Child Safeguarding Practice Review

Overview Report in respect of

Nadia

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I have nowhere to go

(Nadia)

Executive Summary

At the heart of this Child Safeguarding Practice Review (CSPR) is Nadia. Nadia was 16 when she was found at an inpatient unit with a ligature around her neck and could not be resuscitated. The conclusion of the inquest was that Nadia had died because of *misadventure, contributed to by the inadequate care* (at the relevant inpatient unit). Nadia was a child who experienced bereavement, sexual assault and difficult family relationships. There was little multi-agency working throughout Nadia's life. Nadia spent the last 12 months of her life as an inpatient in mental health establishments. During this time there was a powerful sense that Nadia felt she had no place to call home. This review examines Nadia's life story, and the services that were provided, from the age of 12 until she sadly died.

As identified in relevant guidance[1], it is not the purpose of CSPRs to conclude issues such as predictability or to hold organisations or individuals to account; there are separate processes for this purpose that must be followed. The purpose of CSPRs is to focus on a child and family, often in extremely tragic circumstances, to try and understand and make sense of their experiences of multi-agency services, to consider what these experiences might tell us about the health of the multi-agency safeguarding system and decide what is needed to strengthen the way children are safeguarded.

There were practitioners who knew Nadia well and examples of highly committed practitioners who showed care and compassion and did their very best to provide Nadia with what she needed. It is almost inevitable that any case that is the subject of a CSPR will identify a need to improve service provision. This review does not conclude that, had these things been in place, Nadia would be with us today.

This review considers relevant legislation, policy, practice, and procedure, reflects on research, literature and national guidance, and draws learning from the extensive experience and wealth of knowledge held by those who work within the multi-agency safeguarding arena.

CSPRs are usually anonymised to protect the identity and privacy of a child and family. Nadia has been identified in media coverage relating to the inquest and it was thought likely that any media coverage would use her real name, and therefore defeat the purpose of pseudonyms. This was discussed with Nadia's mother and father; their views were that it would be important to Nadia for her real name to be used and that this would not present compromises for family members. Father said: *Nadia wanted to be a social worker, she wanted to help other children. Publishing this report in her real name honours her wish to help others.*

[1] Working Together to Safeguard Children 2018 & Child Safeguarding Practice Review panel: practice guidance DfE 2019.

Introduction

Reason for this review

Cambridgeshire and Peterborough Safeguarding Children Partnership Board[2] (CPSCPB) considered the circumstances of Nadia's sad death. As Nadia had died in an inpatient unit, the criteria had been met for a Serious Case Review. The decision to undertake this review was made at a time when the statutory guidance for Serious Case Reviews (SCRs) was in place. Since this time, Child Safeguarding Practice Reviews (CSPRs) have replaced SCRs and new guidance[3] issued.

Purpose and methodology

The purpose of a CSPR is to learn lessons through a systems analysis of the single and multi-agency work undertaken to assess and support children[4] and their families. The methodology used in this CSPR endeavours to understand professional practice in context, identifying systemic factors that influence the nature and quality of work with children and families. By using one case the aim is to get to systemic patterns, which are generalisable beyond this particular case, providing what is called a 'window on the system'[5]. The intention is to provide a proportionate and meaningful account of what happened from the perspective of the child and family to add reflection and learning into the local safeguarding system.

Process of review

A key aspect of the model is for an independent reviewer to work with a review team. In this case an experienced independent reviewer, Bridget Griffin[6], worked alongside the CPSCPB Head of Service and representatives from the main services involved. These representatives were independent, in that they had no direct involvement with Nadia or her family and no management responsibility for the services that were provided during the period under review. Independent agency reports and an integrated chronology informed the review. Panel meetings were held, and focused discussions took place with representatives from key services, to analyse the data and discuss the emerging findings.

Current guidance stresses the need for proportionality, discourages a detailed narrative of events and emphasises a focus on the learning. The panel were mindful of this new guidance and were aware that there have been considerable changes in multi-agency practice since Nadia's sad death in pertinent areas. The approach taken in this review aims to reflect recent CSPR guidance and to focus on areas where practice still needs to be strengthened. Therefore, there will not be a detailed analysis of all events, only those events directly relevant to the key findings will be presented.

There has been some delay in completing this review. In part this was due to the impact of the pandemic and in part due to the multi-agency resources required in completing the two other detailed Serious Case Reviews (SCRs)[7] at the same time.

[2]Changes in statutory guidance later led to the Board becoming a Safeguarding Partnership.
[3] Child safeguarding practice review panel: practice guidance.Gov.UK 2019
[4]In line with legislation, the term child, or children (applied to all who are under the age of 18) will be used throughout.
[5]Vincent CA, 2004, *Analysis of clinical incidents: a window on the system not a search for root causes,* QUALITY & SAFETY IN HEALTH CARE, Vol: 13, Pages: 242-243, ISSN: 1475-3898.
[6]CQSW, BA (Hons), MA (Tavistock & Portman and MHT), SCIE accredited reviewer.
[7] CPSCPB Sam Gould 2021. CPSCPB Chris Gould 2021

Involvement of families & practitioners

Parental perspectives

Nadia loved and wanted to be loved – she loved to be part of family events – to be invited and to take part ……She was an ordinary teenager who needed ordinary things -she loved to make things such as arts and crafts and made me a beautiful book – on each page there is a note about why she loved me …I loved her very much …she was caring and kind to her friends at the inpatient units - we are all struggling to come to terms with losing her[8].

Nadia lit up our lives and will stay in our hearts forever[9].

Nadia was loved deeply and will never be forgotten[10].

A vital part of CSPRs is to work with families to understand their perspectives. Nadia's parents were separately invited to meet with the Independent Reviewer. Initially, Nadia's mother decided she did not want to make an active contribution to this review for understandable reasons. As the review drew to an end, Nadia's mother felt able to contribute and her perspectives are included. It took great courage for Nadia's mother to make a contribution at what understandably remains a very difficult time. Nadia's father met with the Independent Reviewer and the CPSCPB Head of Service on several occasions and shared his perspective.[11] CPSCPB are thankful to Nadia's father and mother for their time, commitment and patience in being part of this CSPR and are grateful that pictures of Nadia and a beautiful book Nadia made were shared.. CPSCPB offer their deepest condolences to Nadia's parents, siblings and family members for their loss.

Practitioner involvement

Another important aspect of a CSPR is to engage practitioners[12] in the review process. Panel members met with practitioners who provided a service to Nadia and her family, and the Independent Reviewer met with several key practitioners. Practitioners were invited to share their views about the services provided and to identify single and multi-agency learning. It is clear that practitioners were committed to Nadia and wanted the best for her - they worked hard to try and support her and were deeply saddened by her death.

Nadia

Nadia had two birth siblings – an older sister and a younger brother. In her early childhood, she lived with her birth parents and siblings. In middle childhood, just prior to her teenage years, her parents separated and there was a period of acrimony that lasted for some time. Her father relocated to London. Nadia and her siblings remained with their mother, contact with their father was retained and Nadia lived with him for a brief time. Difficulties in the relationship between parents continued over several years and Nadia moved between the care of her father and mother. From the age of 12,

[8] Nadia's father
[9] https://www.inquest.org.uk/nadia-shah-closes
[10] https://www.inquest.org.uk/nadia-shah-closes
[11] It is important to note that it is not always possible to fully triangulate parental perspectives.
[12] The term 'practitioners' is a generic term which includes all practitioners and clinicians who knew Nadia and worked with her &/or who currently work with children in C&P

Nadia struggled with anxiety although she continued to attend school where she was regarded academically very able and was entered for 10 GCSEs.

Nadia was a child of mixed heritage – her father is British of Indian descent, and her mother is of British decent. Nadia described herself as a 'Christian-Hindu.' Before her inpatient admission, Nadia was a keen footballer and was awarded an orange belt in martial arts. She enjoyed arts and crafts and had aspirations to be a social worker. Nadia was described as intelligent and someone who was able to reflect on her past and current circumstances. She was described as showing *real warmth openness and compassion which are great strengthens of character.* Sadly, Nadia felt that feelings of containment and happiness were only fleeting aspects of her daily life. When in deep distress she could be aggressive to staff and other young people in the inpatient units. When calmer, Nadia's true self of compassion, care and warmth was evident. She was known to be supportive to her peers and the letters the family received from these peers, and from inpatient staff, after her death showed how much support she provided and how important she was to them.

Throughout her teenage years there was a powerful sense that Nadia felt she had nowhere she belonged – *I have nowhere to go.* Whilst in the second inpatient unit Nadia described herself as feeling *empty abandoned and profoundly sad* and it was reported that *her family relationships and negative life events led her to believe that the world is a dangerous place, and it is filled with people who do not (and will never) understand her.*

Summary of involvement by key agencies

Nadia first became known to services when she was approaching her 12th birthday. Over the next few months, there was intermittent involvement by police and Children's Social Care (CSC) as a direct result of parental conflict, allegations and counter allegations from members of the family about domestic abuse and about the care provided to the children. Nadia lived with her father for a brief period but returned within a few months to live with her mother. Nadia returned to her school in the local area and attended the drop-in service provided by the school nursing service.

Nadia continued to attend the drop-in service for a period of 20 months when she spoke about her fluctuating emotions, her relationship with family members and on occasions she spoke about self harm and suicidal thoughts. There were additional concerns about 'depression' and her eating. Apart from her intermittent contact with the school nursing service nothing else of significance is recorded in agency records over this period. Nadia attended school, maintained peer relationships, and was expected to do well in her GCSEs.

Nadia was about to reach her 15th birthday when she was admitted to hospital after a suicide attempt, she was diagnosed with a 'Major Depressive Disorder'. Thereafter, Nadia was seen by CAMHS, and she engaged well with the treatment. Sadly, Nadia continued to suffer from anxiety, depression, self harm and suicide ideation – her symptomatology was felt to be indicative of Complex Post Traumatic Stress Disorder (CPTSD). One month later, she was taken to hospital after a second suicide attempt and discharged home with continuing support from CAMHS. Nine months later, Nadia was admitted to hospital after a third suicide attempt, again she was discharged home with support from her mother, school and CAMHS. Later the same month, Nadia was admitted hospital after a significant episode of self harm. She was assessed to be at high risk to herself, and probable risk to others, and was admitted to a

local inpatient unit as a voluntary patient. Almost 3 months later, after an escalation of self harm and suicide attempts, Nadia was detained in hospital under Sc3 (MHA1989)[13]. After 8 months of inpatient care, Nadia was admitted to a PICU (Psychiatric Intensive Care Unit) and then to a Low Secure (inpatient) Unit. Tragically, Nadia was found with a ligature around her neck and later died in hospital. She was 16 years and had been living in inpatient units for 12 months.

Findings

Nadia's sad death was the subject of a coroner's inquest in October 2021 when her death, and the events prior to her death, were examined in detail. In summary, the jury concluded she died because of "misadventure, contributed to by the inadequate care (at the relevant inpatient unit)." Factors contributing to her death included:

- an unsatisfactory implementation of the care plan and a failure to sufficiently engage and provide cohesive care
- *The emergency and resuscitation response was lacking, and CPR was not carried out properly by the clinic staff*.
- *a lack of clarity around the application of the observation policy* and a *failure to report observations to properly inform assessment of risk*.

The Care Quality Commission (CQC) conducted an unannounced focussed inspection at the inpatient unit shortly after Nadia's death. Several areas for development were highlighted. In March 2020 an announced inspection took place which concluded with an overall rating of good. This review will not attempt to replicate the detailed work of the coroner or the CQC, the learning will not be repeated in this CSPR. The circumstances of her death and the learning that has been identified has been the subject of focussed service developments by the responsible organisations. Monitoring and evaluation of the changes required have been the subject of due governance. Nadia and her family, and the multi-agency services that were provided, are the focus of this review.

Key Learning

1. When emotional troubles do not go away: Prevention and intervention

Understanding the impact of parental conflict & responding. When Nadia was reaching her 12th birthday, she and her siblings were referred to Children's Services (CS) by the local police force. It was clear to these agencies that there had been ongoing domestic conflict between the parents for some time with allegations and counter allegations of abuse being made. It was noted that *the children were caught in the middle of warring parents* and frequently witnessed the conflict. Recorded contacts by CS and police suggest that this situation continued for a minimum of 7 months. It was believed that this acrimony had existed for some time prior to agency involvement and was unlikely to be resolved in the medium - short term, even after the parents had separated. There was short term involvement by CS and police

[13] Section 3 of the Mental Health Act 1983 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. It also requires that the treatment cannot be given without the order being in place and that appropriate treatment must be available in the setting where it is applied. It lasts for a maximum of 6 months.

during this period and although the assessments by CS contained a good analysis of the information, and an accurate child centred view of the children's lived experiences, the case was closed after parents separated and Nadia went to live with her father. Although by this point relationships were said to have improved, the long-term impact of this conflict on the children did not appear to be considered and there were no contingency plans in place should Nadia return to the care of her mother/should the parental conflict continue. Both of which happened overtime.

Practice Learning: It is fair to say that at this time the impact of parental conflict on children was not well known to statutory services and as highlighted by a panel member: *we all may be at risk of normalising parental separation and conflict – we need to take a nuanced tiered approach in our response informed by current research.*

Frequent, intense and poorly resolved conflict between parents can place children at risk of mental health issues, and behavioural, social and academic problems. It can also have a significant effect on a child's long-term outcomes. There is a strong body of evidence to show how damaging inter-parental conflict can harm children's outcomes, even when parents manage to sustain positive parent-child relationships, and put children at more risk of:

- *having problems with school and learning*
- *negative peer relationships*
- *physical health problems*
- *smoking and substance misuse*
- *mental health and wellbeing challenges*

The risks can also have an effect on long-term life outcomes such as:

- *poor future relationship chances*
- *reduced academic attainment*
- *lower employability*
- *heightened interpersonal violence*
- *depression and anxiety*[14]

The impact of parental conflict on children has been in focus in recent years and the subject of research and government attention. In part, this appears to have been triggered by the impact of the pandemic on family life, particularly during lockdown[15]. In October 2021, the National Child Mortality Database (NCMD) published a thematic report[16] looking at 91 suicides over a 12-month period in the UK. This research shows no geographic variation across UK or according to socio-economic status. A collection of prevalent factors was identified in all cases. 'Household functioning' (which includes separation and divorce/parental conflict) represented one such factor. This was the most common factor in all these suicides, representing 69% of the sample. It is not being suggested that this parental conflict was directly linked to Nadia's death, as detailed in this CSPR, several factors had a significant impact on Nadia's wellbeing. In addition, it is recognised that suicide is complex and rarely caused by one thing – it will

[14] Reducing Parental Conflict: the impact on children. Department for Work and Pensions. January 2021
[15] Reducing Parental Conflict: the impact on children. Department for Work and Pensions. January 2021
[16] Suicide in Children and Young People. National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2020. Published October 2021

typically be a constellation of factors not a single cause. However, the impact of parental conflict on children requires attention by services.

CAFCASS[17] regularly work with families where such conflict exists, a local CAFCASS representative spoke in detail with the lead reviewer about the impact on children of adversarial relationships within families. This service uses a Child Impact Assessment Framework to assess the harm to children in these circumstances, this framework and the tools that are available[18] are excellent and provide support to multi-agency practitioners in assessing impact of parental conflict and can be accessed by all professionals working with children[19]. In recognising the importance of this issue, the Department for Work and Pensions has recently funded local services across the country to provide support to children and families in these circumstances[20] and this support is available locally through the Early Help Service.

Recommendation 1. C&PSCPB to consider whether any further work is needed in the local area to raise awareness about the impact of parental conflict on children and consider whether current zero suicide multi-agency approaches/strategies/guidance adequately take account of the recent findings from the NCMD.

Providing the right support at the right time. Nadia was 12 years old when she self-referred to the school nursing (SN) service. She described feeling increasingly anxious, of self-harming and having suicidal thoughts. Nadia had been living between mother and father (out of area) over the recent past and she talked about her struggles to find a place where she belonged. At this time, Nadia identified poor family relationships as a key source of her distress.

Nadia's contact with the SN service took place over a period of one year and eight months. A trusting relationship was established with one of the school nurses and it was evident that she valued these contacts and maintained frequent engagement over an extended period - sharing her thoughts and feelings about her struggles across different intrafamilial relationships/reconstituted families. Her moods were observed to fluctuate, and this was regarded as normal adolescent development. After 6 months, a new SN started in post and a Revised Child Anxiety and Depression Scale (RCADS)[21] was completed with Nadia. Nadia scored 81 on this scale which is regarded as the threshold for clinical intervention.[22] A referral was not made to CAMHS at this point.

It has been said that Nadia would not have met the threshold for CAMHS involvement at this time. Although this may have been the case, the RCADS guidance suggests that the threshold for clinical intervention had been met. The SN service continued to provide a safe place for Nadia, and this was commendable. This approach can bring very significant benefits for children in providing a safe place and a trusted adult where their worries can be shared, and these positive relationships can support a child's

[17] Children and Family Court Advisory and Support Service
[18] https://www.cafcass.gov.uk/family-justice-young-peoples-board/fjypb-book-in-our-shoes/
[19] www.cafcass.gov.uk
[20] Reducing Parental Conflict: the impact on children. Department for Work and Pensions. January 2021
[21] The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire with subscales including: separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood (major depressive disorder).
[22] A score of 65 means that the score is roughly in the top 7% of scores of un-referred young people of the same age (described as borderline clinical by the developer) and a score of 70 means that the score is roughly in the top 2% of scores of un-referred young people of the same age (described as the clinical threshold by the developer). Child Outcomes Research Consortium. https://www.corc.uk.net/outcome-experience-measures/revised-childrens-anxiety-and-depression-scale-rcads/

resilience. It is understood that the SN was offering a service that was in line with agreed care pathways of the service at that time although it was clear from the agency report, submitted for the purposes of this review, that there was no mental health support pathway in place and the imminence of the school holidays lead to drift in the case and a missed opportunity to refer to CAMHS.

Previous Joint Area Targeted Inspections JATIs have found a wide variation in the level of service that children received from school nurses. The most recent JTAI[23] exploring services provided to children with mental ill health identified: *In half of the areas visited, school nurses' health assessments of children did not consistently or sufficiently address the emotional well-being and mental health needs of children. This is a lost opportunity to identify needs early.*

When school nurses had limited capacity to work with children, we found that they sometimes focused on the presenting issue rather than showing professional curiosity and delving deeper to understand the causes of the child's problems and identify any potential mental health needs.

It is understood that at the time of the SN involvement, there were significant changes around the 5-19 Healthy Child Programme in which the SN nursing service was based. There was a process of re-organisation and as a result there may have been some organisational flux. In addition, aside from screening there were no other mandated contacts with children aged 5-19 years.

It is understood that there have been some considerable changes in service provision since this time. The Healthy Child Programme is a universal service where young people can self-refer and professional and parents /carers can refer for assessment of unmet health needs which can include physical and emotional health needs. There is now a clear pathway for mental and emotional health support based on the I Thrive[24] model and includes Strengths & Difficulties questionnaires and emotional scaling tools; alongside a Chat Health service for young people aged 13-19 years and a TextUs service for parents who are concerned about their children. In addition, Cambridge Community Service (CCS) provide an Emotional Health and Wellbeing service (EHWBS) to schools in Cambridgeshire which has been growing since 2017. This is a consultation service for schools and other professionals who have a concern about a child or young person who is experiencing emotional difficulties.

In terms of mental health support, the recently established YOUnited Referral Hub offers a single referral route for all young people in Cambridgeshire and Peterborough aged up to 17. YOUnited offers access to a range of support including CAMHS therapies, counselling and guided self-help: *We want to address confusion about how to navigate the system. We want to add capacity into the system so more children and young people can be supported, with shorter waiting times and less delays for assessment. We want to include children and young people in the decision-making process. We want to give options to children and young people who have been falling through service gaps.*[25]As a result of these significant service developments no recommendations are made.

[23] Feeling heard': partner agencies working together to make a difference for children with mental ill health. Joint Targeted Area Inspection December 2020

[24] The THRIVE Framework is an integrated, person centred, and needs led approach to delivering mental health services for children, young people and families Emphasis is placed on the promotion of mental health and wellbeing, and for children, young people and their families to be empowered to be actively involved in decisions about their care through shared decision making. The National i-THRIVE Programme is a national programme that is being implemented in sites across the country.

[25] YOUnited Newsletter. Issue 1 Winter 2022.

2. Seeing a child as a whole: multi - agency and multi-familial working

Multi-agency working

CDOPs[26] highlighted challenges with joint working and information sharing between agencies that have contact with children and young people with mental health issues. The lack of joined up working and poor information sharing limited meaningful multi-agency dialogue….[27]

The services provided to Nadia and her family were almost entirely provided by community and inpatient child and adolescent mental health services. Numerous referrals were made to CS in an attempt to elicit their involvement but, as put by a panel member, the response by CS to Nadia and her family was to *open and shut, open and shut*. This story of single agency working in response to children with mental ill health is familiar – it was identified in two recent SCRs[28] in the local area and is recognised as a national issue. [29]

Since this time there have been numerous changes in the local area to improve the way in which referrals to CS are considered and dealt with. In addition, there is a greater awareness and response to their legal duties under Sc117 (MHA)[30] when a child is an inpatient, and there have been several improvements in multi-agency working with children who have mental ill health. However, Nadia's story reflects not just the absence of multi-agency working but also a siloed approach to working with young people with mental ill health. Little multi-agency dialogue was evident in the referrals that were made or during the assessments that were completed. The information that was held in respective records reflected a confusion about the roles and responsibilities of partners, held partial/inaccurate or misleading information about Nadia and her family and, whilst various diagnoses were shared with CS, formulations[31] were not. This meant that a holistic view of Nadia was absent and there was no shared approach to meet her needs.

What emerged was a clear pattern of working where Nadia's needs appeared to be compartmentalised; with ownership and responsibility for meeting these different needs seemingly split across the two service areas. If a need was categorised as 'safeguarding' or a 'social need' (such as a need to find accommodation or to assess concerns about relationships within the family), this was seen as sitting firmly with CS and passed on. If the need was categorised as 'mental health' – CS stepped away. This reflects a national picture.

The teenagers in these case reviews had long-standing and complex problems and received a wide range of support from different agencies. If services work in silos, this can mean that there is no overall picture of the young person's situation and no overarching plan about how to support them in the best way.[32]

[26] Child Death Overview Panels

[27] Suicide in Children and Young People. National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2020. Published October 2021

[28] CPSCPB Sam Gould SCR 2021 CPSCPB Chris Gould SCR 2021

[29] Feeling heard': partner agencies working together to make a difference for children with mental ill health. Joint Targeted Area Inspection December 2020

[30] Section 117 of the Mental Health Act 1983/2007 (MHA) places a statutory duty on Health Authorities via Clinical Commissioning Groups (Clinical Commissioning Groups) and Local Authorities to work together to provide after-care services for all persons who have been detained in hospital under a treatment section of the MHA.

[31] A formulation is a joint approach between a child/adult and a clinician to summarise difficulties and explain why they may be happening and make sense of them – it is a guide to aetiology, prognosis and treatment.

[32] Teenagers: learning from case reviews briefing. NSPCC Feb 2021

It is without doubt that CS and CAMHS contend with high levels of demand, and it is easy to see why a culture may have developed whereby needs are delineated and split between the multi-agency group/seen as the responsibility of another service to meet. Thresholds are specified and adhered to (in part to control demand and ensure that services continue to be available) and this is understandable, particularly in overstretched systems. But within this system there are risks that children's needs are not seen as whole – a child whose needs cross all domains – needs that are multi-faceted, dynamic and interchangeable – where making changes to one part of the child's world will have little overall effect on a child's lived experiences or outcomes.

A further area of multi-agency work requiring attention relates to how schools are engaged and supported when meeting the needs of children with emotional/mental ill health. Nadia attended school in her local area and during the first two years of the timeline, her attendance was excellent. She enjoyed good relationships with peers and trusted adults, who she felt were a source of protection. Overtime, it was clear that school struggled to meet her needs; Nadia's attendance declined, and she was suspended for an attack on another pupil. She was subsequently enrolled in a local college. There was very little evidence found of a joint approach between CAMHS and school, or CS (when they were involved) and school.

The national review of children's social care[33] interim report, and the later final report,[34] identified systemic problems in how multi-agency working is achieved …*each service has its own footprint, objectives, accountability arrangements and inspectorates, which in turn leads to a system that is confusing and difficult to navigate for professionals let alone children and families.* It describes these siloed approaches as creating a *bureaucratic labyrinth.*

All agency reports completed for this review highlighted the need for this joint working to be improved.

Conclusion: There are signs that joint working has improved since this time and examples of good integrated multi-agency practice, across the management hierarchy and at the front line, were highlighted. Relevant recommendations in recent SCRs[35] relating to joint working, the role of schools/education providers (including the importance of EHCPs) are in the process of implementation, and some substantial changes are evident. However, it is early days in these changes and as described by a panel member and by practitioners – multi-agency working with children who have mental health needs continues to require attention – *there needs to be a cultural change in the way true joint working is achieved.* It was suggested that this required a flexible and creative approach; where bureaucratic constraints are set aside, relationships built, defensiveness reduced by placing the child needs (not a service need) at the centre and building on the collective heart felt desire to improve outcomes for children.

Learning from what works well

Steph was admitted to the local inpatient unit after she was found by police attempting to jump from a bridge over a busy road. Steph had a history of suicidal ideation and extensive self harm – she was clear she wanted to die. Although CAMHS had been involved, there had been no other agencies involved in her care. On her admission a referral was made to CS which was accepted, and an Education Health

[33] The Case for Change: The independent review of children's social care. June 2021

[34] The independent review of children's social care. Final Report Josh Mc Alister May 2022

[35] CPSCPB Sam Gould SCR 2021.CPSCPB Chris Gould SCR 2021.

and Care Plan Assessment commenced. With the consent of her family, weekly multi -agency meetings took place. There was good multi-agency dialogue and respectful challenge. Discharge planning started at the point of admission. Using the Think Family resources available in CPFT, her wider family and kinship were mapped. This enabled the network to understand risk, identify sources of safety in the community and promote resilience. The CPFT Crisis Team worked closely with the CAMHS Home Treatment team and core CAMHS to ensure that communication between the teams was consistent. When it became clear that Steph could not return home, a joint funding arrangement between CS and CPFT was quickly agreed and after careful multi-agency planning, Steph was discharged to a community placement where she remains.

As demonstrated by this example, creative and innovative ways of placing the child at the centre of multi-agency working are emerging in the local area. Practitioners and panel members were clear that this needs to be replicated across the system so that all children benefit from this approach.

Recommendation 2: C&PSCPB are encouraged to learn from the examples of good practice and consider what more may be needed to embed a culture of muti – agency working across the system.

Multi-familial working

Changing the trajectory of children's lives, and making a significant difference to children's outcomes, cannot be achieved by professional intervention alone. There is a need to understand and embrace family, kinship, and communities.[36]

Difficulties in family relationships during adolescence is a normal part of this developmental stage. As a child seeks their autonomy and independence/seeks their own sense of unique self that is joined but at a distance from family so the dynamic of family relationships change, adapting to these changes can present challenges. These challenges can be influenced by contextual factors that may be present for adolescents such as navigating peer relationships and re-negotiating family relationships within re-constituted families. This is all happening at a time when seeking a sense of unique self, of identity and belonging, is at the core of adolescent development.

Nadia was part of a wide extended family, including birth and step siblings, parents and stepparents, a maternal grandmother and step grandfather, maternal and paternal aunts, uncles and cousins. Members of this extended family visited her at the local inpatient unit, Nadia visited family members when staying with her father and she spent a period of overnight leave with her stepbrother. During this review, father spoke about the importance of family members in her life. During the early part of the timeline, whilst there was some engagement with Nadia's mother by CAMHS and fleeting engagement by CS, there was very little engagement with father and no engagement with any other family members. Once Nadia had moved out of area to the Psychiatric Intensive Care Unit (PICU), and later the Low Secure Unit (LSU), there was no engagement with mother by services. During this time, Nadia was clear she did not want contact with her mother or for her mother to be informed of her treatment or care and she was assessed as

[36] Croydon Vulnerable Adolescent Review. CSCP 2019

having capacity to make this decision. In the last few weeks of her life she said she wanted her mother to be involved in family meetings, but this did not happen.

Mother said her place in Nadia's life was not appreciated or understood by professionals - she wanted contact with Nadia, but little was done to facilitate this. Whilst it is understood there were occasions when Nadia said she did not want contact with her mother, there needed to be greater efforts to nurture this relationship overtime. Mother told the Lead Reviewer she felt she was painted as a 'bad person' by the agencies involved and that there was no consideration of the importance of Nadia's relationship with her, with Nadia's siblings and step – father.

Nadia's father was in regular contact with Nadia throughout the timeline, he was periodically engaged by the respective inpatient units but only fleetingly by CAMHS and he told the Lead Reviewer: *CS had no contact with me whatsoever – I was invisible to them. There was a need to support us (mother and father) to be the best parents we could be and help us both to keep Nadia safe.*

As identified in an agency report: *The primary focus for all three young people[37] was their mental health resulting in case management being health and hospital led with less attention to parenting, family dynamics and wider support systems.*

Nadia often spoke to clinicians about difficult family relationships with her parents and of not feeling she belonged in her family. Nadia spoke about misgivings and mistakes made by her parents and felt much of her unhappiness was down to these relationship difficulties. Whilst this was clearly Nadia's perspective and may have influenced how far practitioners engaged family members, it was also important to; appreciate that a normal part of adolescent development is to challenge parental care and control, triangulate her perspective with the perspective of family members and pay attention to who was in Nadia's family and kinship and what they meant to her.

There are numerous benefits in mapping and understanding a child's family, kinship and friends. It can promote a sense of belonging, nurture connections, establish sources of safety and risk, engender a felt sense for the child that they are held in mind and facilitate a collaborative approach to care and safety planning. Whilst the various practitioners and clinicians may well have held knowledge about Nadia's kinship - this did not translate to a coherent picture. Nadia's journey in inpatient units, characterized by the involvement of multiple practitioners and various transitions, meant that this knowledge was lost overtime.

Some family meetings and family therapy were facilitated by CAMHS and by the inpatient units which included her mother, but this stopped when Nadia decided she wanted no contact with her mother and was not reinstated when she changed her mind.[38] Whilst it is understood that she had capacity to make her own decisions about contact, a question arises as to whether more could have been done to strengthen this relationship and support both mother and father in caring for a vulnerable child.

Parents/carers need consistent and empathetic support and understanding if they are to meet their children's needs in the short and long-term. Professionals need to help parents hold on to feelings of self-worth and self-esteem by valuing them and the contribution they have made, and continue to make, to

[37] CSC Agency Report submitted for this Review

[38] Family work continued to be facilitated by the inpatient unit with Nadia and her father at this time

their children's lives and respecting the critical place parents occupy in being the key repair agent in their child's recovery.[39]

Conclusion: As stated by clinicians and supported by research, of utmost importance is the need to avoid inpatient admission wherever possible. Clinicians spoke about the fear that can be felt by parents/carers about keeping their child safe at home and how this can add to the reasons why a child might be admitted, or why discharge is delayed. There was a need to support Nadia with her various familial relationships to enable these relationships to be the best they could be and to construct an emotional scaffold around the family to enable them to provide care and manage risk and uncertainty.

Locally, some important work is taking place in the Cambridge and Peterborough Foundation Trust (CPFT) to strengthen a Think Family approach which prompts clinicians to think about a child's network and builds a picture over time and the new multi-agency framework brings together multi-agency services to support children with mental ill health and their families. It remains important for CPSCPB to maintain an overview of how this work is progressing and consider how the systemic problems, identified by the Child Safeguarding Practice Review Panel[40] about engaging father's, are being overcome.

Recommendation 3: CPSCPB to review how far current developments to strengthen multi-agency work includes the importance of mapping and engaging immediate and extended family, proactively engages fathers and builds provision in the community that, wherever possible, avoids inpatient admission.

3. Breaking the silence: sexual violence

Secrecy compounds the trauma of sexual abuse[41]

The secrecy that shrouds sexual abuse/assault is an organising principle that keeps sexual violence hidden beneath a veil of silence. Driven into silent isolation by intimidation, shame and fear of not being believed, victims struggle to speak about the abuse - some never do.

Throughout Nadia's contact with clinicians in the community and inpatient care Nadia was able to list traumatic events in her life that she felt contributed to her ongoing distress, the list she provided was consistent. One of these traumatic events related to an incident when she was aged between 11/12 years when she alleged that she and a friend were sexually assaulted in a public space by a group of boys aged between 12 - 18 years old. Nadia first disclosed this to a CAMHS clinician, and later to inpatient staff at the 3 inpatient units. She identified this as a significant time in her life which brought up strong feelings of shame and anger and described the images as being very vivid *like it happened yesterday* and of having nightmares related to this trauma.

[39] CPSCPB Sam Gould SCR 2021 CSCPB Chris Gould SCR 2021
[40] "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel. September 2021
[41] Breaking secrecy. Adult survivors disclose to their families. E Schatzow, J L Herman The Psychiatric Clinics of North America. National Library of Medicine 1989.

When Nadia first disclosed this assault, she was living at home with her mother. She said she did not want her mother, or other professionals, to know of this disclosure. The CAMHS clinician concluded that as this was a historic event - there were no current risks to Nadia. They were mindful of the difficulties in the relationship between Nadia and her mother, and Nadia was judged to have capacity to make the decision that her mother would not be informed. As a result, her mother was not told. The clinician suggested that attempts would continue to be made to create a safe space to enable Nadia to revisit the emotional impact of this event during subsequent sessions. Nadia agreed with this approach.

The trusted space the clinician had created for Nadia undoubtedly enabled her to speak of the sexual assault for the first time, and the therapeutic plan seemed appropriate. However, it was also important to be mindful of the corrosive impact of secrecy on children, the therapeutic value of seeking justice and the need to consider other children who may be at risk of sexual assault. Whilst it is understood that Nadia's disclosure was discussed within the clinical team, safeguarding supervision or advice was not sought at this time (see below).

Three days later, the clinician referred Nadia to CS. In this referral the focus of concerns was about the impact of Nadia's family environment on her wellbeing and the 'sexual assault' was referenced. The referral was passed to Early Help – the response was to take no further action. This referral was appropriate, at minimum it reached the threshold for a child and family assessment to be completed. As previously discussed, at the time there was little multi-agency working across CAMHS and CS – it was routine practice to decide that if CAMHS were involved there was no need for CS involvement. It is not entirely clear why the sexual assault was not viewed with the seriousness that it warranted. It is quite possible that as the assault was referred to as historic extra-familial abuse it was assumed there were no current safeguarding concerns.

There is no later reference to this assault being discussed with Nadia within CAMHS although it is important to note that over the next 2 months Nadia's difficulties escalated and Nadia was admitted to an inpatient unit 2 months later. Therefore, by necessity, much of the work became crisis driven.

Key learning

Silence compounds the trauma: It is not intended that the narrative of events set out above is interpreted as a linear causation from disclosure to escalation – there were clearly several events over this period that would have contributed to Nadia's increasing distress, and to mother's difficulties in providing an emotionally containing environment at home. However, subsequently, Nadia went on to disclose this assault on several occasions when she was admitted to the different inpatient units and so over time this assault was known to a discreet number of clinicians/ practitioners in community and inpatient settings and within CS (although there is no evidence that it was discussed with any family members). Mother's perspective was that it was important for her to know about this assault so that she could have responded to Nadia's distress. She told the Lead Reviewer that she sensed something awful may have happened - *I knew my daughter – I could tell through her body language that something traumatic had happened and I told clinicians, but I did not know what had happened until after she had died.*

Whilst a number of therapeutic interventions were provided to address a variety of Nadia's symptoms, specific work focussing on the sexual assault was not clear and the original stance that this was a historic event, and therefore no safeguarding action was needed, seemed to become the dominant narrative.

It is important for all in the children's workforce to carefully consider what action to take when a child courageously makes a disclosure of sexual abuse/assault:

- How will their feelings, relating to this specific trauma, be explored and validated over time?
- How might justice be sought over time?
- Are other children at risk as a result of maintaining the secrecy?
- What part does secrecy play in a child's ongoing trauma?

Conclusion: In choosing to include this learning in the report, the author has been mindful of what Nadia would have wanted to be shared about her life in the public domain. The author is conscious that when Nadia disclosed the assault, she did not want the clinician to tell anyone else (although she went on to speak to others about the assault). The author is mindful of the research[42] suggesting that; the secrecy that traps victims is in itself profoundly painful creating a cycle of silence that perpetuates the trauma; it hides the extent of sexual violence in current society and puts other children at risk. Therefore, after careful consideration, it was felt that to avoid raising this important issue risked colluding with the silence and thereby minimizing the extent of sexual violence in current society.

Recommendations: Recent SCRs in the local area[43] have highlighted relevant themes about child sexual abuse that resonate with Nadia's experience of the response by services to her disclosure of sexual assault. These SCRs were focussed on intrafamilial sexual abuse and highlighted the importance of responding to disclosures of sexual abuse in a planned and co-ordinated way across the multi-agency network and the importance of seeking justice overtime.

Since Nadia's death, and the aforementioned SCRs, there have been significant service developments across the multi-agency partnership which have; strengthened the awareness and response to sexual abuse, increased the involvement of safeguarding advisers within the local inpatient unit and within community CAMHS and there are promising signs that a multi-agency approach is being embedded. The relevant recommendations contained in these SCRs are relevant. It was the view of panel members that whilst progress has been made since these reviews, it was important to maintain a strong focus on raising awareness and strengthening partnership work. Therefore, the following recommendation is made.

Recommendation 4. CPSCPB to review current service developments, in relation to identifying and responding to CSA, to identify any barriers/gaps and consider whether these developments sufficiently include extra familial sexual assault.

[42] There is substantial research and literature on the silence that surrounds sexual assault as highlighted by the #METoo movement. Recent research paper: *I've Never Told Anyone:* A Qualitative Analysis of Interviews With College Women Who Experienced Sexual Assault and Remained Silent. Sandra L. Caron, Deborah Mitchell June 2021

[43] CPSCPB Sam Gould SCR 2021 CPSCPB Chris Gould SCR 2021

4. A place called home: few good options

I have nowhere to go[44]. Throughout Nadia's inpatient admission, plans were made for her discharge 'home.' During her early stay at the local inpatient unit, home was defined as her home with her mother, birth siblings and stepfather, and plans put in place for her to return there. Nadia's mother told the Lead Reviewer that she wanted Nadia to return to her care but that she did not feel supported by services to enable this to happen. She was acutely aware of the impact of Nadia's mental ill health on her siblings (on her younger brother who has additional needs and on her sister who shared a bedroom with Nadia) and felt services did not make sufficient attempts to understand the impact on family members and the challenges of providing care. She felt that Nadia was left believing that mother did not care for her.

Overtime, Nadia was increasingly clear that she did not want to return and concerns about Nadia's emotional wellbeing at home emerged. At this point, the local inpatient unit referred to CS identifying these concerns and requesting that CS comply with their duties under Sc85 (CA1989)[45] and to consider their duties under Sc20(CA1989)[46] in line with 'The Southwark Ruling'.[47] An assessment was completed by CS with a conclusion that there were no safeguarding concerns in relation to Nadia's return home and no further action was taken. This assessment lacked depth; it was over reliant on maternal self report, insufficient attention was paid to Nadia's voice and the views of clinicians and the challenges of providing care to a child who had significant mental ill health did not appear to be understood. Of critical importance was that overtime a stale mate appeared to be reached – the views of clinicians was that Nadia could not go home and was in effect homeless – the view of CS was that Nadia had a home with her mother. A pattern then emerged throughout the 12 months of inpatient care when discharge was being planned; Nadia's self–harm increased, her aggressive and violent behaviour intensified, and her mental health appeared to significantly deteriorate. Ultimately, this led to her admission to a PICU.

Nadia revealed a very good level of insight, and she has showed having an excellent explanatory account of her difficulties. She is currently struggling with the uncertainty about her future and admits this is impacting on her presentation. She doesn't have anywhere to go…. [48]

At this unit, this pattern of deterioration at point of discharge was noted and as a result when Nadia moved to the LSU, she was given no prior warning of this move. Once at the LSU, the same pattern emerged and at the time of her death plans were afoot for her discharge but no home, either a general adolescent bed or a supported living arrangement, had been identified.[49]

In terms of multi-agency working, another pattern ran in parallel. When Nadia's discharge was planned, referrals were made to CS. CS accepted these referrals and their involvement commenced in planning for

[44] Nadia throughout her inpatient care

[45] Section 85 of the Children Act 1989 places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and/or likely to exceed 12 weeks.

[46] Section 20 of the Children's Act 2989 sets out the duty of Local Authorities to provide a child with somewhere to live if the child doesn't currently have a home, or a safe home…. regardless of whether this is short term or long-term problem.

[47] The Southwark Judgement, made by the Law Lords in May 2009, is a piece of case law that obliges children's services to provide accommodation and support to homeless 16- and 17-year-olds. ... If they do then the young person must be accommodated under the Children Act 1989 (s. 20) and considered a 'looked after child'.

[48] Cygnet Health Care: Care Plan

[49] No referral was made to CSC at this time – there was confusion about whether Nadia had an allocated SW/whether a new referral was needed/had been made. The view of CSC is that if this referral had been made a response would have been provided.

discharge. No alternative to home was identified during this planning stage and, once Nadia's mental health worsened, CS closed their involvement on the basis that she would remain an inpatient and so was the sole responsibility of mental health services.

Throughout her stay in the inpatient units, Nadia had little sense of where home might be. There were some discussions with Nadia about possible supported homes in the community, and on one occasion she visited such a home only to be told later that she would not be able to be placed here as she was not a 'looked after child.' When discharge was being planned at the LSU in the last few months of her life, there was an idea that she might be discharged to a 'step down house' but again, this was a concept that had been shared with Nadia but the practicalities of realising such a placement were never established. So when Nadia said she had nowhere to go – she was right - she was a child whose only place she could call home were inpatient units and there was nothing in place that enabled her to envisage a different future.

Inpatient stays: risks of contagion and dislocation……..*she (also) feels that staying in hospital especially in a PICU, will only contribute for further deterioration of her mental health difficulties. When I asked her to clarify, Nadia reiterated that her peers acute presentation deeply affects her.*[50]

Nadia's father accepted that Nadia struggled with mental ill health but was of the firm view that the longer Nadia remained an inpatient – the more unwell she became*: She had a cocktail of medication and began to use medical terms to describe herself – she was given 7 -8 different diagnoses – these seemed to define her.* He spoke about Nadia searching for a sense of belonging in inpatient care and *copying some of the behaviour of her peers in order to fit in.*

Nadia was given a range of diagnoses during her various admissions including Complex Post Traumatic Stress Disorder (CPTSD), CPTSD with psychotic features, emerging Emotionally Unstable Personality Disorder EUPD, CPTSD with emerging schizophrenia and multiple personality disorder.[51] Nadia's father said that *each unit disagreed with the diagnoses made at the previous unit.* When admitted to the Psychiatric Intensive Care Unit (PICU), Nadia was taken off all medication and her phone removed for a week. During this time, it was the view of the clinical team that Nadia *did not appear to be suffering from a mental illness*. The view of the clinical team was that Nadia's symptoms fitted a diagnosis of emerging EUPD and that her continued stay in PICU was unhelpful: *I do not understand why I am in hospital, and I believe this admission is only making me feel worse*[52]*.*

The lived experience of mental ill-health and admission to hospital pose risks to young people's psychosocial development, their educational achievement, and family and peer relations.[53]

…….longitudinal datasets suggest that admission to hospital does not reduce the risk of suicide, and multiple admissions to manage suicide risk is associated with an increased risk. [54]

[50] PICU Care Plan
[51] Known as Dissociative Identity Disorder
[52] Nadia when at PICU
[53] What do we know about the risks for young people moving into, through and out of inpatient mental health care? Findings from an evidence synthesis. Deborah Edwards, Nicola Evans, Elizabeth Gillen, Mirella Longo, Steven Pryjmachuk, Gemma Trainor, and Ben Hannigan 2015 : https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689041/
[54] https://www.cambridge.org/core/journals/bjpsych-open/article/interventions-to-reduce-selfharm-on-inpatient-wards-systematic-review/45D158CCE75BD49345BD7822A4CA387B

Clinicians in the local community CAMHS and local inpatient unit are keenly aware of the research and guidance and are clear that inpatient care should be avoided but in the absence of alternatives; be it appropriate accommodation, a wrap around community care package, and perhaps *a societal misunderstanding that inpatient care offers a cure*, there are often few viable options.

Throughout Nadia's stay in inpatient care her voice was loud and clear:

- She felt unable to return to her mother's care and was concerned that her mental health would deteriorate if she did so.
- When plans were made for her discharge 'home' the rapid deterioration in her mental health symptoms was a communication of her concerns about being returned 'home.'
- She did not want to remain in inpatient care, but she was well aware there were no viable alternative options: *I want to go to a foster placement……I do not fit the criteria of CSC…… I have nowhere to go.*

Nadia's voice was heard by clinicians and practitioners, but this did not result in any tangible changes to Nadia's lived experiences in the areas she wanted most change. The question that arises is - why was it so difficult for the multi-agency system to respond? Several systems issues have already been discussed which would have contributed to this position (including the lack of multi-agency work and the lack of partnerships/ engagement with family members). There is a further systems issue that requires attention, and this appeared to be that the practitioners in the system found themselves contending with a binary choice about where Nadia should be – in the care of the LA or in inpatient care?

Few good options = a binary choice?

The lack of an alternative placement to home with mother was a significant factor in her death.[55]

As previously identified, staff in community CAMHS and in the inpatient units made several referrals to CS when they raised concerns about Nadia's return home to her mother's care. CS were asked to take up their statutory duties under Sc117 and, when it was clear that Nadia's mother was unwilling for Nadia to return home, referrals were made asking CS to find her accommodation/accommodate Nadia under Sc20 (CA1989) and thereby receive her into the care of the LA. The response by CS was to *open and shut* Nadia's case. Some of the reasons for these responses have already been identified in the section multi-agency working. However, from talking with clinicians and CS managers, a systems issue emerged which seems to be of critical importance and one that impacts on multi-agency working with vulnerable children who are in similar circumstances as Nadia; there are few good options, and this leads to binary choices.

The position taken by the inpatient units and CAMHS was that CS were responsible for finding her alternative accommodation. The position of CS was that this would mean Nadia would need to be taken into the care of the LA - outcomes for children who come into care late are poor and so every effort should be made to avoid this course of action.

[55] Nadia's father

Increasing numbers of children are coming into care late and the outcomes are generally poor[56]*. Although use of S20/S31*[57] *'can create some short-term physical safety, and give agencies a sense of false relief, this is often short lived and can be to the detriment of the child's relationships and psychological well-being'* (Firmin, 2019).

In addition, it is understood that there are some very real stubborn challenges in finding placements for children like Nadia. Such as:

- The lack of availability of placements that will accept a child who has a history of mental ill health particularly if this includes self harm and suicidal ideation.
- Semi-independent units are not registered, and this means that children who have care needs over a certain number of hours cannot be placed here
- Reluctance of residential therapeutic communities to accept a child after a certain age
- Remaining gaps in CAMHS crisis provision for children in the community

It is a very sad reality that sourcing placements for children who are in state care is a marketplace: residential placements (businesses) are paid very significant sums of money to care for a child but there are no incentives for the business to contend with the challenges of providing care to a child with complex needs, when they can be replaced with another child who is less challenging/less risky to provide care to.[58]

These issues have been raised with the Independent Reviewer during CSPRs across the country and have been recognised as a national issue:

We continue to hear that there are not enough of the right homes for children with the most complex needs…... What is clearly true is that at present the state is not meeting the needs of a very vulnerable group of children. We desperately need better planning, coordination and investment for this group with leadership across health, justice, and children's social care.[59]

Mental health practitioners identified the critical need for children who are in inpatient care to*: Mentalize hope for the future post discharge to envision a different future: How do we give them an articulated hope for the future?* and all practitioners spoke about the urgent need for the multi-agency system to tackle the stubborn challenges of exploring what options are available if a child cannot/should not return home. This is a world of complexity and in this complex world, there is a risk that agency working can become split in a belief that one agency may have a resource or a service that could be 'the solution.' The reality is that there is currently no local solution in terms of a bespoke resource, and this is reflected across the country – it is therefore a national issue that potentially requires a national response.

However, children cannot wait for the national changes that are needed. There is a passion amongst practitioners and managers across the local multi-agency partnership to come together to pool budgets, knowledge and resources to find creative solutions for children in Nadia's circumstances. Evidence is

[56] The Nuffield Family Justice Observatory (October 2021).
[57] Section 20 (S20) of the Children's Act is a voluntary care arrangement based on agreement between, the person or people with Parental Responsibility, the child and the local authority. Section 31 (S31) of the Children's Act is a court order placing the child in the care of a designated local authority, with parental responsibility being shared between the parents and the local authority.
[58] Croydon Safeguarding Children's Partnership CSPR Chloe (awaiting publication)
[59] The Case for Change: The independent review of children's social care. June 2021 DfE

emerging of recent examples where this passion has resulted in finding solutions, however, this is not consistent.

Recommendation 5. CSCPB to explore how multi-agency partners are working across the organisational hierarchies to find bespoke solutions for children in Nadia's circumstances and consider what more may need to be done to support this challenging work.

Conclusion

Nadia was a child who struggled with her emotional wellbeing and mental ill health from the age of 12, she was eager to access the support that was on offer and engaged well. The services provided to Nadia were split across the multi-agency system, there was no coming together of these services or with family members in a meaningful way that placed Nadia at the centre and sought to find creative solutions to find a place Nadia could call home. Nadia's home became inpatient units where she often spoke of feeling overwhelmed by these environments and the mental ill health of her peers, she was known to provide empathetic support to her peers, but she struggled to fit in. Many of the issues identified in this CSPR are already known - they are national issues that require a national response. Locally, there have been some significant service developments in key areas. Nadia's wish was to help others. In honouring this wish, CPSCPB are committed to learn from Nadia's story and strengthen service developments to find creative ways to work together across agencies and hierarchies so that a child and their family are placed at the centre of multi-agency work.