Local Child Safeguarding Practice Review

‘Simon’

OVERVIEW REPORT

Final Version

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Acknowledgements

Governance

The author can declare that he has found no conflict of interest in completing this review, and that he is independent to Warwickshire Safeguarding Adults and Children Partnership Board and partner agencies. The report has been commissioned by, and written for, the Partnership and overseen by a multi-agency child safeguarding practice review panel of local senior managers and practitioners from the following agencies:

- Coventry & Warwickshire ICB formerly CCG (GP)
- Coventry & Warwickshire Partnership NHS Trust
- George Eliot Hospital
- Hunterscombe Hospital
- Park View Hospital Birmingham
- Secondary School
- University Hospital Coventry & Warwickshire
- Warwickshire Police
- WCC Children's Social Care
- West Midlands Ambulance Services
- West Midlands Police

The details of the child and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Version Control		
Version	Event	Date
0.1	To second panel	
0.2	Following feedback from second panel	01/06/22
0.3	Following feedback from third panel	24/08/22
0.4	For presentation to review sub-group	15/11/22
0.5	Following presentation to review subgroup	22/11/22

Contents

1.0 Introduction and background

1.1 This review focuses on the life of, and how agencies inter-acted with, Simon. In March 2021, Simon was found hanged in a wooded area, he was 16 years of age at the time of his death. Simon had previously made a significant attempt to hang himself in May 2019 and since that time a number of agencies engaged with him and his family.

1.2 The review has been commissioned by the Warwickshire Safeguarding Children Partnership in accordance with statutory guidance[1] which states that where a child dies or is seriously harmed in an area and it is known or suspected the child has been abused or neglected, the Local Authority for that area must notify The National Child Safeguarding Practice Review Panel.[2] A rapid review meeting will be convened by Safeguarding Partners for that area and as well as identifying immediate learning and action, a decision will be made on whether a Local Child Safeguarding Practice Review is required.

1.3 Simon came from a family where English was not their first language. Whilst Simon spoke fluent English neither of his parents did and they required the services of interpreters. Simon's mother and father separated around 10 years ago.

1.4 In September 2018, Simon suffered a serious fall which left him with a brain injury, which is said to have affected his behaviour. Simon returned to school and there is good evidence that he was well supported by the school. Simon engaged well and this included him leading an assembly to discuss his injury with other students. He returned to a full timetable in January 2019.

1.5 In February 2019, the school were informed by Simon's family that they had concerns regarding Simon's behaviour outside of school. The school in discussion advised a referral to RISE[3], which was done. In March 2019, Simon presented to hospital reporting suicidal thoughts.

1.6 In May 2019, the family informed the school that alcohol was missing from home, and they believed Simon had it. Simon was sent home with his mother. The following day Simon attempted to take his own life himself at home.

1.7 The case was referred to the Warwickshire Safeguarding Partnership who discussed the case and agreed that although it did not meet the criteria for a review there was learning to be drawn from the case, so the group undertook a tabletop learning review. The review identified a number of areas of learning for practice.

- Referrals to the Multi Agency Safeguarding Hub (MASH) should be made by use of a Multi-Agency Referral Form (MARF).
- There was learning for some agencies in recording Simon's voice to evidence that he had been a part of the decisions being made regarding him and his care.

[1] Working Together 2018, HMG
[2] Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)
[3] Rise is a family of NHS-led services providing emotional wellbeing and mental health services for children and young people in Coventry and Warwickshire (CAMHS)

- The use of interpreters and agencies, not relying on Simon or other family members when communicating with non-English speaking members of his family.
- Learning around support being offered to Simon's family and for agencies to ensure they adopt a Think Family approach.

1.8 Following Simon's death the case was again referred to the Rapid Review group. Following scoping and discussion it was agreed that the case should be reviewed as a Local Child Safeguarding Practice Review. The following agencies provided information for the purposes of scoping and subsequently providing an agency report.

- Coventry & Warwickshire ICB formerly CCG (GP)
- Coventry & Warwickshire Partnership NHS Trust
- George Eliot Hospital
- Hunterscombe Hospital
- Park View Hospital Birmingham
- Secondary School
- University Hospital Coventry & Warwickshire
- Warwickshire Police
- WCC Children's Social Care
- West Midlands Ambulance Services
- West Midlands Police

1.9 Terms of reference for this review determined that the period in focus would be from 1st April 2019 to the time of Simon's death, in March 2021. The rapid review developed some key lines of enquiry, which the review was asked to focus on. These are detailed below: -

- Was there recognition of the relevant risk factors in this case and did this result in appropriate analysis and mitigation of the risk?
- Where assessments were undertaken, was historical information effectively used to inform them?
- In the assessment of risk was the cumulative effect of Adverse Childhood Experiences (ACEs) considered?
- How effective was the support afforded to Simon after his first suicide attempt and in particular the Child in Need plan implemented at this time? Were the identified outcomes achieved and was the closure of the plan appropriate?
- How were allegations of sexual abuse dealt with, was information effectively shared and the appropriate action taken?
- What consideration was given to the wider risk presented by the allegations made by Simon during his work experience, and allegations made by hospital staff including the involvement of the Local Authority Designated Officer and actions taken to safeguard young people during work experience opportunities? What support was available for Simon following the allegation of sexual abuse?
- How apparent was Simon's voice in the recording of interactions with agencies and how was it used in decisions, assessments and interventions being delivered? What were the concerns raised by him on his appearance and did these impact on his self-esteem?
- Were the right areas of learning identified in the tabletop learning exercise of 2019? Were the areas of learning communicated effectively to professionals and did this result in the necessary improvements?

- Were the cultural and language challenges to Simon and his family identified in the table top review and appropriately addressed?
- What was the effect of Covid both on Simon and his family and on the ability of agencies to deliver services?
- Was Simon's brain injury factored into risk assessments and was the relationship between this and his mental health considered? Did professionals working with Simon adapt their approach when engaging with Simon to ensure he fully understood the support being provided?

2.0 Narrative Chronology:

2.1 In April 2019, Simon presented at hospital, just prior to this he had been at a first-floor window and told his parents that he intended to take his own life. At the hospital Simon was assessed by the mental health crisis team and stated that he had no intention to jump and denied any suicidal thoughts. He did state that he was sad all the time and that he had lost all interest in his previous hobbies. These changes in his behaviour were attributed to a serious fall that Simon had suffered and as a result was left with a brain injury. A referral was made to Children Social Care (CSC) and this was passed to Early Help. The hospital also made a referral to RISE.

2.2 In May 2019, Simon made a significant attempt to take his own life. This took place in his home and Simon was discovered by his family. This was a significant attempt where Simon was unconscious for 8.5 minutes[4]. Simon was treated in hospital. CSC undertook a child and family assessment which recommended that Simon and his family should be supported by a child in need plan (CiN)[5]. This plan was effective from May 2019 to June 2020. For significant periods of this plan Simon was an inpatient in hospital under section 2 and 3 of the Mental Health Act 1983[6] and was not discharged until the end of October 2019.

2.3 In mid-November 2019, Simon self-presented to hospital with what was described as an acute deterioration in his behaviour. Simon had been having persecutory thoughts and auditory hallucinations. It was recorded that there was no suicidal ideation. Simon made attempts to abscond from the ward and his medication was increased. He was detained under section 2 Mental Health Act awaiting a Tier 4[7] bed.

2.4 Towards the end of November 2019, a Tier 4 (Psychiatric Intensive Care Unit – PICU) bed became available, and Simon was transferred to another hospital. This hospital was a considerable distance from Simon's family home, some 200-mile round trip. The day before this happened West Midlands Police (WMP) were informed by Warwickshire Police that Simon had alleged that he had been the victim of a serious sexual assault. WMP were being informed as the offence was alleged to have occurred in their policing area. WMP initiated enquiries and established that there was no potential for forensic evidence due to when the

[4] Coroner bundle
[5] Section 17 Children Act 1989 - Children in Need (CiN) are defined in law as children who are aged under 18 and need local authority services to achieve or maintain a reasonable standard of health or development/ need local authority services to prevent significant or further harm to health or development.
[6] Section MHA 1983 – hospital admission for assessment/ Section 3 MHA 1983 – hospital admission for treatment.
[7] Tier 4 - CAMHS Tier 4 are specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties (NHS England)

offence had occurred. Call handlers from WMP spoke to the hospital where Simon was now admitted under section 3 Mental Health Act. It was established that at this time Simon was too ill to be interviewed regarding the allegations he had made. There is no record at this time that there was a strategy discussion[8] between professionals or any consideration of what other support could be made available to Simon.

2.5 In mid-December 2019, there was a CiN review. This review was undertaken by email updates, the reason given for this was that the parents were at the hospital every day and the lack of professional availability. On the same date as the CiN review the hospital social worker notified the Local Authority social worker of what was by then a historical allegation of sexual abuse whilst Simon had been on informal work experience, which had been arranged by his family. It is apparent that this was the same allegation previously made to WMP. During this communication the hospital also informed the social worker of allegations that Simon had made relating to peers at his school being involved in the use of drugs and alcohol and girls being sexually abused whilst under the influence of substances. There is no record of this information being shared with a manager or any consideration of a strategy discussion.

2.6 During December 2019, Simon's school liaised with the Tier 4 hospital regarding his education and arranged for an Education and Health Care Plan (EHCP) to be put in place for Simon. The details of the plan were explained to Simon's family using a member of staff who spoke the family's language.

2.7 In January 2020, Simon again told his social worker that he had been sexually abused by an adult, this was a repeat of the allegation made previously. On this occasion the information was shared with a manager and a strategy discussion was arranged. Warwickshire Police were invited to the strategy discussion but declined the invitation on the basis that the allegation occurred in the West Midlands Police (WMP) area. It is not clear whether WMP were invited to the strategy discussion, but they did not attend. The strategy discussion considered that the allegations should be taken seriously and investigated. Staff at the Tier 4 hospital and the social worker re-visited the allegation with Simon on a number of occasions however Simon was not deemed fit to engage in a formal interview. It was the view of CSC that the hospital, who were in contact with Simon would establish when Simon was ready to be interviewed and contact the police. There is no evidence that this was recognised by or communicated to the hospital. The only reference to the sexual abuse was in April 2020 during a Care Pathway Approach (CPA) meeting where it was recognised that a combination of physical and psychological trauma, which included the alleged sexual abuse had contributed to a decline in Simon's mental health.

2.8 In mid-April 2020, the hospital social worker notified the CSC that Simon had made a complaint regarding unprofessional behaviour of a member of staff. The hospital confirmed that a report had been made and the member of staff had been moved from the ward. Consideration was being given at that time for notifications to be made to the Local Authority Designated Officer (LADO) and CQC. It is not clear if this happened and there was no further information passed to CSC.

[8] Strategy discussion - A strategy meeting/discussion is an opportunity to share as much of the available information as possible between participants to inform the next steps. (West Midlands Multi Agency Safeguarding Procedures)

2.9 During his hospital admission Simon was treated with anti-psychotic medication. This medication caused some significant weight gain for Simon, and this became what the RISE care coordinator would describe as a source of unhappiness for Simon. Advice was given to Simon regarding his weight gain on diet and exercise. The family confirm that the weight gain did cause Simon some concern but did not feel that this was a major factor for him.

2.10 Simon was discharged from the hospital at the end of April 2020. The hospital communicated this to RISE, there had been no period of home leave due to the Covid pandemic. There was no notification of the discharge to other agencies until the day and therefore the only agency to attend the CPA discharge meeting was RISE. The care plan included the local authority social worker to support Simon to pursue his allegation of sexual assault and for the care coordinator to have daily phone contact with Simon.

2.11 At the beginning of June 2020, there was a joint review of the CiN and EHCP plans. This meeting had an interpreter present, and the options were explained to Simon and his parents. Simon was offered a place at college to study motor mechanics which he accepted. In July 2020 the CiN plan was closed. During the course of the CiN plan there had been four meetings all of which had been conducted whilst Simon was in hospital and by email or virtually apart from the final meeting.

2.12 In May 2020, August 2020 and March 2021, Simon had three admissions to hospital following accidents on his pushbike. In the incidents he sustained relatively minor injuries.

2.13 In June 2020, Simon was referred to the Early Intervention Psychosis Team[9] (EIP). At this time, he had a diagnosis of schizoaffective disorder and Post Traumatic Stress Disorder. Simon was not accepted into this service as it was deemed that he had an organic presentation, in that it was believed that his condition emanated from his brain injury. The Psychiatrist sought clarity on this from Neurology at the hospital. In mid-September 2020, a response was received that Simon had symptoms of mental health prior to the brain injury. Two months later in November 2020, the EIP communicated with the Psychiatrist that Simon was not suitable for the service, re-stating that his condition resulted from his brain injury. During this time Simon continued to express unhappiness regarding his increase in weight.

2.14 There was continued contact from the care coordinator and in February 2021 a review was conducted by a consultant by telephone. During this meeting Simon interpreted for his mother who expressed some concerns over Simon's recent behaviour. There was ongoing and regular contact between Simon and the care coordinator. In Mid- February 2021, Simon presented at hospital with deteriorating mental health, he stated that he felt unsafe and had suicidal ideations. After being assessed by CAMHS Simon was discharged. Two days later there was a face-to-face review by the Consultant Psychiatrist with Simon's parents present. There was no interpreter or measures put in place to aid the parents understanding, with Simon being asked to translate for the meeting. The reason given for this was the relatively short notice for the meeting being arranged. A further referral was made to EIP, which was on this occasion accepted.

[9] EIP - A team of NHS and Social Care professionals working together with other teams, including hospital services and the Crisis teams, to provide care to people in the community who have been diagnosed with a form of psychosis, such as schizophrenia or bi-polar disorder. They provide treatment and signpost to other services depending on individual needs.

2.15 Whilst there is evidence of good contact by the care coordinator there is also evidence of Simon feeling that his mental health was deteriorating. In mid- March Simon again attended hospital and expressed overwhelming feelings that he wished to harm himself. Earlier the same day Simon had been contacted by the care coordinator and expressed to them that he had no concerns, this was an indication of how Simon's feeling could fluctuate quite quickly. Following a review by CAMHS Simon was again discharged with care to be followed up by the care coordinator. This contact included a face-to-face meeting with a EIP care coordinator, who now accepted that Simon's condition was not attributed to his brain injury. It is not clear how the language barrier issue with the parents was dealt with at this meeting.

2.16 On 18th March 2021, the hospital made a referral to the MASH expressing concerns that Simon had presented to the hospital with overwhelming suicidal thoughts. The referral stated that Simon had no actual plans to harm himself and had felt like this on numerous occasions. It noted that Simon had been a previous hospital inpatient for mental health issues and was under the care of CAMHS. There was no discussion with other agencies or apparent consideration of previous incidents. Some 8 days later a letter was sent to Simon's mother stating that no further action would be taken and signposting the family to the Family Information Service, this letter was sent in English.

2.17 The day following the meeting Simon was in town with a female friend, who he had discussed during the meeting. Simon was the subject of an un-provoked attack by a group of youths and punched and kicked several times. This was reported to police but Simon did not seek medical attention.

2.18 At the end of March 2021, Simon attended a routine mental health review which was conducted face to face, Simon's mother was present and aided by the services of a translator. Simon disclosed feeling unsafe at time and having thoughts to harm himself but not having plans to do so. Simon's mother agreed to take steps to ensure that the home environment was as safe as it could be. The agreed plan was to increase medication, whilst acknowledging Simon's unhappiness over his weight gain and the link to medication it was considered that the stability was required.

2.19 Following the review, on 26th March 2021, both family and professionals attempted to contact Simon on a number of occasions. A report was received that a young person had been found unresponsive, it was established that this person was Simon and that he was deceased. It was apparent that Simon had met a female friend in the park and had been informed by her that their relationship would not progress in a way that he had hoped.

3.0 Discussion

3.1 How effective was the support afforded to Simon after his first suicide attempt and in particular the Child in Need plan implemented at this time? Were the identified outcomes achieved and was the closure of the plan appropriate?

3.1.1 The CiN plan was initiated in May 2019 and concluded in June 2020. For extensive periods of the plan Simon was an inpatient in hospital following the first attempt he made on

his life. Simon was often deemed too unwell to engage in visits from his social worker or to be involved in reviews of the plan. At a review of the plan in September 2019, which was attended by all relevant agencies, it was discussed that within the hospital and whilst on home leave Simon had engaged in risk taking behaviour and this included being found in the ward toilets with a belt around his neck. This was said to be following his first return day to school, which he had found challenging. At a review meeting in October 2019, Simon's return home was discussed. It was agreed that Simon had engaged well and an EHCP[10] had been put in place for his return to school.

3.1.2 On his discharge from hospital Simon felt too unwell to return to school and was to be supported by the Flexible Learning Team. Before this arrangement could be put in place in mid-November 2019, Simon self-presented to hospital with what was described as an acute deterioration in his behaviour. Simon had been having persecutory thoughts and auditory hallucinations, this was only three weeks after his previous hospital discharge.

3.1.3 Simon then remained in hospital as an inpatient until April 2020. During this period the CiN plan was only reviewed by email contribution or by virtual meetings. The hospital did not have access to an interpreter and therefore the contribution by the family was limited.

3.1.4 When Simon was discharged from hospital it would be fair to anticipate that the CiN plan would become more relevant and perhaps more focused on support and monitoring Simon's progress as he transitions back into the community. This is not evident from the plan. There were no further review meetings except the joint CiN/EHCP meeting, which effectively closed the CiN plan.

3.1.5 The Warwickshire Child in Need Policy[11] commits to a whole family and culturally competent approach to recognise the needs of the whole family. It is not apparent that either of these areas were considered within the plan or that there was sufficient consideration of the family background and the support they may require.

3.1.6 It is evident there was a perception from CSC staff involved in plan of feeling redundant due to the time that Simon spent in hospital, and they felt that their role was more to be a 'friend' to the family. The CiN closed at time when a plan with SMART objectives which was family centred could have provided a better multi agency approach to support Simon and his family. That said there was evidence of continued good support from the school and RISE coordinator after the plan closed.

3.1.7 Careful consideration should have been given to the closure of the plan for Simon. His discharge from hospital had been quite recent, there had not been a monitored period of the plan being in place whilst Simon had been in the community. At the time of closure Simon had not been provided support from the Early Intervention Psychosis Team, this was still being negotiated up to the time of Simon's death. At the time the plan closed it was also relatively close to the first national covid lockdown (March 2020). This was a time of uncertainty, and it was not clear what the ramifications to the pandemic and consequences of it would be.

[10] EHCP – Education, Health and Care Plan
[11] Warwickshire Country Council Child In Need Plan, The Right Support at the Right Time,2018

3.1.8 Section 85, Children Act 1989[12] places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and / or likely to exceed 12 weeks. The intention behind the legislation is to provide a 'safety net' for vulnerable children living away from home where the child is not accommodated under Section 20[13] and where the child is not subject to the usual processes of Care Planning and review by an Independent Reviewing Officer.

3.1.9 This requirement was relevant on Simon's first admission to hospital in May 2019, which lasted 5 months and also in November 2019, which lasted 6 months. On both occasions Simon was being supported within a CiN Plan. The statutory guidance for this requirement[14] states that where a child or young person's needs have been assessed for the purposes of section 17 of the Children Act 1989 in the preceding 12 months, the representative must visit within three months, and thereafter at intervals of not more than six months. There may have been consideration of section 85 within the context of the Child in Need plan, but this is not evident to this review. Consideration should be given to offering clarity to professionals regarding making notifications regarding section 85 and how Children Services should respond to this, particularly where other assessments are in place.

Learning

A Child in Need Plan should adopt a family wide approach that seeks to identify and address the hidden issues and harm. The plan should have set out clear measurable outcomes for Simon and expectations for his family. It should have included areas of concern and how these would be addressed. Careful consideration should be given to the closure of a plan where it is not clear that key issues have been addressed and how the transition will be managed by a step-down plan.
Children Services and other agencies involved with care of children need also to consider section 85 Children Act and how this works with other assessments.

Recommendation 1

The Warwickshire Safeguarding Partnership should seek assurance on effectiveness of Child in Need Plans in the context of providing support to children and young people at risk of suicide and how these relate to other relevant plans such EHCP, RISE Care Plans and Risk Plans.

[12] Section 85, Children Act 1989 - https://www.legislation.gov.uk/ukpga/1989/41/section/85 (accessed 20/07/22)
[13] Section 20, Children Act 1989, Section 20 agreements allow the local authority to remove a child and place them in foster care without the need for a court order. Whether or not to enter into a section 20 agreement is a voluntary decision made by the parents with the local authority.
[14] HMG, 2017, Statutory visits to children with special educational needs and disabilities or health conditions in long term residential settings Statutory guidance for local authorities, health bodies and health or educational establishments

Recommendation 2

Warwickshire Children Services and relevant partners should review the process and policy of receiving and responding to notifications under section 85, Children Act 1989.

3.2 How were allegations of sexual abuse dealt with, was information effectively shared and the appropriate action taken?

What consideration was given to the wider risk presented by the allegations made by Simon during his work experience, and allegations made by hospital staff including the involvement of the Local Authority Designated Officer and actions taken to safeguard young people during work experience opportunities? What support was available for Simon following the allegation of sexual abuse?

3.2.1 In November 2019, Simon was detained under section 2 of The Mental Health Act awaiting admission to a Tier 4 provision. This provision became available towards the end of November. The day before Simon was transferred to the provision, he made an allegation of a very serious sexual assault. This allegation centred on a person who Simon had worked with on a voluntary basis to gain experience in motor mechanics. This arrangement was one that had been put in place by Simon's family and was not one that was facilitated by any of the agency working with Simon or one that they were aware of. This allegation was passed to Warwickshire Police, but it was quickly established that the alleged activity had occurred within the jurisdiction of West Midlands Police. West Midlands Police were duly notified.

3.2.2 West Midlands Police recorded the alleged offence and call handers made contact with CAMHS and established that Simon was held under the MHA, and it was a view that Simon was too ill at that time to be interviewed. Although CSC, CAMHS, Police and hospital staff were aware of the allegation there was no consideration of a strategy discussion at this stage. Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, a strategy meeting/discussion should be held.[15] At the time agencies were working with Simon under a Child in Need Plan, this new information which clearly indicated potential significant harm should have initiated a strategy discussion.

3.2.3 The lack of a strategy discussion led to an uncoordinated approach to the sexual abuse allegation which overly focused on the police led investigation and did not focus on what the trauma implications were to Simon and his health. There was no clear plan on how the investigation would proceed and who would be taking the lead. There was a lack of consideration of what support may be available to Simon to support him in both progressing the criminal investigation or his overall support. There is no evidence that an Independent Sexual Violence Advisor (ISVA) was considered.

3.2.4 There is a lack of evidence that the risk of the allegation was considered in a wider sense. It is not clear that the alleged offender was identified, and consideration given to possible access to other vulnerable young people. There was also information given by Simon that peers at his school had indulged in alcohol and drugs and had been sexually

[15] West Midlands Multi Agency Safeguarding Procedures

assaulted. It transpires that this information was vague, and identification of individuals would not have been possible, but this information was not followed up or shared with the school, at the time, so the appropriate enquiries could be made.

3.2.5 Other recent reviews have shown that the lack of a timely strategy meeting involving the right agencies results in uncoordinated and poor action leading to poor outcomes. The sexual assault allegation was made again and raised by the hospital social worker to the local authority social worker in mid- December 2019, this was immediately following a CiN review. Again, there was no consideration of a strategy meeting, this was not considered until January 2020, when the allegation came to the attention of a manager. This would indicate that there was a lack of appropriate management oversight at the earlier stages.

3.2.6 West Midlands Police were not invited to the strategy discussion, which was now some 6 weeks following the allegation by Simon. Warwickshire Police declined to attend the strategy discussion on the basis that West Midlands Police were dealing with the allegation. The net result was that police did not attend the strategy discussion and it would therefore have to be viewed as a professional's discussion as opposed to a strategy discussion as set out in the guidance. The meeting agreed that the allegation should be taken seriously but there is no clear evidence on how this would be taken forward. It is recorded that CSC and hospital staff re-visited the allegation with Simon on a number of occasions but information on this is lacking. It was accepted by Warwickshire Police at the learning event for this review that it would have been good practice for them to attend the strategy discussion even though the location of the offence was outside of their area.

3.2.7 The matter was not effectively re-visited by West Midlands Police. There is a record that there was discussion between police and the local authority social worker in January 2020, around the time of the strategy discussion but there was no plan as to how the matter would be progressed. It would appear that West Midlands Police were not informed when Simon was discharged from hospital and the next time they attempted contact with Simon or his family was in September 2020. They record that attempts to speak to Simon's family and social worker were unsuccessful and contact regarding this matter was not achieved before Simon's death in March 2021. The family when spoken to for this review were not aware of any attempts to contact them and their contact details had remained the same.

3.2.8 Overall the coordinated response to the allegation made by Simon would have to be viewed as poor. The CiN plan was closed in July 2020, without consideration of the allegation and how it was to be resolved. The West Midlands Police initial enquiries established that the likely date of the alleged offence, it may be significant that it was shortly after this that Simon presented to hospital with what was described as an acute deterioration in behaviour, with persecutory thoughts and auditory hallucinations. There is little evidence that the potential trauma of being subjected to very serious sexual assault was considered in the context of Simon's deteriorating mental health and how this would be addressed.

3.2.9 Learning from multi agency inspections found that practice in the area of child sexual abuse is too police led and not sufficiently child centred.[16] The Independent Inquiry into Child

[16] Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (2020)

Sexual Abuse[17] is clear that it is important for survivors to feel heard, listened to, understood, believed, and not judged, by a caring, empathetic professional. As identified in the strategic direction statement by NHS England[18] when providing services to children who have been the victim of sexual abuse a trauma informed approach is needed that appreciates the devastating impact of CSA, and one that is centred on the needs of the survivor to build a trusting relationship with those who can help.

3.2.10 It has been established that the work placement that Simon was undertaking when he made the sexual abuse allegations was not one arranged by any of the agencies involved but one arranged by his family. The alleged perpetrator involved was not a person working with children and therefore it did not fit within the requirement to involve a Local Authority Designated Officer (LADO). There was information regarding potential use of drugs and alcohol leading to sexual abuse of Simon's peers. This information was not discussed when a strategy meeting was finally arranged. Whilst the information was vague it should have been appropriately shared with the school via the strategy meeting for the necessary enquiries and action to be taken.

Learning

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, a strategy meeting/discussion should be held. This discussion should include all relevant partners and in a case such as this it should include relevant health professionals and the school. Where a strategy discussion does not take place, the following action is uncoordinated and lacks the necessary follow up. The issue of strategy discussions not occurring in relevant cases has been noted both locally[19] and nationally. There should be good management oversight to ensure that strategy discussions are appropriately convened and attended. The timeliness strategy discussions was also identified the Warwickshire thematic review on exploitation.

In addition, a number of audits indicated that strategy meetings were delayed, however there was no evidence that this had been escalated as a concern by the partner agencies involved.[20]

Where there are allegations of sexual abuse relevant agencies should ensure that the approach is not over reliant on the criminal prosecution. That the child and their family are put at the centre of the approach and that the approach is trauma informed and appropriate support considered. Where an allegation is made the police should ensure that the victim and where appropriate those acting for him receive regular updates on the progress of the case.

[17] Independent Inquiry Child Sexual Abuse 2020
[18] Strategic Direction For Sexual Assault And Abuse Services - Lifelong care for victims and survivors: 2018 – 2023 NHS England
[19] Warwickshire SCR Alice and Beth September 2020
Warwickshire SCR Child K February 2020
[20] Warwickshire Safeguarding Exploitation Strategy (2020-2023)

The approach to dealing with survivors of exploitation in Warwickshire will be trauma informed.[21]

Recommendation 3

Considering the findings of this review, previous local reviews and National reviews the partners of the Warwickshire Safeguarding Partnership should seek to understand if there are barriers to convening strategy discussions in relevant cases. This should also look at the timeliness, attendance, management oversight and effectiveness of strategy meetings that do take place. Consideration should be given to how this assurance can be monitored going forward.

Recommendation 4

The Warwickshire Safeguarding Partnership should ensure that the learning on this review is considered by the Exploitation sub group to consider how they link to the Exploitation Strategy and are used to help to develop a trauma informed approach for child sexual abuse.

Recommendation 5

West Midlands Police should provide assurance to Warwickshire's Safeguarding Partnership that victims and where appropriate parents of children and young person's reporting offences of rape and serious sexual assault are appropriately updated and offered support.

3.3 How apparent was Simon's voice in the recording of interactions with agencies and how was it used in decisions, assessments and interventions being delivered? What were the concerns raised by him on his appearance and did these impact on his self-esteem?

3.3.1 There are areas where Simon's voice is reflected and captured well and that this then featured into discussions and considerations regarding plans and interventions for Simon. Equally there are areas where the same consideration is not evident.

3.3.2 Simon's school involved Simon in discussions on the plans for his return to school following his accident. This involved allowing Simon to educate his peers about his injury in discussions and a school assembly. There is good evidence of the school approach being child centred with them securing support from the Brian Injury Trust and an Education, Health and Care Plan (EHCP) and supporting him towards post 16 learning.

3.3.3 There is a lack of evidence of the CiN plan being child centred. The first review was conducted by email updates due to lack of professional availability and the parents being at the hospital every day. The subsequent meetings were also conducted in this fashion. This approach was partly as a consequence of the covid virus, and this is more fully discussed in the previous section.

[21] Warwickshire Safeguarding Strategic Thematic Review on 'Exploitation of Children and Adults (November 2019 to February 2020)

3.3.4 Simon's voice was well documented within interactions with his RISE coordinator and Consultant Psychiatrist, this is particularly the case around his medication and weight gain. It was noted that his weight gain had a significant impact on his self-confidence and a plan was put in place to support him, which included support from a dietician. Simon requested to have his medication reduced but this had to be balanced against stabilising his mental health. Simon's care coordinator is said to have formed a good trusting relationship with Simon and as a result was able to discuss many issues and areas of interest with him.

3.3.5 Simon's voice was lacking in the allegations that he made regarding being sexually abused. He was not interviewed for the criminal matters at the time of the allegation, or when he repeated the allegations due to the fact that he was unwell. There was no follow up to the allegations as discussed in the previous section. This would have had the effect of leaving Simon unheard and possibly not believed in this regard.

3.3.6 Part of the picture of a young person will come from their family and those close to them, as well as what they say themselves. This may have been impeded due to the language barriers with Simon's parents not having English as their first language. From discussion with family for this review there are also differences with how agencies approach support in the UK with that of what the family were accustomed to in their own Country. It would demonstrate good cultural awareness for agencies to explore this aspect where the family have experiences in other Countries.

Recommendation 6

When agencies are dealing with children, young people where there is a risk of suicide consideration should be given to a 'Think Family' approach, with particular consideration to areas of culture.

3.4 Were the right areas of learning identified in the tabletop learning exercise of 2019? Were the areas of learning communicated effectively to professionals and did this result in the necessary improvements?

Were the cultural and language challenges to Simon and his family identified in the tabletop review and appropriately addressed?

3.4.1 In May 2019, Simon made a significant attempt to take his life at his home and was found by his family. This incident was discussed at a Rapid Review meeting.
The aim of the rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children

• decide what steps they should take next, including whether or not to undertake a child safeguarding practice review [22]

The meeting confirmed that there was learning to be achieved but did not feel that the case met the criteria for a Local Child Safeguarding Practice Review. It was agreed that the Partnership would arrange a tabletop review on the case and this took place in November 2019.

3.4.2 The tabletop review identified the following areas of learning. These areas were subject of learning briefing, which was disseminated to the Partnership.

- Recording of issues in the Multi Agency Safeguarding Hub (MASH) and these concerns being followed up by a written referral (MARF).
- Evidence that Simon's voice was sought and he had real involvement in decisions being made.
- Evidence was lacking that Simon's parents and wider family were involved in discussions and a Think Family approach should be sought with emotional support being offered to the family.
- English was not the parents first language, some agencies relied on either Simon or his English-speaking sibling to translate for them. The review recommended that accredited interpreters, signers or others with special communication skills should be used.

3.4.3 Generally there should be more evidence that the learning from the tabletop review has resulted in action to ensure that the lessons are understood and embedded into practice. The benefit of the learning briefing is limited as it will only be accessed by a limited number of staff. Some of the areas from the tabletop review are repeated themes as those being considered in this, the subsequent review.

3.4.4 The tabletop review was undertaken at a time when Simon had recently been admitted to hospital and detained under section 2 MHA. This was an ideal opportunity to discuss what support was to be offered to the family, as identified as a learning theme but there is limited evidence that this was done and feedback from the family would indicate that this was not the case.

3.4.5 The tabletop review rightly identified that agencies when dealing with families where English is not their first language should use accredited interpreters to ensure that the views from families are accurately given and recorded. There is evidence of good practice with Simon's school and CSC either using interpreters or introducing staff who had the necessary language skills. Despite the learning achieved in the November 2019 tabletop review there continued to be some instances where Simon or his sibling were used to interpret for their parents. In February 2021 the care coordinator asked Simon to interpret for this mother and in February and March 2021 during consultations with the consultant psychiatrist it is not clear that there was support of an interpreter. During this meeting important information was given on diminishing the risk of suicide, which was vital that the parents and family fully understood.

[22] Working Together 2018, HMG (Chapter 4.20)

Learning

There still remains an issue with the ability of agencies to access appropriate interpreting services. There will be a difficulty with this where agencies are responding to an unplanned dynamic situation but where there is a long-term relationship between professionals and families there should be scope to pre-plan the appropriate support.
Where there is a learning process and the subject of that review is still living there should be built into that process the ability to review the case at given points to evaluate whether the learning identified has been implemented and the same issues do not still exist.

Recommendation 7

The Warwickshire Safeguarding Partnership should seek assurance to ensure that the learning from the Simon tabletop review of 2019 is effectively communicated to all agencies and should in due course consider a multi-agency audit on the learning theme of the use of interpreters.

3.5 What was the effect of Covid both on Simon and his family and on the ability of agencies to deliver services?

3.5.1 The UK went into the first national lock down in March 2020, at this time Simon was still at in the Tier 4 hospital under the Mental Health Act. He was discharged in April 2020, other agencies involved in supporting Simon were not informed of the discharge. The Covid restrictions also impacted on the periods of home leave that Simon was able to have, this had bearing on his discharge.

3.5.2 The restriction implemented as a result of the pandemic had a notable impact on the ability of agencies to undertake face to face visits. Simon articulated to the RISE coordinator that he preferred face to face contact. Where it was not possible to have face to face meeting a number of other alternatives were used.

3.5.3 The CiN plan was started in June 2019 and most of the reviews and subsequent meetings were undertaken virtually and by email. This approach cannot be entirely attributed to the pressures brought about by the covid pandemic.

3.5.4 The school acted very responsively when Simon was discharged from the Tier 4 hospital. This included placing him in the most vulnerable cohort and resulted in him being contacted regularly by the school. The school liaised well with other agencies and facilitated a joint CiN/EHCP review meeting. The school sourced an accredited interpreter for the meeting. The school had researched an area of work which Simon was interested in and provided translated information for Simon's parents.

3.5.5 Whilst there is a lack of consistent evidence to support the view that children and young people with pre-existing mental health conditions before the pandemic were exacerbated as a result of the pandemic and resulting restrictions[23], there can be little doubt

[23] Covid 19 mental health and wellbeing surveillance report, April 2022 (Chapter 4), Office for health improvement & disparities, HMG

that the pandemic presented challenges for Simon. One of these was recorded as him not being able to have the face to face contact with professionals that he would have wished.

3.6 Was there recognition of the relevant risk factors in this case and did this result in appropriate analysis and mitigation of the risk?

Where assessments were undertaken was historical information effectively used to inform them?

Mental Health Assessment

3.6.1 There were indications that Simon was prone to risk taking behaviour. His accident in 2018, which resulted in his brain injury, involved him climbing on a building and falling through the roof. After his accident the family describe Simon as angry, impulsive, anxious and stressed. In April 2019, Simon jumped from a window in his family home and Simon described this as thrill seeking activity having lost his ability to ride motorbikes since his injury. There was also evidence during the course of the timeline of this review of Simon having at least three accidents on his pushbike. Simon's family, when spoken to for this review, felt that Simon's behaviour was unpredictable and the evidence available would support this.

3.6.2 There is good evidence that Simon recognised his mental ill health and self-presented to hospital on four occasions seeking support (April 2019 leading to first hospital admission, November 2019 leading to second admission, February 2021 where he was reviewed and discharged pending psychiatric review in the community and March 2021 which was a week before Simon's death). Following the February 2021, presentation Simon was reviewed by his psychiatrist who felt that his visit to the hospital two days previously was an early sign of relapse[24], although there was consideration of substance misuse (Simon denied recent use of alcohol and drugs). In this appointment Simon agreed to an increase in his medication. Following this meeting a further request was made by letter for involvement with the EIP team.

3.6.3 Following Simon's last presentation at hospital he was reviewed by the psychiatrist a week later as part of a follow-up review, which also considered the recent hospital attendance. There was continuity in the psychiatrist involved as they had reviewed (either virtually or in person on 13 occasions since November 2019) so the history was well known to them. The care coordinator was also involved who had regular contact with Simon for a considerable time.

3.6.4 During this review Simon again requested a reduction in his medication. This had been an enduring feature of Simon's requests over a period of time and it was felt that this was mainly due to Simon's weight gain whilst being on the medication. There had been agreed gradual reduction to maintain engagement, and this was supported by regular review. Following the February 2021 and March 2021 presentations at hospital the medication was increased. Simon's desire to reduce his medication was acknowledged but this was counterbalanced by the need to keep Simon stable. The level of medication was addressed regularly in reviews with Simon and advice and suitable guidance was given.

[24] Inquest witness statement, CWPT

3.6.5 Simon's last mental health assessment was on the morning prior to his death. During this review Simon stated that he felt unsafe but there was no specific reason for this feeling. Simon admitted fleeting thoughts of harming himself. These thoughts were probed, and Simon detailed means of causing harm but stated he had not gathered such items as they were freely available at home. Simon stated that he had no immediate plans of suicide, and he was future orientated discussing future plans freely. Simon rated his mood at 3/10 (1 being low and 10 being good) and his anxiety 8/10 (1 being no anxiety and 10 being very anxious). Simon was assessed as having capacity to make decisions about his treatments and management.

3.6.6 The psychiatrist felt that there were possible risks of further deterioration of Simon's mental state if he was non-compliant with his medication. They acknowledged that there were unpredictable risks of self-harm or even suicidal acts, also that due to Simon's past history and recent reported abuse of substances it could lead to an impairment of Simon's mental health or influence his decision-making ability, including increased impulsiveness. Simon's previous attempt take his own life in May 2019, had been a concerted attempt at hanging where he was discovered in the family home having been unconscious for 8.5 minutes. There had been no red flags to this behaviour to alert family or professionals before it occurred. This also supported the potential for impulsive but concerted action by Simon.

3.6.7 There was discussion (through an interpreter) with Simon's mother who stated that she was not aware of Simon's suicidal thoughts. Simon and his mother agreed to safety strategies. Simon's mother was asked to remove/lock away all the potential materials that Simon could use to cause harm to himself. Advice on crisis support was given and arrangements for the RISE care coordinator to call on a daily basis.

3.6.8 Simon's mother disclosed that she supervised Simon at night by sleeping in the same room. From discussion with the family for this review, they found the advice regarding the removal or articles difficult both in practical terms but also the onus and responsibility it put on them for what was almost an impossible task. Whilst this course of action is understandable, as a risk mitigation measure the effectiveness is questionable as it was not clear to the family that there was an expectation that someone should be with Simon on a 24/7 basis. Where the act of suicide is completed, it also had the effect of increasing the sense of guilt and feeling of responsibility for the family. There may be an opportunity to review how this request is made and what support can be offered to families to help them achieve the request whilst sharing responsibility.

3.6.9 Whilst this review does not seek to question or challenge the mental health assessment made on the day of Simon's death it does highlight the difficulty of such assessments where there is potential of such fluctuations and tendency to impulsive and extreme behaviour.

MASH assessment

3.6.10 Following Simon presenting at the hospital in March 2021, the hospital made a referral to the MASH. The referral was made in the required fashion using a Multi-Agency Contact (MAC). The use of this process had previously been highlighted in this case during the tabletop exercise and this contact complied with the identified learning.

3.6.11 The MAC stated that Simon had attended the hospital with mental health issues and suicidal thoughts. He disclosed that he wanted to physically harm himself and these feelings were overwhelming. He went on to say that he had no actual plans and was not aware of the contributing factors. The MAC covered that Simon had previously been a psychiatric inpatient and that both Children Social Care and CAMHS were involved with him.

3.6.12 This referral in the MASH was dealt with poorly. There was no consideration of the history of the case both within CSC and other agencies. The referring agency was not contacted nor were any agencies currently involved with Simon (RISE and school). Simon and the family were not contacted and there was no consideration of an assessment of what support could be made available. The only action was that a letter signposting support was sent to the family. This letter was in English and despite previous interactions with the family and the recommendations of the tabletop review, there was no consideration of language and cultural issues.

3.6.13 There was recognition of this poor response following Simon's death and the Rapid Review and as a result remedial actions were implemented in the MASH. In September 2021, the Warwickshire MASH was replaced with the Warwickshire Families Front Door, which incorporates Early Help and Family Support. There is support from partner agencies, with plans to incorporate RISE. This review would suggest that RISE should be incorporated as a matter of priority. Warwickshire Safeguarding Partnership will be completing a full multiagency review of the Front Door and MASH provision.

Early Intervention Pathway

3.6.14 The guidance for implementing EIP and setting the standards for waiting times[25] identifies good evidence that these services help people to recover and to gain a good quality of life. EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. The guidance was introduced due the unacceptable level of persons with psychosis being able to access timely treatment. The standards set out two high level aims:-

- Anyone with an emerging psychosis and their families and key supporters can have timely access to specialist early intervention services, which provide interventions suited to age and phase of illness.
- Individuals experiencing first episode psychosis have consistent access to a range of evidence-based biological, psychological and social interventions as recommended by the NICE guidelines and quality standards for psychosis and schizophrenia.

For children and young people, the standards set a week target form the time of first referral. The importance of an effective EIP is also recognised locally in the CAMHS Transformation Plan.[26]

3.6.15 Upon discharge from the Tier 4 setting in April 2020, Simon was diagnosed with schizoaffective disorder and Post Traumatic Stress Disorder, due to this and Simon's continued presentation with psychotic symptoms the treating psychiatrist referred Simon to the EIP in June 2020. Simon was not accepted by the service on the basis that he had a head injury which may have contributed to his condition. In a dialogue that lasted throughout 2020 and into 2021, clarity was sought from the Consultant in Paediatric Neurology who treated Simon when he received his head injury. Simon was not accepted onto the EIP caseload until March 2021, some eight months following the first referral.

3.6.16 The NICE and NHS England guidance state that when dealing with access to the service that the only exceptions to these services will be where a person has a confirmed organic cause (such as brain diseases or tumours). This was not the case and as the final

[25] NICE and NHS England, 2016, Implementing the Early Intervention in Psychosis Access and waiting time standard: Guidance
[26] Coventry and Warwickshire's Child & Adolescent Mental Health Services (CAMHS) Transformation Plan Year 5 Refresh: 2021/22

acceptance recognised, Simon should have been accepted at a much earlier stage to the service.

3.6.17 Early acceptance to the service would have provided several benefits including support to Simon and his family, supporting Simon with co-existing health conditions such as weight gain, supporting with social issues. It would also have supported Simon as he transitioned into adult services.

Learning

The identification and management of risk for those with mental health conditions and experiencing suicidal ideation is difficult. Simon had demonstrated a real previous intent to take his life, there had been instances where he had been found with items to cause harm to himself and had also talked about suicide. It was recognised that Simon could act impulsively and that on and around the time of his death he was suffering high levels of anxiety.
It would not be appropriate for this review to comment negatively on the mental health assessment that was undertaken on the day of Simon's death but the circumstances should act as a reminder to all working in this very challenging area of the changeable dynamics of a person's mental health and despite their assurance and future orientation, completed suicide is an potential outcome at almost any stage.
When working with families, professionals need to be aware of the realities of mitigation measures, such as the cleansing of homes from items which may be used to cause harm. It may be that balanced and informed written guidance could be provided or professional support, but being mindful of what is actually achievable.
The MASH has undergone some changes since the events of this review but there is a need to understand that these changes will result in more positive outcomes.
The panel for this review recognised that there needs to be greater representation of the RISE service within the front door. Local discussion is required to establish what this service looks like.
The pathway for early intervention for Psychosis needs to be more easily achievable than it was in this case.

Recommendation 8

In reviewing the forthcoming contract for child and adolescent mental health services, the partnership should seek to embed a new model into the contract that should move away from a medicalised model based on diagnosis towards a needs led approach to ensure that appropriate support is provided in a timely manner whilst a young person awaits assessment or a treatment plan is agreed

Recommendation 9

All professionals managing the risk of suicide with families should seek to work with them when proposing measures involving the removal/storage of items potentially used to cause harm and consideration should be given as to the best method of delivering this information.

Recommendation 10

The Warwickshire Safeguarding Children Partnership in the planned review of MASH and the Front Door should be assured that a concern of the same nature as in this case would be appropriately and effectively dealt with. The Partnership should seek assurance that RISE

presence within the Front Door model is a priority and there is local dialogue to shape and achieve this.

Recommendation 11

The commissioners of the Early Intervention in Psychosis Access pathway should ensure that the service is delivering within the NICE and NHS Guidance on Access and Waiting Time standards.

3.7 In the assessment of risk was the cumulative effect of Adverse Childhood Experiences (ACEs) considered?

3.7.1 Adverse Childhood Experiences (ACEs) are defined by Public Health Wales ACE's as *'traumatic experiences that occur before the age of 18 and are remembered throughout adulthood'*
They state that *'Evidence shows children who experience stressful and poor-quality childhoods are more likely to develop health-harming and anti-social behaviours and are more likely to experience poor mental health due to poor self-image and self-worth'*

A thematic review of child suicides in The Black Country[27] looked at 6 cases of confirmed and suspected childhood suicides and found that in 5 of the 6 cases (83%) there were 3 or more recognised ACEs present. Different childhood experiences and the duration of exposure to them will have an effect on the impact of the experience.[28]

3.7.2 A recent report exploring the rate of likely suicides among all children and young people between April 2019 and March 2020 found that the top three factors that were present amongst many suicides were household functioning (69%), loss of key relationships (62%), and the mental health needs of young people (55%)[29].

3.7.3 Simon had alleged sexual abuse and there was evidence that he felt that there was an important person in his life, the close friend who he may have felt he was losing contact with[30]. Simon's parents were estranged. There was also more latterly in the chronology of the case information from the family that there had been two instances of family suicide in their home Country. Simon also suffered an injury that had a significant social impact on him, there is evidence that he was searching for the person that he used to be before his accident[31].

3.7.4 The Black Country Thematic review made two recommendations concerning ACE's and suicide antecedents. *There should be a consideration of incorporating ACE's and the link to increasing suicide antecedents into all assessments and discharge planning processes within mental health services* and *to ensure professionals understand ACE's, the risk of cumulative harm and the impact of these adversities and for this approach to be applied within decision making, whether the child is seen to be coping or not.*

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[27] Black Country and West Birmingham CCG, 2021, Safeguarding Review of suspected child suicides in The Black Country and West Birmingham
[28] BMJ 2020;371:m3048
[29] NCMD. (2021). Suicide in Children and Young People—National Child Mortality Database Programme Thematic Report. https://www.ncmd.info/wp-content/uploads/2021/11/NCMDSuicide-in-Children-and-Young-People-Report.pdf

[30] Record of Inquest
[31] Family interviews

3.7.5 There should be consideration of ACEs and the recognised suicide antecedents when undertaking assessments and discharge planning within mental health and that professionals understand ACEs and the impact of cumulative harm.

3.8 Access to and provision of Tier 4 settings

3.8.1 In this case a Tier 4 provision was found for Simon but this entailed him moving some 100 miles away from his family and therefore required the family to make a 200 mile round trip on an almost daily basis. The inability to access a more local provision put considerable additional pressure on the family and undoubtedly caused Simon additional concern. This is a national issue and was recognised in the CQC Review of Children's Mental Health Services[32] which states

'For those children and young people who need more intensive and specialist care, there are significant challenges in accessing services. There are long waiting lists for many of the services that provide specialist mental health care in the community, and the imbalance between demand and capacity in inpatient care means that children and young people cannot always find an appropriate bed in an inpatient ward close to home.'

3.8.2 Simon was discharged from the Tier 4 in April 2020, the hospital was inspected in November and December 2020, with a report published in February 2021. The hospital was deemed to be inadequate overall and placed in special measures. The findings included young people and families not being involved in care plans and risk assessments. A new management team has since been established in the hospital but the changes made it difficult for this review to access all records, although the current leadership did their best to assist the review.

Recommendation 12

NHS England should be made aware of this review to assist in informing the national review of the service specification for Tier 4 CAMHS services.

4.0 Recommendations:

Recommendation 1

The Warwickshire Safeguarding Partnership should seek assurance on effectiveness of Child in Need Plans in the context of providing support to children and young people at risk of suicide and how these relate to other relevant plans such EHCP, RISE Care Plans and Risk Plans.

Recommendation 2

Warwickshire Children Services and relevant partners should review the process and policy of receiving and responding to notifications under section 85, Children Act 1989.

Recommendation 3

[32] CQC, 2017, Review of children's and young person's mental health services phase 1

Considering the findings of this review, previous local reviews and National reviews the partners of the Warwickshire Safeguarding Partnership should seek to understand if there are barriers to convening strategy discussions in relevant cases. This should also look at the timeliness, attendance, management oversight and effectiveness of strategy meetings that do take place. Consideration should be given to how this assurance can be monitored going forward.

Recommendation 4

The Warwickshire Safeguarding Partnership should ensure that the learning on this review is considered by the Exploitation sub group to consider how they link to the Exploitation Strategy and are used to help to develop a trauma informed approach for child sexual abuse.

Recommendation 5

West Midlands Police should provide assurance to Warwickshire's Safeguarding Partnership that victims and where appropriate parents of children and young person's reporting offences of rape and serious sexual assault are appropriately updated and offered support.[33]

Recommendation 6

When agencies are dealing with children, young people where there is a risk of suicide consideration should be given to a 'Think Family' approach, with particular consideration to areas of culture.

Recommendation 7

The Warwickshire Safeguarding Partnership should take action to ensure that the learning from the Simon tabletop review of 2019 is effectively communicated to all agencies and should in due course consider a multi-agency audit on the learning theme of the use of interpreters.

Recommendation 8

In reviewing the forthcoming contract for child and adolescent mental health services, the partnership should seek to embed a new model into the contract that should move away from a medicalised model based on diagnosis towards a needs led approach to ensure that appropriate support is provided in a timely manner whilst a young person awaits assessment or a treatment plan is agreed[34].

[33] Recommendation requested by WS Executive Board
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Recommendation 9

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Recommendation 10

The Warwickshire Safeguarding Children Partnership in the planned review of MASH and the Front Door should be assured that a concern of the same nature as in this case would be appropriately and effectively dealt with. The Partnership should seek assurance that RISE presence within the Front Door model is a priority and there is local dialogue to shape and achieve this.

Recommendation 11

The commissioners of the Early Intervention in Psychosis Access pathway should ensure that the service is delivering within the NICE and NHS Guidance on Access and Waiting Time standards.

Recommendation 12

NHS England should be made aware of this review to assist in informing the national review of the service specification for Tier 4 CAMHS services.