Sunderland Safeguarding Children Board

Serious Case Review

Young Person Mark[1]

[1] *Not his real name*

Final - 8th November 2017

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1 Local Safeguarding Children Boards (LSCBs) and Serious Case Reviews

1.1. The main responsibilities of Local Safeguarding Children Boards (LSCBs)[2] are to co-ordinate and quality assure the work of member agencies to safeguard children. The statutory guidance[3], which accompanies legislation and underpins the work of LSCBs, is very clear in its expectation that LSCBs should maintain a local learning and improvement framework so good practice can be identified and shared.

1.2. In situations where abuse or neglect of the child is known or suspected, and children die or are harmed, LSCBs are required to undertake a rigorous, objective analysis of what happened and why, to see if there are any lessons to be learnt which can be used to improve services in order to reduce the risk of future harm to children. There is an expectation that these processes known as Serious Case Reviews (SCRs) should be transparent with the findings shared publicly.

2 The circumstances which led to this Serious Case Review

2.1. Mark came to the attention of agencies in 2013 when he was 12 years old and his school were concerned about his misuse of drugs. During the next three years, professionals from different services were involved with Mark and his Mother in response to his continued and escalating drug use, his offending behaviours and frequent periods of going missing. Early in 2015 Mark was made subject to a Child Protection Plan under the category of Neglect but concerns about his safety and wellbeing continued. Despite professional optimism that things were beginning to change for Mark, his mental health began to deteriorate and in September 2015 Mark was sectioned[4] first under S2 and later under S3 of the Mental Health Act[5] and was placed in a secure setting amid continued concerns about his safety, behaviour and mental health. The Youth Offending Service (YOS) referred Mark's situation to Sunderland Safeguarding Children Board (SSCB) as they were of the view that Mark had suffered significant harm because agencies did not act early enough to safeguard his safety and well-being.

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[2] *Children Act 2004, s14*

[3] *Working Together to Safeguard Children 2015. HMSO*

[4] *'Being 'sectioned' is the term that is often used when someone is detained under the Mental Health Act 1983. The Mental Health Act is the law which **can** allow someone to be admitted, detained (or kept) and treated in hospital against their wishes.*

[5] *Section 2 of the Mental Health Act (1983) allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days. Section 3 of the Mental Health Act is commonly known as "treatment order" it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met. These are that the person is suffering from mental disorder and that the mental disorder is of a nature or a degree which warrants their care and treatment in hospital and also that there is risk to their health, safety of the service user or risk to others.*

2.2. The retiring SSCB chair took a decision in October 2015 to undertake a SCR in respect of Mark, but this decision was challenged by Children's Social Care (CSC) and the SCR did not immediately commence. The decision to commission a SCR was later reviewed in May 2016 by the incoming Interim chair of SSCB who confirmed that the circumstances which led to Mark being sectioned under the Mental Health Act together with concerns about multi-agency working met the criteria for a SCR.

2.3. Given the context in which this SCR was commissioned[6], the Interim Chair of SSCB requested a **short focused report** [7] which reviewed decision -making and practitioner involvement with Mark and his family between March 2013 and September 2015 and which considered:

- To explore how well the system worked together in identifying, responding, and meeting the needs of both young people.
- To determine what collective understanding there was in terms of the young person's vulnerabilities and the risks to which they were exposed.
- Building on learning from previous [and not dissimilar] SCRs to examine the barriers and system challenges for agencies and professionals in working effectively with young people with complex and challenging behaviours.
- How well were staff supported and supervised when working with these young people and were they able to, use evidence, research, and good practice to exercise professional judgement in a safe and appropriate way?
- Identify required system changes to enable and support practitioners to work more effectively with older children like Mark and Rachel.
- Identify opportunities to learn from and improve frontline practice when working with vulnerable adolescents.

3 Family Involvement

3.1. The Review Team took advice on three occasions to determine whether Mark could contribute to this SCR but was informed by social workers and health professionals that his mental health was not good and he was, at the time of writing this report, extremely vulnerable. The Review Team therefore agreed not to contact Mark directly and left open the possibility that he may at some point in the future want to know more about the SCR and its findings.

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[6] *The context was in relation to the sheer number of reviews already underway in Sunderland and the learning already identified. This required a more proportionate form of SCR rather than a disproportionate use of resources rehashing learning already identified. In addition a Children's Company was being formed to run the local authority's children's service and the implementation of significant changes were already taking place.*

[7] *The Chair of LSCB advised the Lead Reviewer that given the context in which this SCR was being undertaken, the SCR report was required to be a short focussed report and agencies were not required to submit the usual Agency Learning Reports. This posed a particular challenge for the SCR Review Team which then had to rely on scoping and review meetings to review agency practice.*

3.2. Attempts were made by the SSCB to involve Young Person Mark's Mum in the process but she declined to be involved. Further attempts will be made to share the overview report with her and if she would want to add anything to the report regarding her views on the work undertaken with Young Person Mark and his family an addendum to this report will be published.

4 Links with other Serious Case Reviews

4.1. In late 2015, two SCRs in Sunderland were finalised, which related to the sad and tragic deaths of two adolescents. There were some similarities which emerged from both reviews, and the then independent Chair of SSCB commissioned a thematic review to ensure that the learning from both reviews was collated and the lessons fully captured. The report from that review was completed in June 2016 and is referred to in this report as the **Thematic Report**.

4.2. The themes identified in the **Thematic Report** have already led to some significant changes in processes and systems in Sunderland, some of which have already been introduced and some which at the time of writing this report are still in progress. In the recent past, SSCB has published other SCRs which although not related to adolescents, nevertheless identified common themes which all highlighted that multi-agency services in Sunderland at that time were not working as well as they should have been.

4.3. At the same time as the SCR for Mark began in September 2016, another SCR, which related to a 16-year-old female, also began. The Safeguarding Board partners agreed that both SCRs should have due regard to any common areas of learning and should also relate these to previous findings from other reviews which related to work with adolescents. The Review Team were also asked to take into account the changes already being embedded in Sunderland, especially given that the SCRs related to roughly the same period.

5 The context in which this SCR took place

5.1. In July 2015, children's services and safeguarding departments in Sunderland were placed into special measures when they were deemed by Ofsted to be inadequate. As a result of that rating, many changes to single and multi-agency systems were introduced and other longer-term improvements are currently underway. Recent monitoring visits by Ofsted in 2017 have confirmed that steady progress is being made and there is clear evidence of significant and steady improvements.

5.2. To date, nine SCR reports have been published in Sunderland and 5 more are moving towards completion. Given that all these SCRs have reviewed practice up to and including 2015, it is not surprising that some of the findings also reflect those identified in the Ofsted report. The challenge therefore for this SCR was to

ensure that any findings were viewed against a landscape of significant change within and across the authority which continues to emerge and develop. There is an acknowledgment by SSCB that certainly in relation to work with adolescents there is still much to be done but it is encouraging to see this work has been identified as a priority in the 2017 – 2018 SSCB Business Plan.

5.3. In light of this context and in relation to the findings in this SCR, the Review Team has sought to identify where changes have taken place, where changes are in progress and where further work is still required. It must also be reiterated that this SCR is reviewing practice 2 to 3 years old, and whilst other SSCB reviews and the Ofsted monitoring visits suggest that the improvement journey is still on-going, there is evidence of steady progress being made to achieve better outcomes for children and young people in Sunderland.

5.4. The Review Team was grateful to the practitioners involved in this review, who willingly engaged in this process and volunteered their reflections and professional insights, which have helpfully contributed to this report.

6 The approach used

6.1. A Review Team was established which included senior managers from all the agencies known to Mark and his family. The members of this group are listed below:

- Independent Lead Reviewer
- SSCB Strategic Business Manager
- Northumbria Police
- Sunderland City Council: Youth Offending Service, Children's Social Care, Education
- Northumberland, Tyne & Wear NHS Trust
- South Tyneside NHS Foundation Trust
- Housing Provider Gentoo
- North East Ambulance Service
- Sunderland Clinical Commissioning Group

6.2. The senior managers also identified practitioners from their own agencies who knew or had worked with Mark during the period under review. These practitioners were known as the 'Practitioner's Group' and they contributed to the SCR process and offered an opportunity to discuss lessons from previous SCRs and how and where these had relevance for their work with Mark.

6.3. The practitioners were extremely forthcoming about the issues they faced in working with adolescents and their reflections of the challenges of working with Mark and other adolescents were particularly illuminating. The group later came together for a full day with the Review Team and other practitioners who had not worked with Mark, to discuss and to explore whether single and multi- agency

systems and processes were changing to better support existing work with adolescents.

7 Analysis and Findings of Practice

7.1. The purpose of Serious Case Reviews is to support improvements in safeguarding practice. This means it is not sufficient just to describe professional activity in a case or to identify elements of practice that were problematic, without explaining why they occurred. The analysis needs to provide an explanation of what influenced professional activity and decision-making at key points in the management of the case.

7.2. This SCR has not identified a significant contravention or action by any professional that was a critical factor in what happened to Mark in September 2015. Indeed there was evidence that many professionals with whom Mark came into contact were concerned about his welfare and safety and sought to engage him or seek access to other services.

7.3. The learning from the SCR does, however, invite and require a better understanding by managers and practitioners in education, health and social care of the interplay between adolescent choice and risk, especially in terms of substance misuse, the importance of shared assessment processes for children showing indicators of need or vulnerability but who have not reached thresholds for statutory safeguarding, and the management of concerns and referrals when dealing with young adolescents whose life style, circumstances and mental capacity may be factors that require a more assertive and inquiring approach.

7.4. *Understanding adolescent behaviours*

7.4.1. Risk-taking is a normal part of adolescent development and most young people experiment with the increased opportunities for risk that their growing independence allows. For some young people this includes experimenting with drugs and alcohol. However, unless professionals understand the difference between normal experimentation and the signs which identify seriously troubled young people, opportunities for effective and timely interventions will be missed leaving some young people at greater risk.

7.4.2. The first recorded concerns about Mark's substance misuse occurred soon after he began secondary school at around 11 years of age. Education records suggest that Mark had four moves between schools between the ages of 11 and 13 in connection with his drug use

7.4.3. In May 2013, Mark's school made a referral to Children's Social Care (CSC) referring to his persistent use of use of cannabis and indicating concerns that that although he was an able pupil, his health and presentation had deteriorated significantly over the last few months. CSC assessed the referral but took no

further action noting that Mark and his family were working with YDAP. This decision was made by a duty social worker that appears to have been reassured that the family were engaging in early intervention services and therefore the referral did not meet the threshold for statutory intervention**.**

7.4.4. There is however no evidence to suggest the duty social worker sought to establish with YDAP the extent and impact of their involvement, which would have been expected given the nature of the school referral. Had this contact been made, it would have emerged that although some initial contacts had been made, Mark and his family were not in fact engaging with YDAP.

7.4.5. The school were verbally advised by the duty social worker to contact them again if further concerns emerged. This response was accepted by the school as they believed that CSC had fully assessed the situation and concluded there was no immediate risk to Mark. This readiness of referring agencies to accept the decisions of social workers without being offered a clear rationale for their decision-making has emerged in other SCRs, both in Sunderland and elsewhere. If CSC are noted '*not to be concerned*', referring agencies can sometimes be reassured that '*things can't be that bad*'. Despite Mark's continued deterioration, no other referrals to CSC were made by education services around that time or later.

7.4.6. Given Mark's age and the nature of the schools concerns – persistent drug use and a marked deterioration in his health and appearance - the referral to CSC should have led to an Initial Assessment which would have provided an opportunity to gather more information about Mark and his family and importantly would have highlighted YDAP's difficulty in engaging effectively with Mark's Mother and his Father, who did not live with the family and worked abroad six weeks of out every nine.

7.4.7. Practitioners suggested to the Review Team that that the CSC decision not to pursue an Initial Assessment may well have been influenced by a range of additional factors not least of which were the numbers of young people on caseloads and in the locality who also misused substances and who were disengaging with education. The issue of Mark's behaviour being viewed as '*similar to that of many other young people'* in some parts of Sunderland was acknowledged by some practitioners although they pointed out that Mark was at the time thought to be receiving a service and his Mother was seen then as a protective factor. When Mark's Mother informed YDAP that they no longer required their services, increasing the potential risks to Mark, this should have prompted contact with CSC given the earlier referral by the school. Had there been more collaboration between the three services, this would have been seen as an appropriate and necessary course of action.

7.4.8. The Review Team was curious to know how YDAP was working at the time as there was no evidence that Mark had been assessed by the service or that subsequent action had taken place when he failed to engage with the service. The Review Team learnt that the model and systems used in YDAP at the time were not as robust as they could have been and at the time of this review, YDAP were not using a structured assessment framework to plan interventions. A framework is now in place which betters identifies levels of vulnerability in young people and can better evidence when the threshold for a referral to CSC is needed.

7.4.9. There was an acknowledgement that some professionals supported by their agencies can too easily view substance misuse as '*something that young people do these days*' and therefore may unwittingly minimise the dangers and risks involved. These early days were an opportunity to better understand what was happening to Mark and to try and identify the reason for his substance misuse so that the right services were offered and taken up by the family. This did not happen and Mark's vulnerabilities went unrecognised and remained so for almost two years.

7.4.10. ***Finding 1:*** *Without analytical assessments, multi-agency collaboration and challenge, the harmful behaviour of some adolescents may be too easily viewed as 'just what teenagers' do' and this perception can prevent early intervention for those adolescents at greatest risk. Training and workforce development, including quality supervision, must ensure practitioners have the skills to work with adolescent choice and complex behaviours and have opportunities to develop their understanding of the adolescent world, including substance misuse and other forms of risk.*

Issues previously identified in SCRs/Thematic Report: *Multi-agency working, assessments, supervision, appropriate training for workforce*

7.5. Responding to adolescent risk- taking behaviours

7.5.1. Mark's offending and use of alcohol and substances escalated during 2013 and became daily occurrences. He was frequently reported to be using legal highs including MCAT[8]. It is worthy of note that even the young people with whom Mark associated and who also took drugs, raised their concerns with education staff about Mark's welfare and suggested that he was too often '*out of it'* and would take anything to '*get high'*. There is little to evidence that any action was taken in response to these concerns, which in itself raises questions about how well young people are listened to and their views taken seriously.

[8] *MCAT is a stimulant drug belonging to a group of drugs related to amphetamine compounds like speed and ecstasy.*

7.5.2. Concerns began emerging around this time that Mark was being sexually exploited. There has been, since 2009, an array of public documents and initiatives aimed at local authorities to advise about how to recognise and respond to concerns about CSE. Even so, as late as 2014 professionals in Sunderland were slow to respond to Mark's vulnerabilities and the risk of sexual exploitation.

7.5.3. Mark was referred in 2014 to SEAM[9], a set of multi-agency arrangements aimed at meeting needs of children at risk of sexual exploitation but no disruptive or preventative actions were taken. The Review Team was of the view that had Mark been female there may well have been a far more urgent response by professionals, a view supported by professionals given the services to young people ***at that time***. An Ofsted report (2015) recorded that services for children and young people missing and at risk of child sexual exploitation were at that time '*insufficient and poorly coordinated* and *the report* was critical about the viability and effectiveness of the SEAM arrangements. SEAM was replaced later that year by MSET, a set of multi-agency arrangements designed to be a more robust and efficient multi-agency response to child sexual exploitation.

7.5.4. The Review Team had access to the minutes of the MSET meetings which related to Mark, and were concerned to note how often actions by social workers were not progressed within the agreed timeframe. There was evidence that even after 5 months, when issues about inaction had been escalated to senior managers; these concerns had still not been acknowledged. This is very poor practice and impacts upon the effectiveness of MSET from both operation and strategic perspectives. SSCB needs to continually monitor this service to ensure that current MSET[10] arrangements are not compromised by such practices which can too easily lead to drift and delay for some young people.

7.5.5. Mark was discussed at an MSET meeting in February 2015 following Police reports about the number of times Mark was going missing. According to CSC records, there were at least 14 contacts or referrals to children's services between May 2013 and January 2015 including child concern notifications (CCNs) from the police. Each of these described or highlighted the same concerns, but it was not until the intervention of the MSET Coordinator that a decision was taken that Mark would be subject to a MASH[11] discussion to determine whether further enquires were required under child protection procedures. Even so, Mark was assessed as low risk, but given what was known about his circumstances, the MSET co-ordinator urged CSC to undertake an Initial Assessment. This was good practice.

[9] *Sexual Exploitation and Missing arrangements*

[10] *Missing, Sexually Exploited and Trafficked arrangements – these arrangements were multi-agency focussing on operational activity and replaced the SEAM arrangements.*

[11] *Multi-Agency Safeguarding Hub: The Sunderland MASH was a joint initiative between Sunderland City Council, Northumbria Police and the NHS to co-locate key members of staff in order to ensure a timely, appropriate response to safeguarding children concerns*

7.5.6. It is important to note that at that time CSC were not subject to any challenge by other agencies about their lack of response. Whilst YOS did challenge CSC about drift and delays and the frequent change of workers, the Review Team concluded that these challenges were not sufficiently robust and were certainly not escalated, as they should have been.

7.5.7. What is clear is that referrals and concerns when they were raised with CSC were viewed as individual and singular episodes rather than emerging and escalating patterns of risk and consequently opportunities to view what was happening to Mark from a wider perspective were lost.

7.5.8. At twelve years old and certainly until he was 15, Mark was showing clear signs of being a troubled young person, yet it appears that no serious questions (a seeming lack of professional curiosity) were asked by professionals as to why he misused alcohol and substances, what the underlying reasons might be for such behaviour and what the impact of long term drug misuse could be on his mental and emotional health.

7.5.9. What emerged from discussions within the Review Team and with practitioners and managers was evidence that for some professionals the interplay between adolescent choice and risk was not well understood nor carefully explored. According to various agency records, Mark's behaviours seem to have been seen as *'freely chosen, informed, and adult-equivalent'*. In one agency report there is reference to Mark making a '*lifestyle choice'* in terms of his continued substance and alcohol misuse. Even the rationale for placing Mark on a child protection plan for 'Neglect', in March 2015 was recorded as '*not being a reflection of the care offered by his Mother'* but was in response to Mark's '*informed decisions'* which placed him at risk of significant harm. Research[12] suggests that where choice and behaviour are playing a part in the lives of children about whom there are growing concerns, this is typically because one or more of the following factors or processing are at work or are interacting;

- Normal adolescent developmental processes (risk taking, peer influence, the desire for high status with friendship groups)
- Adaptive behaviour in response to previous maltreatment and/or adversity
- Societal attitudes and policies which increase risk or harm in response to adolescent choices and behaviour i.e. responding to youth offending which inadvertently reinforces criminal identify)

7.5.10. The Review Team was not confident that any of the above factors were explored in sufficient detail as part of any assessment process and this was very possibly due to an unconscious bias which left professionals reassured by what appeared

[12] Beyond simple models of adolescence to an integrated circuit-based account: A commentary BJ Casey(2015)

to be a protective family and a young adolescent just making the '*wrong choices'*. Mark was most certainly viewed as 'the problem' within his family and this perception seems to have been mirrored by some professionals, evidenced in case notes when for example, discussions about Mark continued with his Mother even when Mark was clearly angry and left the room.

7.5.11. It seems that the view that Mark was 'the problem' was also reflected in a professional system, which sought to stop his substance misuse rather than understand it. There was a sense that despite her reluctance to engage in family therapy or with services, Mark's Mother was seen as deserving of extra support and sympathy rather than an assessment as to whether she or Mark's Father were adequately meeting their son's emotional needs. Yet there are references in CSC records which suggest that Mark was emotionally distant from his Mother and her behaviour towards him and her unwillingness to engage with services may have contributed to his difficulties and may have been a form of unintentional emotional neglect. This was however, not explored in any detail and so the focus remained on Mark's behaviour.

7.5.12. There are some vague references in CSC case notes to family conflicts in the home prior to this time and records which infer there was a poor relationship between Mark and his Mother and conflict between Mark and his absent Father but without any assessment which captured information from other agencies, the full picture of Mark's life did not emerge. From records seen by the Review Team, there appears to have been a greater focus by some professionals on educating Mark about the dangers of substance misuse and the impact of his behaviour on his Mother's well-being rather than any professional curiosity about what may have happened to him which made substance and alcohol abuse such an apparent necessity in his life.

7.5.13. Many factors influence whether an adolescent tries drugs, including the availability of drugs within the neighborhood, community, and school and whether the adolescent's friends are using them. The family environment is also important and family conflicts, parent's lifestyle and mental illness can increase the likelihood an adolescent will use drugs. In addition, an adolescent's inherited genetic vulnerability; personality traits like poor impulse control or a high need for excitement; mental health conditions such as depression, anxiety, or ADHD; and beliefs such as that drugs are "cool" or harmless make it more likely that an adolescent will use drugs.[13]. Add to this all the vulnerabilities that arise if a young person is at risk of or involved in sexually harmful behaviour or sexual exploitation and the need to understand the source or cause of such drug use becomes evident. Again the Review Team were unable to evidence any curiosity or

[13] *Alcohol and drug use among adolescents: and the co-occurrence of mental health problems. British Medical Journal (2010)*

consideration by parents or professionals as to why Mark took refuge in substance misuse and this led the Review Team to conclude that his behaviour was indeed perceived as a '*lifestyle choice'*.

7.5.14. It is clear from records and discussions with practitioners, that Mark's Mother was concerned about her son and sought help to address his behaviours at various times during the period under review. What is less clear is how professionals sought to engage both Mark's parents in discussions about the best way to help Mark. Direct work that incorporates a family-centred approach, with the adolescent and family engaged together, has the best chance of achieving successful outcomes for adolescents with substance use disorders. Family members are a critical component of the adolescent's recovery process and some level of family involvement is essential for successful outcomes. In contrast to interventions that focus just on the young person, family-centred work capitalises on the youth's and family's strengths, resources, values and culture and maintains the integrity of the family-unit while developing resiliency and demanding responsibility and accountability.[14] Although records suggest that neither parent elected to engage with professionals, the Review Team was unable to determine if this was as a result of a lack of commitment or a lack of understanding about what would best help Mark.

7.5.15. The notion of 'problematic' drug or alcohol use is different for young people than for adults. This is partly because they are younger – what might seem to be 'normal' adolescent experimentation in a 17 year old should be grounds for intervention in an 11 year old. Crucially, drug and alcohol use among young people is often thought to be problematic because of its relationships with other problems in the young person's life. Research[15] highlights that drug and alcohol misuse among teenagers 'is usually a symptom rather than a cause of their vulnerability', and compounds other problems in their lives such as 'family breakdown, offending, truancy, anti-social behaviour, and mental health concerns such as self-harm'. There was evidence to suggest that Mark's behaviours were initially viewed within the category of normal adolescent risk taking behaviour rather than adaptive responses to maltreatment, emotional neglect, and/or adversity.

7.5.16. ***Finding 2****: There was a lack of* ***professional curiosity*** *about Mark's background, what had happened, and what was happening in Mark's life, which meant that his behaviour and substance misuse were regarded as 'the problem', rather than being symptomatic of other stressors in his life.*

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[14] *Santisteban, D.A. (2008). Engaging reluctant family members into an adolescent's substance abuse treatment: A guide for practitioners. Southern Coast Addiction Technology Transfer Center.*

[15] *NTA: 'Substance in Young People 2010 – 2011 data, Public Health England Young People's Drug, Alcohol and Tobacco use: Planning for Services 2016 - 2017*

Issues previously identified in SCRs/Thematic Report: *Quality Assessments, lack of professional curiosity.*

7.5.17. It was suggested to the Review Team that many professionals are not sufficiently aware of the impact of different illegal substances, including the relatively new range of synthetic and often legal drugs, which are now easily available. It was also suggested that cannabis can sometimes still be seen as less of a risk than LSD or heroin. Various research studies[16] highlight the trend for young people to use synthetic cannabis, which has been developed to be more potent than the cannabis in use in previous years, but which can have negative effects on emotional and mental health. The use of legal highs such as MCAT for example, can lead to dis-inhibited behaviours and can result in low mood, anxiety and paranoia all of which were evidenced in Mark's behaviour at various times.

7.5.18. Although recreational alcohol and drug use are more common in adults, studies[17] have shown that youths who engage in drugs and alcohol use are at greater risk for lifelong negative consequences, especially when they start using at a young age. Because the teenage brain is still growing and changing, alcohol and drug use at an early age have a greater potential to disrupt normal brain development. The most affected brain regions include the hippocampus—which is related to learning and memory—and the prefrontal cortex, which is responsible for critical thinking, planning, impulse control and emotional regulation. Drug and alcohol use also interfere with many other physiological processes and have been shown to destabilize mood. Thus, adolescent substance use is associated with higher rates of depression, aggression, violence and suicide. These findings are particularly disturbing given that, for most teens, like Mark, initiation of substance use tends to be at an early age. During discussions with practitioners, the Review Team were told that an unintended consequence of having specialist youth and alcohol services in an authority can mean professionals are less likely to learn more about substance misuse as they perceive that to be the remit of other services.

7.5.19. Certainly, Mark's continued use/progression from cannabis to the use of MCAT and other drugs did not appear to generate any additional concerns and despite his young age, referrals to CSC were not actioned until early 2015, almost two years after concerns had first been raised about his substance misuse. Given the diversity of drug and alcohol use in young people, practitioners told the Review Team it is not always easy to decide what constitutes problematic use. Not all young people who experiment with substances develop problem substance misuse and the Review Team was told it can be challenging to decide who should

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16 *NPS: Coming of Age. Drug wise May 2014*

17 *as above*

receive targeted interventions or more comprehensive, multi-agency interventions.

7.5.20. ***Finding 3 (NEW)*** *Many practitioners are not always clear what they should be doing in relation to substance use and their role expectations vary according to their specialist area of practice, their knowledge of substance use, and their levels of confidence. Whilst adolescents who use and misuse substance require specialist services that function as an integrated part of a broad range of support, professionals who work with adolescents in a wider range of services need to develop their skills and knowledge base about substance misuse.*

7.6. Risk Assessments and Planning

7.6.1. Numerous agencies were involved to varying degrees with Mark and his Mother during 2013 and 2014 including YOS, CAMHS and the family GP, but the Review Team could find no evidence of any risk assessments which sought to identify his needs or which captured views and information from other agencies. It is these assessments, which are needed to contribute to carefully design, and purposefully maintained child in need and child protection plans.

7.6.2. Some agencies clearly considered risks to Mark in the context of his repeat offending and failure to reach educational targets, but there was no evidence of any shared assessment between agencies about the risks to which Mark was exposed and which were impacting his well-being or future safety and welfare. There is little to evidence however that Mark was assessed during 2013/2014 in terms of his psychological vulnerabilities which, had they been recognised, may have indicated he was at significant risk of mental health problems known to be associated with cannabis and MCAT and other legal highs. The absence of a multi-agency risk assessment is not only the outcome of agencies not working collaboratively, it is, according to practitioners also a result of there being no agreed multi-agency risk assessment tool in use in Sunderland, so agencies inevitably resort to their own systems when undertaking risk assessments and opportunities to share information with other agencies are lost. A clear framework is needed to undertake comprehensive, multi-agency assessments of the unique needs of all young people and a case management structure to ensure a seamless service and accountability.

7.6.3. ***Finding 4:*** *Without a purposefully designed multi-agency risk assessment tool, embedded within all organisations and accessed through a single point of access, professional judgment about risk is more likely to be flawed and this will reduce the likelihood of effective interventions leaving some young people vulnerable. Such tools are known to be most effective when if the practitioners and managers who will be using them are engaged in their design and implementation.*

Issues previously identified in SCRs/Thematic Report: *Use of Assessment tools including risk assessments to aid professional judgment*

7.6.4. It was of concern to the Review Team that many practitioners who had contact with Mark were unaware of many aspects of his life. The Review Team discussed with practitioners the single and multi-agency systems in place to support the production and maintenance of quality records and in particular why chronologies, an essential and invaluable assessment tool, were not used to better effect. The Review Team were of the view that practitioners were not being negligent in not ensuring that chronologies were maintained but that inadequate and failing ICT systems, pressure of work, poor quality supervision and not having enough time combined to make the production and upkeep of useful and effective chronologies less likely to happen. Inevitably, this leads to criticisms when chronologies are either missing from reports or full of inaccuracies. Whilst professionals acknowledged that the time has yet to come when single agency IT systems communicate with each other, they also pointed out that there is currently is no system or agreed process in place to support the production of shared chronologies within a multi-agency framework.

7.6.5. Creating integrated chronologies is time consuming and costly but unless there are more simplified systems and clearer expectations that these must be produced when opening, reviewing or closing a case, practitioners will struggle to see the child's history and the significant events and transition in their lives. This issue has been raised repeatedly in SCRs. It will always be practitioners who must determine the key events in a case and the degree of impact on the child. Learning what should be transferred into a chronology is an important skill which managers should help professionals to develop but without functioning and effective IT systems it will remain a challenging task. To do justice to chronologies of course, practitioners need to spend time with families and the Review Team was told that very often that time was simply not made available to establish good working relationship with adolescents and their families. Practitioners advised the Review Team that this remains a key challenge in terms of current practice.

7.6.6. Mark was made subject to a child protection plan in March 2015 under the category of neglect. Education records indicate that the designated safeguarding person in school was asked by the IRO to submit a referral to YDAP. The referral to YDAP was made as requested although it is unclear why the referral is dated 14.10.2014 whilst also referring to the ICPC conference which did not take place until March 2015. There does not appear to have been any education representative at the subsequent Core Group meetings and the Review Team was unable to ascertain why and were informed that the safeguarding records for Mark had been mislaid.

7.6.7. The child protection plan produced at the first core group meeting was of poor quality. It did not identify defined goals, expected outcomes, or the measures by which progress or actions could be measured clearly. In effect the plan was not SMART[18] and consequently it did not drive forward any improvements in Mark's life. Despite the information available, the plan did not address issues with Mark's mental health, neither did it refer to risks of sexual exploitation, possibly the Review Team was told, because Mark was already on the radar of MSET, illustrating what may be a significant misapprehension about the role and function of the MSET service, which is to support casework with young people, not to replace it.

7.6.8. Mark's child protection plan was reviewed in June 2015 and Mark and his Mother both reported good progress in that Mark was back at school part-time and was reporting that he no longer took legal highs. He was reported to be far '*less angry'*. A decision was taken that Mark should remain subject to the plan for a further 3 months; this was a sensible move given this was still early days and Mark at the time, was being investigated for a serious offence.

7.6.9. Although the child protection plan had, in March 2015, identified the need for a paediatric assessment this action had still not been actioned three months later by the social worker and Mark was seen by the YOS nurse for a health assessment only. The Review Team was unable to determine why the request for a paediatric assessment was not actioned. As there were no records available and no practitioner or manager could recall what happened, it was suggested that because there was significant activity regarding MSET and drug and alcohol issues, professionals possibly became involved in that activity rather than following the agreed child protection plan. Even if this was the case, it simply reiterates the point made above about the importance of producing and implementing good quality plans which are regularly reviewed.

7.6.10. There is a reference in CSC records, to Mark having ADHD, however it is unclear when and where this diagnosis was made and by whom. Certainly most of the practitioners who contributed to the SCR process were unaware of this diagnosis. Mark and his Mother continued to report improvements in the spring of 2015 but any changes, if they existed, were not sustained, and concerns about Mark escalated in the summer of that year.

7.6.11. ***Finding 5:*** *When concerns are raised about a child, a clear chronology of events can show agencies where risks lie but unless practitioners understand how to build and maintain purposeful chronologies and without clear systems to gather, record and share this information, the use of chronologies to inform good assessments and decision making is less likely to happen.*

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[18] *Specific, Measurable, Achievable, Realistic and Timely*

Issues previously identified in SCRs/Thematic Report: *Use of Chronologies as multi-agency tool.*

7.6.12. As concerns about Mark's safety and welfare increased during the summer of 2015 and into September, social workers sought to secure a suitable placement for Mark, once it became apparent that family and services could not meets his needs within the community and keep him safe. What emerged from this process was recognition of the difficulty in finding suitable mental health provision for Mark which could meet his needs without depriving him of his liberty. As his mental health rapidly deteriorated Mark began to threaten others and continued to self-harm eventually resulting in the need for him to be sectioned under the Mental Health Act 1983.

7.6.13. ***Finding 6:*** *There remains a significant national shortfall in placements for children and young people with complex needs who require placements that can keep them safe and manage their vulnerabilities without needing to deprive them of their liberty.*

Issues previously identified in SCRs/Thematic Report: *Shortage of placements for young people with mental health needs*

7.7. Multi-Agency Working and Collaboration

7.7.1. The Thematic Report states that in Sunderland, there was '*a safeguarding partnership seemingly operating at a basic and pragmatic level only, and working in parallel rather than in an integrated, cohesive manner'.* This was evident in reviewing practitioner involvement with Mark between 2013 and 2015.

7.7.2. Practitioners intimated that within their own agencies there is still considerable reliance on their own agency procedures and recourse to multi-agency working is not always a first consideration. Other issues include barriers to specialist intervention and multi-placements, differing thresholds within each agency or differing interpretation of the thresholds. The SSCB threshold document, practitioners suggested, is not user friendly and given that agencies have differing protocols the threshold document needs to be simplified in order to facilitate better multi-agency working.

7.7.3. Practitioners acknowledged the benefits of multi-agency working but suggested that actually collaborating across agencies is not always easy given other time and workload pressures. Findings in relation to the lack of multi-agency collaboration have been widely publicised in previous SCRs and SSCB have acknowledged in their response to the Thematic Report that the changes they have introduced will lead to improvements in partnership working and agencies will be better supported to ensure that practitioners work more effectively with multi-agency partners.

7.7.4. Research carried out by ADCS[19] suggests that many areas in the UK are seeing an increase in adolescents such as Mark coming to the attention of formal CP services and without sound and effective multi-agency working, interventions are likely to be less than effective. Practitioners stated that they knew the value of multi-agency working but suggested there was and still is a need for greater clarity as to when professionals should have recourse to multi-agency meetings outside CIN and CP processes and what the status of those meetings should be. Agencies confirmed there remains a tendency to give greater priority to meetings called by CSC than by other agencies and this led the Review Team to conclude that more could be done to ensure that systems and processes better support multi-agency working.

7.7.5. In attempting to understand and attend to the needs of young people who misuse substances the Government's Drug Strategy stressed even in 2010 the '... *range of vulnerabilities which must be addressed, by collaborative work across local health, social care, family services, housing, youth justice, education and employment services'*, In a report on UK child health services, Kennedy[20] (2010) endorses such a '*whole systems'* perspective. He observes that '*providing high-quality services for children and young people requires agencies to work collaboratively*.'

7.7.6. Until March 2015, when Mark was placed on a Child Protection Plan, there was little evidence of any multi-agency working. Some agencies were working in isolation and were unaware of other agency involvement or the extent of work being undertaken by other professionals. For some professionals, it was only when they participated in the SCR process that they became aware of the involvement of other agencies in Mark's life. The School Nurse for example was not aware of Mark's background and until the SCR process; she did not know and was not consulted about Mark's substance misuse and deterioration in presentation and health whilst he was attending school. Not only are nurses uniquely qualified to spot early warning signs of mental ill-health they are also able to offer pupils a different sort of relationship to teachers. The Review Team was unable to determine why the school nurse was not consulted about Mark but the ensuing discussions with practitioners suggested that unless there is a visible presence in school and clear roles and communication channels, recourse to collaboration with school nurses is less likely to happen. The issue has been raised in previous SCRs and is clearly highlighted as an issue in the Thematic Report.

[19] ADCS is a membership organisation. Our members hold leadership roles in children's services departments in local authorities in England. They specialise in developing, commissioning and leading the delivery of services to children, young people and their families, including education, health, youth, early years and social care services

[20] *Kennedy I (2010) Getting it Right for Children and Young People*

7.7.7. Mark was referred to Intensive Community Treatment Service in September 2015 a children and young people's service to children and young people living in South Tyneside and Sunderland who present with mental health difficulties. The referral was made by YDAP due to concerns that Mark was withdrawn and writing suicide notes. The referral was deemed a priority and attempts were made to see Mark that day. He was eventually seen in late summer 2015 and workers indicated that Mark's mental health problems were due to his substance misuse and no intervention had been offered other than YDAP.

7.7.8. Mark was seen and acknowledged his low mood but denied any suicidal ideation and denied writing a suicide note. The assessment concluded that Intensive Community Treatment service was not required, but a further appointment was offered later the same month. According to ITCS records, Mark kept the appointment and self-reported that he had been excluded from school, but had stopped using cannabis and he claimed to be in a brighter mood. The assessment concluded that Mark making more positive life choices/progress and he was discharged by ITCS. The Review Team were unable to determine why there does not appear to have been any liaison with other agencies to find out more about Mark's background and history although the Review Team were informed this would be usual practice.

7.7.9. ***Finding 7****: Assessments should be comprehensive addressing physical and emotional needs as well as risk of self-harm and sexual exploitation. This requires close collaboration between agencies and inevitably raises the question of who takes responsibility of coordinating this work. Multi-Agency collaboration did not work as well as it should have done with Mark and this left him vulnerable.*

Issues previously identified in SCRs/Thematic Report: *Multi-agency information sharing and collaboration.*

7.8 Working with and engaging adolescents

7.8.1 The Review Team could find no evidence of any shared values and principles to govern specific work with adolescents. Reading through records and the integrated chronology for Mark, the Review Team did find evidence of child centred work; Mark was encouraged to take responsibility for the impact drugs were having on his health and the impact this was having on his Mother; a written agreement was put in place to help Mark and his mum manage the perceived risks, but whenever talk centred on his drug use, Mark often became angry, left the room and the sessions usually continued without him, a response eminently suitable for younger children, but perhaps less so for adolescents. The Review Team and the practitioners considered that even the term child-centred, while laudable in work with young children was not a particularly useful or appropriate approach when working with adolescents. These discussions highlighted the

need for a different way of working and perhaps a different language when working with young people.

7.8.2 Practitioners suggested that for the most part the existing child protection/child in need systems do not adequately fit in with young people's lives and experiences but in the absence of any different service designs they have to make the most of existing processes. It was also suggested that risks to young children are too often seen as more of a priority for services/intervention because adolescents are thought to be able to ask for help or 'choose' to remove themselves from risk situations.

7.8.3 The pathways leading to a number of harms that adolescents experience are however complex and do not easily fit with accepted child protection categories. Mark was made subject to a CP plan under the category of neglect although Substance Misuse would have been a more appropriate categorisation, had it existed. Maltreatment in adolescence is no less harmful than maltreatment at an earlier age. Indeed it could be argued that the opposite is true given what we know about the cumulative impact of harms over a given period and that adolescents are more likely to be subject to 'polyvictimisation' i.e. being victim to multiple forms of harm because of the external world/environment they also inhabit.

7.8.4 Harnessing and working with the risks of adolescent choices and behaviours is an essential aspect to them keeping safe but existing child protection processes, public opinion and media coverage make this a particular challenge for practitioners trying to work with, rather than for adolescents. Whilst the Thematic Report urges a wide-ranging review of services to those adolescents who are known to be vulnerable, the Review Team would argue that there is an equal and perhaps more pressing need to examine how well risks in adolescence are understood in Sunderland. Research in Practice argues that a child protection system that is conceptualised primarily around preventing harm and maltreatment in younger children, who may be at risk within their own family, may not be well placed to serve the needs of adolescents and an adolescent- centred approach as opposed to a child-centred approach requires a different set of underpinning principles.

7.8.5 The Thematic Report states that '*without a clear statement of values guiding and underpinning the actions of those with responsibilities for safeguarding [young people] with often complex needs and at considerable potential risk, there lies an opportunity for inconsistency and outcomes for [these young people] will fall short of what good parents would accept as 'good enough*'.

7.8.6 In reading the Sunderland's Themed Report, the Review Team were struck by the similarities between the experiences of the four young people who were each subject of SCR processes during 2015 and 2016. Although there were different

circumstances, each young person had to varying degrees experience of the following:

- Complex and difficult families
- Domestic abuse and/or family breakdown and family disruption
- Subject to child protection plans
- Appeared unable to make and sustain good relationships or develop strong attachments
- Self-harming, going missing, struggling to stay in education, and using substances, and 'legal highs'
- Emotionally vulnerable, distressed and depressed and at times in need of specialist mental health interventions
- Experiencing difficulties at school and used or were bullied through social media
- Associating with older men and sexually active from a young age

In addition, professionals were unable to effectively engage with family members.

7.8.7 Professionals acknowledged that many of the adolescents with whom they worked or who were referred to CSC, also had these factors in common and expressed some frustration in a system, which was predominantly focused on younger children. Examples were given of having to record the 'voice of the child' but not having enough time to build a relationship with the adolescent in order to ascertain their 'wishes and feelings'. Practitioners were very vocal in expressing their views that a different way of working with troubled adolescents was urgently required. They expressed the view that senior managers in all agencies needed to address this despite the challenges of shifting resources from already stretched services.

7.8.8 ***Finding 8 (NEW)*** *The range and nature of adolescent risks are different to those facing younger children and the traditional response to such risks does not necessarily fit with young people's lived experience and research. The identification of a multi-agency framework with clearly defined underpinning principles would support better practice for those professionals working with adolescents at risk of harm.*

7.8.9 The evidence suggests that professionals struggled to engage Mark to the point where he felt able to participate meaningfully in activities or with services. One of the key negative outcomes for Mark, which is common to many adolescents who require services,[21] appears to have been a lack of trust in adults including the many professionals who had attempted to intervene in his life. The lack of trust led to a pattern of seeking help and then withdrawing and this led to the professional perception of a '*hard to reach'* adolescent who did not engage with

[21] *Brandon / NSPCC / University of East Anglia, 2013*

services. The model of his Mother's inconsistent engagement with professionals may also have reinforced his non-engagement attitude.

7.8.10 The use of non-engagement as a coping strategy is known to be a common feature in adolescents. Professionals trying to help sometimes interpret such behaviour as sabotaging attempts to support the young person and too easily may rationalise non-engagement as adolescent 'resilience', within a 'self-determining and young person's rights' perspective. This can lead to a negative cycle of mutual rejection and result in a lack of effective help for the young person, leading to them becoming even more vulnerable. References in agency records to Mark's laughing ripostes when professionals tried to talk with him about the dangers of sexual exploitation may well have unwittingly led practitioners to feel reassured about Mark's ability to keep himself safe.

7.8.11 Changes in social worker or other key professionals are a constant complaint from young people. For adolescents who have strained or fragmented relationships with their family, and particularly for those who have experienced abuse or neglect and have poor attachments to their parents, frequent changes in key professionals can be unhelpful or even devastating and militate against attempts to engage or support them in a meaningful way. Changes of social worker can also undermine care planning and contribute to placement difficulties. Mark had contact with 4 social workers between March 2013 and September 2015, but the nature of three of those contacts were essentially short term or assessment based. A fourth social worker was involved with Mark just prior to his hospital admission. Despite the child protection plan no core groups took place in April or May 2015 and it is significant that it was just after this period that Mark and his Mother self-reported that all was going well and Mark had 'changed'.

7.8.12 It is acknowledged that there are significant challenges for professionals in trying to engage adolescents who resist attempts by professionals trying to help. There is evidence that many individual practitioners certainly tried hard to work with Mark but without a multi-agency understanding of how best to work with adolescents with complex and harmful behaviours, individual work was compromised. In addition, many practitioners spoke of not having the time, or not having a managerial/organisational mandate, to prioritise the building of a relationship with the young person, despite the volumes of research and young people's voices which say this is what they need before they can feel confident to engage with workers.

7.8.13 Practitioners involved in this Review said that the need to develop authentic and sufficiently intensive long-term relationships with young people is not fully recognised and is not yet part of the service response in Sunderland.

7.8.14 **Finding 9 (NEW)**: *If authentic and sufficiently intensive long term relationships are not part of the service response to young people and professionals are not*

actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people is likely to be ineffective.

7.8.15 The issue of professional supervision was explored with practitioners and the very clear message that emerged from this discussion was that practitioners in all agencies needed and wanted access to regular and quality supervision by managers well skilled to deliver reflective supervision. Whilst some practitioners said they were satisfied with their supervision sessions others were far less so and cited sessions that were too often cancelled, reduced to 'catch up' conversations or even left to email exchanges. Practitioners were acutely aware of the demands placed on their managers but many felt that vacant, interim, or merged managerial positions significantly weakened managerial oversight of their work and supervision was not always a high priority.

8. The Situation now

8.1. The Thematic Review identified six overarching issues in relation to work with adolescents in Sunderland which also have a bearing on this SCR:

- Importance of values and principles to underpin multi-agency work with young people
- Age appropriate services to vulnerable adolescents
- Working with young people and their families
- Recognition of and response to Child Sexual Exploitation
- Need for quality assessment, timely interventions and robust planning processes
- Multi-Agency collaboration

8.2. The response of SSCB to the findings from previous SCRs is captured in Appendix 1. If these actions are implemented as stated, they will support improved practice across the Children's Workforce and drive forward improvement in outcomes for children and young people. Care does however need to be taken to ensure that action plans, improvement plans, indeed plans of any sort, clearly identify intended outcomes or impacts rather than just state what actions have been or are to be implemented. Equally important is that the processes through which changes or the desired results are measured are clearly identified. Unless action plans are robust, purposeful and explicit and progress regularly reviewed, agencies will struggle to demonstrate how and if learning from reviews are making a difference to the lives of children and young people. Reading even the revised impact statements attached to this report, it is clear that agencies need to further develop skills and knowledge in respect of this area of work.

8.3. The Review Team asked practitioners for feedback about what if anything is different now. Responses indicated that they were beginning to sense changes in their organisations and especially within Children's Services but they also indicated that many developments were not involving practitioners in a way which was inspiring and importantly the changes were not happening fast enough and this left young people vulnerable.

8.4. Further details in relation to changes in Sunderland can be found in Appendix 2.

9. Conclusion

9.1 The risks that adolescents face are particularly complex and wide-ranging but there is no reason to believe that they are any less harmful than those experienced by younger children. It is important to acknowledge that there are likely to be some young people in Sunderland who may not be having their needs met effectively by services and this review and other more recent reviews relating to adolescents suggests more needs to be done as a matter of some urgency to work with young people to avoid, reduce and recover from risks they face.

9.2 The Review Team concluded that the lack of active engagement between the professional system and the young person and his family was a key factor in not being able to get effective help to address his vulnerability and emotional wellbeing during the time frame of this review. There is a wealth of talent and knowledge across partner agencies, which needs to be galvanised through multi-agency working, strong leadership, and appropriate adolescent-centred policies to create a more sophisticated model of risk prevention and protection for adolescents in Sunderland.

Appendix 1

Summary of Findings and Recommendations

A. Findings from this SCR which have identified new learning:

Finding 3 (NEW) *Many practitioners are not always clear what they should be doing in relation to substance use and their role expectations vary according to their specialist area of practice, their knowledge of substance use, and their levels of confidence. Whilst adolescents who use and misuse substance require specialist services that function as an integrated part of a broad range of support, professionals who work with adolescents in a wider range of services need to develop their skills and knowledge base about substance misuse.*

Finding 8 (NEW) *The range and nature of adolescent risks are different to those facing younger children and the traditional response to such risks does not necessarily fit with young people's lived experiences. The identification a multi-agency framework with clearly defined underpinning principles would support better practice for those professionals working with young people at risk of harm.*

Finding 9 (NEW) *If authentic and sufficiently intensive long term relationships are not part of the service response to young people and professionals are not actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people is likely to be ineffective.*

Recommendation for SSCB

In order to improve the effectiveness of multi-agency practice with adolescents who are at risk due to substance misuse, other forms of risk taking behaviour and/or abuse/exploitation, the SSCB should work with the Children's Strategic Partnership, the Safer Sunderland Partnership and the Sunderland Safeguarding Adult Board to develop a multi-agency framework to support the development of resilience and improve outcomes for vulnerable adolescents. This framework should include:

a) A *strategy, robust systems, protocols and tools for working with vulnerable adolescents and*
b) Workforce Development opportunities to support staff to engage effectively with young people, better assess and understand issues of risk such as CSE, substance misuse and transition etc.
This will be implemented by June 2018.

B. Findings which have been previously identified *(and therefore should already have led to changes)*

Finding 1: *Without analytical* ***assessments****,* ***multi-agency collaboration*** *and challenge, the harmful behaviour of some adolescents may be too easily viewed as 'just what teenagers do' and this perception can prevent early intervention for those adolescents at greatest risk.* ***Training*** *and workforce development, including* ***quality supervision****, must ensure practitioners have the skills to work with adolescent choice and complex behaviours and have opportunities to develop their understanding of the adolescent world, including substance misuse and other forms of risk.*

Finding 2*: There was a* ***lack of professional curiosity*** *about Mark's background what had happened and was happening in Mark's life which meant that his behaviour and substance misuse were regarded as 'the problem' rather than possibly being symptomatic of other stressors in his life*

Finding 4: *Without a purposefully designed multi-agency risk assessment tool, embedded within all organisations and accessed through a single point of access, professional judgment about risk is more likely to be flawed and this will reduce the likelihood of effective interventions leaving some young people vulnerable. (Thematic Report Recommendation) Such tools are known to be most effective when if the practitioners and managers who will be using them are engaged in their design and implementation.*

Finding 5: *When concerns are raised about a child, a clear chronology of events can show agencies where risks lie but unless practitioners understand how to build and maintain purposeful chronologies and without clear systems to gather, record and share this information, the use of* ***chronologies*** *to inform good assessments and decision making is less likely to happen.*

Finding 6: *There remains a significant* ***shortfall in placements*** *for children and young people with complex needs who require placements that can keep them safe and manage their vulnerabilities without needing to deprive them of their liberty. (Thematic report Recommendation)*

Finding 7*: Assessments should be comprehensive addressing physical and emotional needs as well risk of self-harm and sexual exploitation. This requires close collaboration between agencies and inevitably raises the question of who takes responsibility of coordinating this work. Multi-Agency collaboration did not work as well as it should have done with Mark and this left him vulnerable.*

Appendix 2a

What have we done, what are we going to do and what difference has it made/will it make?

Sunderland Safeguarding Children Board (SSCB) impact statement

A new Board structure was implemented from April 2017 with a new permanent Chair in place from May 2017. The new arrangements have strengthened governance arrangements to ensure high support and high challenge across the system, with clearer functions, a new structure, and newly developed and robust approaches to performance management, quality assurance, practice development, and the application of learning from research, evidence and review, as well as evaluating compliance with required standards of practice. The Board has been more effectively supporting (and challenging) the improvement programme for Children's Services and continually evaluating the improvements taking place, the investments being made and the differences these are making to children, young people and vulnerable families as well as supporting and challenging each partner agency's own improvement and development plans.

The SSCB has strengthened its MSET Sub Committee arrangements and this was confirmed by an independent review in 2016 which identified that the Board's MSET Subcommittee showed clear evidence of coordination, scrutiny, and challenge, including of the work of the MSET Operational Group, challenged partners to provide updates on their activities to address the risks to children, and raised issues about the attendance of key partners. The Reviewer concluded that the outcome of this work has been to deliver a focussed discussion of current, local safeguarding risks to children with clear leadership. The Ofsted Monitoring Visit Letter published December 2016 also found improvements concluding that "Sunderland's multi-agency arrangements to respond to children at risk of going missing and being sexually exploited and trafficked have been strengthened. The quality of information recorded and collated in the risk management tool ensures a well-coordinated multi-agency response. The child sexual exploitation referral tool is a comprehensive assessment document that has a strong focus on the views of the child. Arrangements for return interviews for children missing have been strengthened through the commissioning of a voluntary agency to undertake this work. Analysis of information and intelligence is informing preventative work for individuals and more widely. Examples seen were detailed and focused on risk, and were used well within the missing, sexually exploited and trafficked children meetings to inform practice on individual cases and also in relation to wider disruption activities."

Work undertaken by the Sub Committee includes:

- Multi-agency detailed audits undertaken in respect of 6 CSE cases and a sample of 20 CSE Risk Assessment Tools led to a review of the toolkit to strengthen practitioners' skills in respect of CSE cases. Both SSCB audits identified positive aspects of practice since the adoption of the revised tool and the inclusion of professional judgement and the voice of the child have

informed the continued learning and reflective practice. This gives a demonstrable influence of frontline practice on strategic direction. This was confirmed by practitioners who were part of this SCR and the Young Person Rachel SCR.

- The toolkit is currently under consultation and implementation of the new tool aims to lead to more robust identification, assessment and intervention for young people who are being sexually exploited/at risk of CSE. The tool will be launched March 2018
- In September 2016 the SSCB undertook a multi-agency Self-Assessment against the Joint Targeted Inspection Framework for children at risk of CSE or who go missing from home. The response included only 10 completed responses with a variety of approaches but demonstrated high levels of confidence in the awareness of CSE and the MSET arrangements across agencies, leadership and the SSCB and the overall effectiveness of the multi-agency arrangements were deemed Good by 80% of respondents. Gaps were identified in the ability to capture the preventative work undertaken and any work with adult offenders. These areas of work will be taken forward as part of the work of the Board and included in the development of a vulnerable adolescent framework.
- Challenged the commissioner and provider of the contract for the return home interviews for children who go missing from home and care. This has resulted in improved commissioning arrangements and improved provision for vulnerable adolescents. Performance data demonstrates an improved completion rate but further analysis of quality is required as outlined below.
- The Strategic CSE Co-Ordinator funded by Children's Services to work across the partnership delivered MSET (Missing Sexually Exploited and Trafficked) briefings to multi-agency practitioners and the voluntary sector, that is, 780 practitioners, 30 foster carers/adoptive parents, 220 taxi drivers, 15 licences, and 30 elected members received this training which also included changes to the Trafficking legislation brought in by the Modern Day Slavery Act
- Robust scrutiny and analysis of performance data relating to vulnerable adolescents to better understand the vulnerable adolescent population, their needs and how these can be addressed. The outcomes of this analysis has to date identified issues with the return home interview provider as mentioned above, a potential gender bias in respect of application of the missing vs. absence category by the Police. This relates to similar gender bias issues identified in this SCR with males being seen to be better able to protect themselves. The Board is developing a strengthened performance monitoring and assurance framework for the MSET Operational Group to more effectively focus on these areas. The VASPG will start to monitor this data from November 2017
- In recognition of the wider issues related to CSE the Board has ended the MSET Sub Committee and established a Vulnerable Adolescent Strategic Project Group (VASPG) which has a wider focus on the risks to vulnerable adolescents. The MSET subcommittee was sufficiently robust to support this

shift and this is in keeping with the updated definition of CSE in Working Together 2015 (amended February 2017). The anticipated outcome is that there will be a more comprehensive and robust approach to addressing the needs of vulnerable adolescents in Sunderland. This was originally for a 12 month period and as a result of this and the Young Person Rachel SCR, the Group has been extended until September 2018

- Learning from this SCR and the SCR for Young Person Rachel the Group has commissioned focussed reports from the commissioner and provider of the Return home interview contract November 2017, the YDAP service October 2017, the CAMHS Transformation work in October 2017 and the Transition Board. These reports are intended to provide an understanding of how effective these services are and what difference they making to children and young people, including when an adolescent is transitioning into adult hood.
- Met with the CSE National Working Group (NWG) regarding transitions and the learning that has been identified from this and the Young Person Rachel SCR. The learning from the SCRs was shared with the NWG as part of research they were producing. The Board has agreed to undertake a benchmarking exercise in 2018 led by the NWG to have an evaluation of the arrangements for CSE etc. in Sunderland. This will provide the Board with a progress check; identify what difference we have made and where we can improve to better meet the needs of our vulnerable adolescent population.

The SSCB Strategic Plan 2017-2019 and the SSCB Business Plan 2017-2019 has been developed partially based on learning from this SCR. The Board has 3 Service Priorities in these plans which are neglect, vulnerable adolescents and compromised parenting.

In conjunction with the Children's Strategic Partnership the Board is developing a framework for vulnerable adolescents which will address the key learning identified from this and the Young Person Rachel Review.

Working with the other partnerships across the City to deliver a campaign highlighting where young people and adults can seek help if they are struggling to cope due to issues such as emotional or mental health issues. The aim of this campaign is to highlight that there are services available for our young people and their parents/carers and to reduce the incidence of self-harm and suicide.

A further SSCB audit of neglect practice is planned for 2018 to understand and asses if practice is improved around identifying and dealing with child neglect. The Board will continue to audit to understand how effectively learning from the reviews has been embedded access the partnership. An audit undertaken in early 2017 around the Learning from 6 Serious Case Reviews published in September 2016 identified some evidence that learning has been embedded. It has identified further work is needed to embed the learning. A second audit will be completed in November 2017.

Appendix 2b

Individual Agency Impact Statements

Sunderland CCG

The CCG Safeguarding Team will take a key strategic and operational lead role in sharing the learning from this review with all GPs and Practice staff across Sunderland to support individuals to meet their learning and competency needs in accordance with the Intercollegiate Guidance 2014 and their role and responsibilities. Young people will be seen by a highly skilled workforce who understand the importance of liaising and sharing information with professionals involved with young people, and make appropriate referrals in a timely manner therefore ensuring the needs of young people are met.

The aim of the Team's work specifically in Primary Care (GP) is to:

- Provide telephone advice and support to individual practitioners who have identified a possible concern about a child or young person – ***this can be measured by the number of calls to the team and evidenced on a tracker tool held by the team.***
  Work is evolving with Together for Children – Sunderland to ensure that their Liquid Logic system can identify the separate agencies representing "health" and ensure feedback to relevant health leads on referrals which may be inappropriate or contain insufficient information. Should concerns be identified from TfC the Team will work with individual GPs/practitioners to improve safeguarding practice.
  ***There have been no quality assurance issues highlighted by TfC to the CCG regarding referrals from Primary Care since April 2017*. In addition the annual primary care safeguarding audit cycle includes an audit into the quality of referrals submitted from GPs/practice staff. This will be undertaken November/December 2017.**

- Support individual Practices in developing their internal systems and processes to monitor outcomes of referrals. ***This can be evidenced by the Practice visits undertaken by the Named GP (either planned or in response to queries, incidents or significant events) and the CQC inspection framework.***

- Provide peer support and supervision to GP Safeguarding GP leads. ***Evidence - there is an annual programme of quarterly peer support sessions.***

- Plan, deliver and evaluate bespoke training packages to those staff requiring Level 3 Safeguarding Children Training – ***Evidence - an annual training programme is in place and numbers of attendees and evaluation reports are compiled by the CCG Safeguarding Team – copies available on request.*** Regular updates are also provided via Time in Time out sessions – ***a calendar of events is available.***

- Disseminate immediate learning from reviews via a Primary Care briefing – this can be evidenced within the CCG files. ***Evidence - copies available on request.***

- Disseminate safeguarding updates by a quarterly safeguarding newsletter – ***this can be evidenced within the CCG files – copies available on request***.

- Seek assurance that the GPs in Sunderland understand their statutory responsibilities and respond to learning identified in reviews. ***Evidence – annual SSCB S11 audit, SSCB mystery shopper audit and the SSCB multi-agency audit programme. In addition to the multi-agency audits a range of single agency audits are undertaken with GPs – reports available on request***.

Appendix 2c

Education and School

The learning has been focused on ensuring that safeguarding procedures and protocols are more robust and properly followed, particularly in relation to record keeping, information etc.:

- Handover arrangements between the Link School and the excluding or dual registered school are conducted face to face with all relevant information shared and files handed over;

- All safeguarding information now recorded electronically at Link School on Child Protection Online Monitoring System (C-POMS) which is regarded as the best practice system;

- C-POMS, a referral system for any concerns records information in real time, requires receipted responses and note of any further actions. It also produces electronic chronologies;

- No concern considered too small or insignificant to be recorded;

- As a result of the above procedures for archiving have also been tightened up for historic and paper files;

- Stronger professional curiosity and challenge to other agencies is encouraged and followed up in school safeguarding meetings

Issue with Mark was the swift acceleration and manifestation around drug taking/ behaviour etc. Link School referred appropriately and were involved in strategy meetings with agencies and with Ferndean etc.

Appendix 2d

General Practitioner (GPS)

1) All GPs in Sunderland to receive information in training and briefing papers regarding the learning and recommendations from this review.
    - On publication of the SCR a briefing document will be circulated to all GP practices.
    - Learning from the SCR will be highlighted in the GP Safeguarding Newsletter
    - Learning from the SCR will be discussed at the quarterly Safeguarding leads meeting; the Safeguarding Leads will disseminate the learning to practice staff.
    - Learning will be shared at future TITO events.
    - There will be a coordinated approach to the dissemination of the learning to ensure all staff across primary care have knowledge of the themes identified within the report.
    - The dissemination of the learning from this review will reinforce lessons learned from previously published SCRS in Sunderland in relation to young people with complex problem

2) When working with complex adolescent/teenagers who have issues which impact on emotional health, GPs to consider if the threshold has been met for a referral to Children's Services or support via Early Help Services.
    - Adolescents/young people will be referred in a timely manner to Children's Services and other supporting services in order to receive appropriate assessment and support for their specific needs
    - GPs will be familiar with Threshold Guidance and liaise with Children's Services/Named GP if unsure whether or not to refer therefore ensuring young people are referred to the correct service
    - The learning is similar to previous SCRs and highlights the complexities and challenges within GP practice when working with extremely vulnerable adolescents who are being neglected and who have complex needs.

Appendix 2e

Individual Agency Impact Statements – South Tyneside NHS Foundation Trust

During the timeframe for this SCR Young Person Mark accessed STNHSFT health services provided by the School Nursing service, and the Young Person nurse. Discussions also took place within the ICRT during this timeframe, following concerns raised with regard to Mark this meeting was attended by the ICRT nurse advisor also employed by STNHSFT. Prompt information sharing was noted across all health services involved with Young Person Mark and also prompt attendance at requests to attend multi-agency meetings.

It was evident to the author of STNHSFT learning report that confusion existed across health and multi-agency partners with regard to the role of the Young Person Nurse. The health assessment documentation utilised by the Young Person Nurse during the period reviewed also required updating, with specific reference to sexual health advice and support.

Action	Outcome	Impact
The health assessment completed by the Young Person Nurse needs to reflect the sexual advice given.	The Young Person Nurse health assessment documentation has been amended and incorporates as standard practice advice and support with regard to Sexual health.	YP have a risk assessment completed which demonstrates advice and support either given or sign posted. The assessment form will be audited 2018.
Young person Nurse to be more visible across health and partner agencies.	The Young person Nurse is to be moved into the Sunderland School Nursing team. The YP Nurse works with YDAP who are now part of TfC.	The school nursing team will be able to access the YP as part of early intervention. This will take place in October 2017.

Appendix 2f

Northumbria Police

Changes made to custody procedures for Force Medical Officers:
The processes and model used by Northumbria Police in relation to Force Medical Officers and assessment of detained persons has changed since YP Mark's period in police custody.

A custody nurse was based at all of our 4 sites although at time. However, due to staffing / sickness this may not be the case apart from Forth Banks custody (due to the demand). The FME was generally based at South Shields Custody but may have had to travel to other stations as there are certain tasks only they can do.

It must be noted we are moving from this model and we are in the process of implementing Senior Nurse Practitioners with limited FME cover with on call FME facilities.

Northumbria Police have amended the model to further reduce time delays. TASCOR are the provider and they have performance targets to deal with requests within one hour. TASCOR are hitting targets at 97/98% most months with the others reported upon.

This system will provide improved service and recognition of risks to children and young person's whilst detained in custody.

There were lots of missing episodes which were not always reported by Mark's Mother. His Mother's responses to his missing episodes were poor:
Northumbria Police now have two dedicated Missing from Home Coordinators. Their role includes the flagging of missing persons to MSET. This has a positive impact on the early identification and flagging of those children and young persons at risk.

A lot of Child Concern Notifications submitted by the Police. CCNs not always clear as they do not pick up MSET process. He displayed significant levels of risk taking behaviours which were put in as Child Concern Notifications and not referrals:

The Northumbria Police Central Referral Unit process for submission of CCN's has changed. They are no longer graded as Notifications or Referrals. The receiving organisation now assesses the content. This removes risk of wrongly categorised CCN's.

A 'front end app' is being developed to be used on officers hand held devices (phablets). The app will replace the current CCN process. The app will allow officers to complete the CCN without returning to a station; will be an improved format with revised fields (which will only allow an officer to progress to the next stage of the app on successful completion of each field/page). This will positively impact on the

quality and clarity of CCN's and in turn on the multi-agency information sharing process for children and young persons.

Mark was associating with older males where there may have been exploitation or grooming of him:
Northumbria Police have invested in a bespoke training package with Safeguarding Associates For Excellence (SAFE) for a targeted audience within the force which will be mandatory for all staff involved. This training incorporates all aspects of CSE including recognising the signs. The training will improve officers ability to recognise CSE and in doing so taking the first step towards prevention and intervention for children and young persons at risk.

Appendix 2g

Together for Children – Children's Social Care

Project/Action	**Activity (how much)**	**Outcomes (how well)**	**Impact (what** difference your action has made/will make)
1. To make sure the Together for Children (TFC) children's social care workforce is fully aware of lessons learned from previous serious case reviews involving adolescents	A series of workshops have been delivered to all frontline staff through team meetings (x11) covering the recommendations set out on the single agency action plans Young Person(s) K&I	The TFC workforce will be aware of the risk factors associated with venerable adolescents and will have the knowledge and skills to assess, respond, and reduce the risk/s	Young people receive an appropriate and timely and co-ordinated response from all agencies that reduces risk and creates the opportunity for maximising positive change. This will be evidenced in the outcome of audits, quality of assessments, evidence of timely access to services in children's plans (child protection, child in need, looked after and pathway plans)
	Worked collaboratively with partners to design an adolescent risk management panel (proposed implementation April 2017) Reviewed MSET procedures and	More streamlined multi agency response to adolescents who are assessed as at risk	The impact of the new arrangements will be monitored by the group and shared with the SSCB

	risk assessment tool Planned e safety training for staff for October and November 2017		This has to be put in place – planned for October and November 2017
2. Quality of assessment is improved for adolescents who are at risk • All staff will receive assessment training that includes gender awareness consideration • Self-referrals by young people to children's services should be regarded as an additional level of concern	Assessment workshops delivered by OFSTED in Spring 2017, attended by all frontline practitioners. This will be included this in the development of the assessment training and will be a component of the Strengthening Practice programme	Improving the quality of assessment leads to improved responses to risk and as a result improved outcomes for young people.	This will be evidenced through audit, feedback from young people through MOMO and case closure questionnaires. Evaluation of the Strengthening Practice programme will include risk and adolescence.

Appendix 2h

Youth Offending Service

Mark was not well known to the Youth Offending service but he presented a number of challenges to staff particularly when he was arrested in the summer of 2015 and staff were concerned about his mental health. This led to numerous discussions with health to request further assessments.

Subsequently pathway was agreed with CAMHS and shared with staff in the YOS. However it will not be possible to establish the impact of this unless similar situation arose.

The YOS continued to work with Mark on a voluntary basis after he was detained under the mental health act; by that stage he had also been subject to a Child Protection plan which highlighted concerns about parenting. A workshop was held for all staff in March 2017 which uncovered topics such as disguised compliance, The impact of this is that staff should be better able to identify neglectful parenting etc. and refer parents for appropriate support including specific parenting programmes now in place through Early Help.

Prior to Mark being diagnosed with a psychosis he had been open to the YOS on a caution for 3 months. As a service our performance on first Time entrants (FTE's) was not as good as some of our neighbouring local authorities we therefore reviewed our practice and presented a number of reports to the YOS Board from July 2016. To date our performance has improved markedly from an annual rate in 2015/16 of 591 to a rate in 2016/17 of 434. This rate continues to be monitored by the YOS Board as it is one of our performance targets .The impact of this is that young people can be diverted from the Criminal Justice System.

Appendix 2i

Youth Drug and Alcohol Project

The Youth Drug and Alcohol Project has since April 2017 been incorporated into Targeted Youth Services as part of early help and since then there has been significant developmental activity.

The team has a new manager who has introduced a new assessment and planning framework as well as a programme of quality assurance. The assessment framework is a holistic assessment of all aspects of the young person's life. It is anticipated that the impact of this is that staff are better able to identify safeguarding issues and ensure appropriate support is in place.

A new screening tool and brief intervention toolkit has also been developed and available to any staff who work with young people. A training programme has also commenced in September 2017 which will be evaluated to ensure staff feel confident in working with young people and also that we are reaching staff across all services. It is anticipated that the training programme and screening tool will allow professionals to embed brief interventions in their own work and better identify which young people need a referral to YDAP for a more intensive Tier 3 service .This in turn will allow YDAP to be more effective in targeting the young people they work with.

The YDAP manager has also undertaken a consultation exercise with approximately 150 young people. This consultation will be written up and used to inform service delivery. It is anticipated that the impact of using young people's views to inform service delivery will improve engagement rates. We plan to undertake a data analysis in December to benchmark how many young people we successfully engage in the service and if needed will agree an action plan as to how to improve this in partnership with referring agencies.