what the social worker did with this information, and this is discussed further in paragraph 5.19 in relation to the expectations placed on social workers when they receive information such as this.

4.19 On 21st February the records show that Child R was punching the wall and there was the need for "several restraints". She was again punching walls the next day and used a pillowcase as a ligature.

4.20 During the morning of 24th February Child R was found in her room with a bed sheet tied around her neck and attached to the wardrobe door; this was removed by staff. Fifteen minutes later she had pulled a curtain rail from the wall to scratch her arms and, after some moments of aggression is described as calm by 11.30am.

4.21 The residential home records show that on the early evening of 24th February Child R had a heightened level of anxiety but the next morning was reported to be in good spirits. She went shopping and baked a cake before her therapy session.

4.22 The therapist attended a team meeting on 26th February and a discussion took place about increasing therapy to twice weekly after Easter. Her notes and the sentencing remarks by the Judge in the Health and Safety trial, refer to a conversation with the

home manager about the need to review ligature points within the home. The fact that this conversation took place is disputed by the home manager.

4.23 Later that evening Child R was found in her bedroom with a ligature in the form of pyjamas tied from the shower rail. Staff loosened the ligature and carried her to her bed. She was then left for a five-minute chill out period following which she was monitored from outside her room but with her door open for a further fifteen minutes. During this time Child R told staff that she did not do it for attention. Staff took away her blanket and she settled to bed at 10pm. Although court papers record that her door was locked, all bedroom doors could be opened by the young person from the inside. If a young person locked themselves into the room and staff needed quick access, there was a master key that could open all bedroom doors.

4.24 Records show that staff "monitored from the landing" and went to bed at around 11.30pm. It has not been possible to clarify exactly what "monitored" meant. The next morning Child R was found dead having used the wardrobe handle as a ligature point.

The general picture painted by many comments within the records was that Child R had settled well into the home and was happy. Recordings by residential staff describe her engaging well with school lessons and on occasions opening up to them about how she was feeling. There are periods where episodes of self-harm and restraint had reduced but, when looked at objectively, these still occurred regularly, often in clusters and there were serious episodes which on two occasions resulted in an overnight stay in hospital.

Specific issues relating to CAMHS involvement in out of county placements is explored more fully in Finding Two but in summary, there could have been greater clarity about roles, responsibilities, and a smoother liaison with the local CAMHS service. The role of the therapist and expected approach in delivering an important aspect of her mental health care was also not specified in the placement plan and the records then paint a picture of this therapy being slow to start (the first session was in January). There is no discussion within the records of the implications of therapy not starting until January 2013 and whether this was in line with the expectation of funding agreements.

It is significant that plans for Child R whilst she was in the children's home did not include a specific suicide prevention plan. The understanding that her self-harm behaviour including tying ligatures was 90% help seeking behaviour drove the responses to her. Whatever the cause, there was always a risk of completed suicide, and this should have been reflected in a specific plan which addressed risks within her environment. The placement plan did note the need for a high level of supervision due to self-harm and there were risk assessments within the home. The records show that these did address some risks such as that from clothing, but they did not specifically consider risks from ligature points within the home and specifically within Child R's room. The health and safety prosecution papers described these risk assessments as *inadequate* with a lack of hazard and risk identification. As a result, no control measures were put in place such as removal of ligature points and provision of toughened glass.

Scrutiny of the risk assessments should have occurred when the placement was commissioned, agreed by the social worker and CAMHS consultant and regularly

reviewed and integrated into a suicide prevention plan for Child R. The scrutiny of placements is discussed further in Finding Three.

Of particular concern is the fact that Child R used the same ligature point on 26th February as she had been found using two days earlier. This was described in the Judge's summing up in the health and safety proceedings as a "breach of duty", a "significant cause of death", and at a "stage in [Child R's] life when any reassessment of her should have been assessed again".

The other significant issue is that of the supervision of Child R at night. After her death discussions with practitioners and reports prepared for the serious case review and criminal proceedings indicate that there were various interpretations as to what this would involve.

- Some practitioners may have assumed that 2:1 care was equivalent to the level 3 observations in hospital which meant that Child R was observed through the night.
- The residential care company were clear that they had not been funded to provide waking night cover.
- The view of the Local Authority placement duty team was that where a placement does not include waking night cover the placement would implement it for a specific young person if in their judgement this was needed or there was an incident. They would then discuss this with the funders.
- Child R's social worker, the team manager and the IRO did not expect 2:1 care throughout the night whilst Child R was asleep although two staff would always be available. Their expectation was that staff would watch her until she fell asleep by moving in and out of the room with the door open. If she was unsettled staff would sit outside her room until she went to sleep. Once she was asleep an alarm would be switched on which would alert staff if she moved into her bathroom or tried to leave the room. On the night of her death, the expectation of Oxfordshire Children's Social Care was that that since there had been a previous suicide attempt that day, staff would have consulted with CAMHS, and a staff member would have carried out continual observations through the night.

5 FINDINGS AND RECOMMENDATIONS

5.1 The sad death of Child R took place eight years ago and these findings and recommendations aim to identify what could be learnt from practice at the time and set that within today's context. This means that recommendations have not been made where there is evidence that practice and systems have now changed to improve the help provided to children and young people. The evidence for this change is based on the check of the system that was completed for Oxfordshire Safeguarding Children Board in 2020.

Finding One

Working to keep children safe within their families continues to be a challenge and there is the need to ensure that improvements made since child R was a child are embedded into practice.

5.2 Child R's life provides many examples of the challenges faced by practitioners when trying to understand the risks faced by children and provide the right help at the right time. These challenges relate to the complexity of family life and relationships, alongside a safeguarding system that may not have the right resources to meet children's needs. These resources include knowledge skills and tools to help practitioners in their work from the first moment that a child is understood to have additional needs and management systems and structures that support practice in complex cases. Of particular significance in Child R's situation was the fact that the social workers first assessment of risk was not accepted by the Court and the children returned home. In these circumstances it is challenging for social workers and other professionals to keep a firm focus on potential risk, reflect on the quality of evidence and available assessments and where necessary continue with legal proceedings.

5.3 Much work has been done in relation to working with complex family situations. Neglect is often a feature in these families and there is a continuing focus on supporting practitioners to assess and manage these situations. Case audits showed that there is a need to make sure that all relevant agencies are actively contributing to assessments, and this will strengthen the analysis and quality of evidence should legal proceedings be required. The multi-agency chronology which has been developed in Oxfordshire is a promising tool to help the assessment of neglect, but discussions with practitioners indicate that work will be needed to make sure that it can be used efficiently and effectively to help practice.

5.4 The complex nature of family structures further impact on the challenge of analysis of the children's lived experience for Social Workers and Children's Guardians. It is essential that these key professionals ensure that they see each child within a sibling group, individually, to ensure they have an individual voice.

5.5 Decisions within the court arena continue to present challenges to practitioners and practitioners value the role that the complex case panel can play in sharing the management of risk in these situations. This panel was in place at the time Child R lived in Oxfordshire, is multi professional and made up of senior managers and provides support to practitioners working with children with complex needs whose planned outcomes are not being achieved. Child R and three of her siblings were discussed at the panel and led to the initiation of the second court proceedings which eventually succeeded in achieving care orders.

5.6 Of particular significance to Child R was the response of the system when she alleged sexual abuse within the family. The lack of criminal prosecution had a profound effect on her and her feeling of not being believed and guilt that she could not protect her siblings. Thames Valley Police have reflected on Child R's situation as well as other instances where they have needed to respond to allegations of sexual abuse. The positive developments in practice were clearly seen when in a recent investigation they took time to consider how best to explain to the children why there had been no prosecution. This was addressed through writing letters and carefully explaining what had happened.

5.7 In summary the system-check of current practice in Oxfordshire identified many areas where practice today is vastly different to practice when Child R was a small child. Nonetheless, the following recommendations are made with a view to ensuring continual practice improvement.

Recommendation One
The safeguarding partnership should ensure that there is a cultural shift across universal services so that Early Help Assessments are seen as a helpful multi-agency tool, that practitioners are confident to carry them out and that they ask the questions that will help them understand the child's needs within their family context. There should be evidence that when a professional and family have agreed that early help services at Tier 2 can meet the family's needs, this should be followed through to an early help assessment and plan that achieves clear outcomes. The assessment and plan should be implemented by a named lead professional and the practitioners who know the child(ren) and family

Recommendation Two
There should be evidence that the partnership's neglect strategy is being implemented and neglect tools are being used in practice to contribute to effective assessments and plans.

Recommendation Three
There should be a check in the system so that Children's Social Care maintains their current oversight of court orders by the court progression manager to ensure that the 'complex case panel' automatically reviews cases, where the order applied for in care proceedings has not been granted by the court.

Finding Two

Placement Planning and managing the complex needs of Children in Care needs sufficient placement availability, clarity of role across the professional network and systems that scrutinise and challenge how well the child's needs can be met.

5.8 Once Child R moved into foster care the overall picture is of foster carers who, although initially unsure as to whether they could cope, worked tirelessly to meet her needs and keep her safe. In recognition of the challenges that Child R presented within her placement, Children's Services arranged a comprehensive package of wraparound care and there is evidence of regular multi professional meetings including school, CAMHS and support services.

5.9 The admission to the psychiatric unit was always meant to be short term. Due to her complex needs her social worker alerted the complex case panel and also began to initiate procedures to find a suitable residential placement. A range of placements was discussed by the Placement and Commissioning Panel. The intention to keep Child R close to home could not be achieved and this had a negative impact on how contact arrangements and visits from other practitioners could be managed.

5.10 These discussions took place within a context of placement shortages which are even more acute today. Some of the issues which were narrowing placement choice for Child R continue. For example, the reluctance of placements to admit a young person with behavioural problems that might negatively affect how the home is perceived during an inspection visit. This situation has been recognised within Oxfordshire and a recent report by the complex case panel [6] noted that work was underway with other Southeast Directors to look at what more can be achieved by working regionally. The issue has been highlighted with Ofsted.

5.11 In Child R's situation there were various meetings where placement possibilities were discussed at the same time as the Placement and Commissioning Panel were trying to establish funding agreements. The Health Continuing Care Assessment was a crucial part of this process as was the agreement by Oxford Education, and there is evidence that not everyone caring for Child R appreciated the way that the process worked. In addition, the process at that time for objectively scrutinising the quality of provision, the detail of the placement planning and how far this addressed Child R's specific needs is not clear from the records. Specifically

- The final choice appears driven by previous work by the psychiatrist and the local authority with the overall placement provider rather than the specific home.
- There is no record of matching the residential homes Statement of Purpose with the needs of Child R.
- The specific expectations of therapy (including number and focus of sessions), lines of accountability and how this would be monitored.
- What was meant by 2:1 care was not clarified in any documentation.

[6] Placement Sufficiency and young people with Complex needs May 2019.

5.12 The conclusion from the more recent system-check is that today, systems within Oxfordshire provide a good framework within which placements that meet the need of individual children can be identified, commissioned and monitored. These new arrangements will need to be embedded and monitored with a view to making sure that information held on the suitability of homes out of county is comprehensive and up to date and protocols for out of county placements are fit for purpose.

5.13 The issue of provision of therapy is also crucial and needs to be understood as a vital element in mitigating and reducing risk to children such as Child R. The consequences of a child not receiving the right therapy and the right time are serious and far reaching. This needs specific attention when a child has both health and social care needs, is placed out of area, and cannot access local Oxfordshire services.

5.14 Evidence suggests that current commissioning would be improved if there is greater clarity as to the exact nature of the "therapy" required. Questions that were relevant at the time of Child R's placement remain today. Namely:

- What do we mean by a "placement with therapy" and "therapeutic provision"? Does this mean the same to everyone in the system and are those responsible for agreeing the placement and drawing up the placement contract clear about what is required?
- Is there a process for carrying out a sufficiently detailed joint assessment between children's social care and relevant health providers to establish exactly what the therapeutic provision should look like to meet the needs of this child and the implications of any delay in providing this?

5.15 In Child R's situation, the placement had been chosen because of its ability to provide a therapeutic environment and there were clearly advantages to maintaining continuity of psychiatric care and for responsibility for her mental health care remaining with the Oxfordshire Psychiatrist. Her general health care needs were to be met locally and although there was a delay in the local health care team for Children in Care being contacted the system seems to have worked reasonably well.

5.16 The disadvantages of "long arm" mental health care became apparent within the first week when her consultant did not have time to visit the home and there was initial confusion over roles and responsibilities with the local CAMHS team. This points to a need for commissioning arrangements to formalise the role of the home CAMHS service in the overall monitoring of the way in which the therapeutic needs of child in placement are met if they have been involved with Oxfordshire CAMHS. The current position of Oxfordshire CAMHS is that out of area children should transfer to CAMHS services in the area they are placed but Oxfordshire CAMHS would want to maintain oversight of more complex cases. Exactly how this will work in practice needs to be clarified. There is an inherent risk attached to managing cases from a distance and giving advice without being able to make sure that this is implemented.

5.17 Monitoring appears to have been fragmented with the Local Authority as corporate parent focusing on the progress of Child R's care plan, whereas the continuing health

care worker employed by Oxford Health focused on making sure that the commissioned health services including therapy were being provided.

5.18 A recent redesign of the commissioning and monitoring processes in Oxfordshire aims to enhance collaboration between stakeholders and has been an opportunity to address the specific issues that have become evident through Child R's situation. This is an opportunity to ensure that leadership and systems provide a route for action where anyone has concerns about the way that a young person's needs are being met. In jointly commissioned placements effective joint working between social workers and continuing health care workers will be an important part of the process.

5.19 However, processes are not enough, practitioners need to feel confident to ask challenging questions of providers. This may not be easy when there is a need to form effective working relationships in the best interest of the young person but those visiting the young person in placement are the eyes and ears of the commissioning authorities and will need to play a role in highlighting any information, concerns or issues. For example, the home felt it was relevant to notify the social worker of a young person's death in a fire in another home in the group, but it is not clear that the social worker would have known what to do with this information or considered informing the commissioning team within Oxfordshire. Social workers and Independent Reviewing Officers need more clarity about their role at the interface with commissioning and feel confident in this aspect of their work.

Recommendation Four

(i) National recommendation:

This Review asks the National Panel and the DfE to acknowledge the key learning and findings from Child R's Review including the possible increased risk of harm when children are placed far away from home. The Review asks for particular attention to be paid to the national insufficiency of placements to meet children's needs in their local area and for the learning to inform changes to policy, sufficiency levels and contractual arrangements with independent providers.

(ii) Local recommendation:

In light of the national and local insufficiency of placements the Council and its partners should continue to develop and invest in plans to keep children close to home by expanding local residential and foster care provision to meet children's needs and report to the Safeguarding Partnership on progress on an annual basis.

Recommendation Five

Work should be undertaken across health and social care to define the meaning of the terms being used to describe the therapeutic (mental health) needs of children in care and the different types of interventions that should be used to meet their needs and the role of risk assessments in identifying the implications of any delay in the provision of therapy. This should be disseminated to all relevant health and social care staff so that a child's needs are understood, and the appropriate support is commissioned and provided within the child's placement, and in the local area of the placement.

Recommendation Six

There should be a clear local system for the commissioning and quality assurance of placements for children we care for, including children placed out-of-county. This system should be known and understood by all practitioners in children's social care, contracts and commissioning. This system should provide clarity for social workers as to where to go if there are concerns that a residential provider is not meeting the needs of a child.

Recommendation Seven

There should be a clear local system of scrutiny and governance of the healthcare of children with most complex needs, including children placed out-of-county. This system should be known and understood by all practitioners working with the children in our care and it should provide:

- Clarity for social workers as to where to go if there are concerns that the therapeutic needs of a child are not being met in placement.
- Commissioning arrangements which formalise the role of the home CAMHS service in monitoring of the way in which the therapeutic needs of child in placement are met if they have been involved with Oxfordshire CAMHS.
- Clear expectations as to the specific information about incident within he home that should be shared with the treating CAMHS consultant.
- Oversight by the continuing health care worker which is used to full advantage and integrated into other review systems.

Recommendation Eight

All placement plans should set out specific expectations regarding levels of staffing and how often checks should be made on the young person during the day and through the night. The meaning of "waking night cover" should always be clarified.

Finding Three

Where there is a risk of suicide, Children in Care should have a clearly articulated suicide prevention plan which takes account of emotional, behavioural and situational risks.

5.20 The plans in place for Child R were based on the premise that her self-harm, including the tying of ligatures was primarily help seeking behaviour, designed to gain attention rather than actual attempts to take her own life. However, the assessment at the out of county hospital using a suicide risk assessment tool did record that Child R was "high risk" and there had always been an acknowledgement that 10% of her behaviour did not fall into the help seeking category.

5.21 Cumulative risks and situations involving both suicidal thoughts *and* non-suicidal self-harm have been found to be associated with completed suicide in young people, with

a higher proportion of girls taking their own lives.[7] [8] The stacking of factors causing stress and anxiety needs to be constantly kept under review and for Child R there may have been an opportunity for this to be considered by those looking after her.

5.22 In a situation where Child R's behaviours were challenging to understand and manage on a day-to-day basis, achieving a dynamic assessment, which could identify where risks were escalating, was not easy for any of the practitioners involved. The factors associated with the risk of completed suicide by a young person are unlikely to be static and are likely to evolve and change over time meaning that frequent re-assessment of risk is needed.[9] For example, factors associated with a high risk of self-harm and completed suicide may not always be known from the start, and may include child sexual abuse, issues relating to sexual orientation and identity[10] as well trauma, loss, and mental illness. It may have been significant that on the night that Child R died she had spoken of some evolving personal anxieties and after her first ligature attempt had told staff that she had not done it for attention. However, these issues were not understood as distinct from an established cyclical pattern of behaviours which included periods of self-harm, ligatures and punching out at staff.

5.23 Given these complexities and the challenges of identifying the ever-changing pattern of risk, situational suicide prevention methods became extremely important. The placement plan for Child R was generalised and needed to include a clearly set out suicide prevention plan as part of her overall care plan. Given Child R's history of regularly tying ligatures, this should have included a focus on ligature points within the home and Child R's bedroom.

5.24 Although the residential home was known to have risk assessments in place, there is no evidence that these were scrutinised by anyone in Oxfordshire with a view to ensuring that they were fit for purpose. In this instance, reports from the health and safety prosecution are clear that risk assessments within the home were not adequate in respect of identifying and eliminating ligature points.

Recommendation Nine
Where a young person has been identified by mental health and/or social work assessments as being at risk of taking their own life, placement plans should include a specific suicide prevention plan which is distinct from risks of self-harm. This plan should be shared with the Local Authority where the home is situated.

Recommendation Ten

[7] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017. http://documents.manchester.ac.uk/display.aspx?DocID=37566
[8] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30030-6/fulltext
[9] Troya M et al Investigating the relationship between childhood sexual abuse, self-harm repetition and suicidal intent: mixed-methods study BJPsych Open (2021)7, e125, 1–9. doi: 10.1192/bjo.2021.962
[10] The British Journal of Psychiatry, Volume 211, Issue 2, August 2017, pp. 63 - 64
DOI: https://doi.org/10.1192/bjp.bp.116.197475

Where a child has self-harming behaviours or suicidal ideation. risk assessments by residential providers must include specific assessments of ligature points throughout the home and most specifically in the young person's bedroom. Placing authorities should expect these risk assessments to be shared with them so that they can be scrutinised by commissioners and integrated with the child's placement plan.

6 SUMMARY AND CONCLUSIONS

6.1 Although the death of Child R happened over eight years ago there has been continual reflection within Oxfordshire concerning ways in which practice could be improved in similar situations. Alongside this there has been some frustration that until recently events leading immediately up to Child R's death could not be understood in detail due to the protracted parallel inquiries into health and safety breaches at the residential home. This has also been hard for the family and in particular Child R's siblings.

6.2 Oxfordshire Safeguarding Children Board have not lost sight of the need to learn lessons and identify any areas for improvement and the system check is a manifestation of that approach. The review that took place in 2014 identified a system that had been slow to meet Child R's needs at an early enough stage and timely action was also delayed due to an initial decision by the court that she should remain at home. The approach to working with allegations of sexual abuse did not enable her voice to be heard. There is clear evidence that the system today is very different with a more structured approach to early help, assessing complex needs and improvements in the way that allegations of sexual abuse are responded to.

6.3 Once Child R was in the care of the local authority services were aimed at supporting her placement with foster carers. Unfortunately, this was not achieved in the light of deterioration in Child R's mental health which needed hospital admission and prevented a return to foster care. Finding the right residential placement near to home was not possible and the difficulty of the right placement being available in the right place at the right time remains a challenge in the system today.

6.4 Although Child R did seem happy in her placement, there had been insufficient clarity in some aspects of placement planning. The exact expectations regarding therapy were not clear, specified in her placement plan and agreed with her CAMHS consultant. This issue is not specific to Child R and the more recent system check has highlighted that there continues to be a need to develop a common language across the professional community about what is meant by a therapeutic placement in order to assist the commissioning process.

6.5 The second aspect of placement planning that needed more clarity was level of staffing and waking night cover. There were differing assumptions about what was to be provided and this has become significant as Child R died at night when staff in the home were asleep.

6.6 Finally, Child R died after tying a ligature. This was not new behaviour and had been a regular occurrence throughout her time in care. However, there was no separate suicide prevention plan linked to this behaviour and the health and safety prosecution has found that risk assessment of ligature points within the home were inadequate.

6.7 Given Child R's life, experiences and the complexity of her condition it cannot be said with any certainty that better risk assessment and plans would have stopped her eventually taking her own life

7 SUMMARY OF RECOMMENDATIONS

7.1 The recommendations of this Serious Case Review are in line with the recommendations from the system check in order to reflect more recent practice.

Recommendation One
The safeguarding partnership should ensure that there is a cultural shift across universal services so that Early Help Assessments are seen as a helpful multi-agency tool, that practitioners are confident to carry them out and that they ask the questions that will help them understand the child's needs within their family context. There should be evidence that when a professional and family have agreed that early help services at Tier 2 can meet the family's needs, this should be followed through to an early help assessment and plan that achieves clear outcomes. The assessment and plan should be implemented by a named lead professional and the practitioners who know the child(ren) and family

Recommendation Two
There should be evidence that the partnership's neglect strategy is being implemented and neglect tools are being used in practice to contribute to effective assessments and plans.

Recommendation Three
There should be a check in the system so that Children's Social Care maintains their current oversight of court orders by the court progression manager to ensure that the 'complex case panel' automatically reviews cases where the order applied for in care proceedings has not been granted by the court.

Recommendation Four
(i) National recommendation:
This Review asks the National Panel and the DfE to acknowledge the key learning and findings from Child R's Review including the possible increased risk of harm when children are placed far away from home. The Review asks for particular attention to be paid to the national insufficiency of placements to meet children's needs in their local area and for the learning to inform changes to policy, sufficiency levels and contractual arrangements with independent providers.

(ii) Local recommendation:
In light of the national and local insufficiency of placements the Council and its partners should continue to develop and invest in plans to keep children close to

home by expanding local residential and foster care provision to meet children's needs and report to the Safeguarding Partnership on progress on an annual basis.

Recommendation Five
Work should be undertaken across health and social care to define the meaning of the terms being used to describe the therapeutic (mental health) needs of children in care and the different types of interventions that should be used to meet their needs and the role of risk assessments in identifying the implications of any delay in the provision of therapy. This should be disseminated to all relevant health and social care staff so that a child's needs are understood, and the appropriate support is commissioned and provided within the child's placement, and in the local area of the placement.

Recommendation Six
There should be a clear local system for the commissioning and quality assurance of placements for children we care for, including children placed out-of-county. This system should be known and understood by all practitioners in children's social care, contracts and commissioning. This system should provide clarity for social workers as to where to go if there are concerns that a residential provider is not meeting the needs of a child.

Recommendation Seven
There should be a clear local system of scrutiny and governance of the healthcare of children with most complex needs, including children placed out-of-county. This system should be known and understood by all practitioners working with the children in our care and it should provide:

- Clarity for social workers as to where to go if there are concerns that the therapeutic needs of a child are not being met in placement.
- Commissioning arrangements which formalise the role of the home CAMHS service in monitoring of the way in which the therapeutic needs of child in placement are met if they have been involved with Oxfordshire CAMHS.
- Clear expectations as to the specific information about incident within he home that should be shared with the treating CAMHS consultant.
- Oversight by the continuing health care worker which is used to full advantage and integrated into other review systems

Recommendation Eight
All placement plans should set out specific expectations regarding levels of staffing and how often checks should be made on the young person during the day and through the night. The meaning of "waking night cover" should always be clarified.

Recommendation Nine
Where a young person has been identified by mental health and/or social work assessments as being at risk of taking their own life, placement plans should include a specific suicide prevention plan which is distinct from risks of self-harm. This plan should be shared with the Local Authority where the home is situated.

Recommendation Ten
Where a child has self-harming behaviours or suicidal ideation. risk assessments by residential providers must include specific assessments of ligature points throughout the home and most specifically in the young person's bedroom. Placing authorities

should expect these risk assessments to be shared with them so that they can be scrutinised by commissioners and integrated with the child's placement plan.