Child Safeguarding Practice Review

Hazel and Lilly

West Sussex Safeguarding Children Partnership

in association with

another Safeguarding Children Partnership

Final Report

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Executive Summary

This CSPR has taken place after the tragic death of Hazel. Hazel was sixteen when she sadly took her own life. Hazel, and her youngest sister Lilly, experienced childhood adversity. After the death of their mother, they moved across geographic boundaries to live with their father who they had not been in contact with for many years. Both have received multi-agency services at various points in their lives in response to concerns about maternal care in childhood and in response to their emerging mental ill health in adolescence.

Overall, it is clear that multi-agency services responded to their needs as they arose, and practitioners worked hard to try and provide Hazel and Lilly with support. Excellent support was provided by the schools in the two areas where Hazel and Lilly lived. Several factors influenced their experiences, and nature of service provision, including the impact of the Coronavirus Pandemic.

Since the time under review, services have adapted and evolved in response to children's needs and there have been many promising service developments. This CSPR has identified a number of areas where multi-agency services need to be strengthened, with a particular focus on providing a multi-agency response as early as possible to children who have a history of trauma and emerging mental ill health.

This CSPR has recognised that there are limits to the changes that can be made by local multi-agency services. As identified in recent national reports referenced in this CSPR, if children with mental ill health are to receive the services they deserve - national changes are needed.

Introduction

A decision was reached by West Sussex Safeguarding Children's Partnership (WSSCP) that a Child Safeguarding Practice Review (CSPR) should commence after being notified of Hazel's sad death. The conclusion of the recent inquest was that Hazel died by suicide. This CSPR has been completed in association with another Safeguarding Children's Partnership some distance from West Sussex, known as LA1 (Local Authority Area one).

Methodology

This CSPR has complied with relevant guidance[1]; relevant information has been supplied by agencies involved in providing services to Hazel, Lilly and family members; a panel of agency representatives, who had no direct involvement in the services provided, has met on several occasions; the perspectives of practitioners have been gained through their involvement during a learning event. Pseudonyms are used when referring to the sisters and family members. An independent lead reviewer (Bridget Griffin) has authored this report.[2]

Scope

The scope of this CSPR covers a period of two years which includes Hazel and Lilly's move from LA1 to live with their birth father in West Sussex until Hazel's death. Agencies were asked to consider significant events prior to this timeline. The services provided to Hazel's younger sister (Lilly) are included in the scope.

Involvement of family members

Family members including Lilly, her half-sister (Jodie), her brother-in-law (Alan), her birth father and stepfather were contacted and invited to contribute to this CSPR. The review has benefitted from the involvement of Lilly, her half-sister (Jodie) and brother-in-law (Alan). During meetings with the Lead Reviewer they were fully engaged in sharing their perspectives and correcting factual accuracies. Lilly bravely gave her views; she was both insightful and reflective about her and Hazel's experiences.

Hazel and Lilly

Hazel was a white British child who was the eldest daughter of her parents. Her birth sister (Lilly) is 18 months younger than Hazel. Hazel and Lilly have maternal half-siblings who are adults, they were not living at home under the period covered by this review. Hazel was described as a 'quiet, private person who never complained or made a fuss at school'. Hazel had a history of ear infections as a child and had hearing loss - she wore hearing aids although this did not seem to pose any problems for her. She was tall and favoured wearing dark loose clothing – often jeans and she liked black nail varnish. She loved cats, enjoyed listening to heavy metal music and spoke with joy about accompanying dad on long bike rides. Although her choice of clothes and music was not in line with the popular tastes of

[1] *Working Together to Safeguard Children.* HMG 2018
[2] Bridget Griffin CQSW,BA,MA

her peers – and this meant she stood out from her peers – she was accepted by her peers and enjoyed strong friendships in a group of peers who were described as 'lovely and kind'. Hazel had a close relationship with her sister – Lilly, and positive relationships with her maternal aunts and half-sister who lived some distance from her home with dad. Hazel wanted to be a paramedic.

Lilly is a white British child who is the youngest daughter of her parents. Like her sister, Lilly enjoys wearing dark clothes and often dyes her hair black or dark purple. Like her sister and dad, Lilly enjoys listening to heavy metal music. Lilly enjoys watching films about vampires and crime documentaries. Lilly spent a period in an inpatient mental health unit after the death of Hazel. She currently lives with her half-sister, brother-in-law, nephews and pets in LA1 where she is settled and doing well. Lilly continues to courageously contend with mental ill health and is receiving intensive support from CAMHS. Lilly attends a local college where she is studying animal care, she loves animals and has an ambition to create a zoo in the future – her favourite animals are sugar gliders. Lilly's perspective about her childhood, and the services provided to her during her life, are included in this review.

Summary of multi-agency involvement

There have been various multi-agency services involved in the lives of Hazel and Lilly from a young age. Hazel and Lilly were living in LA1 with their birth mother when concerns about neglect in maternal care were raised by their birth father. This led to a child and family assessment by LA1's Children's Social Care (LA1 CSC) and a brief period of involvement when the family were provided with services as children in need. The relevant school in LA1 provided services under the team around the child (TAC) framework[3] after the case was closed to LA1 CSC. There were concerns about school attendance, missed medical appointments for Hazel, and Hazel was recognised to be a young carer for her mother who suffered with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS). Extensive support was provided by the school over a number of years. Hazel was referred to Child and Adolescent Mental Health Services (CAMHS) in LA1 when she was thirteen after concerns arose about Hazel's suicidal ideation and deliberate self-harm. LA1 CAMHS were actively involved for over 12 months until there were noted improvements in Hazel's mental health.

Hazel and Lilly's mother died when Hazel was fourteen and Lilly was twelve. Shortly after their mother's death, Hazel was keen to move away from the house where her mother had died which contained memories of the past. Her family in LA1 felt that she should remain in close proximity to them and tried to persuade her to stay. Hazel felt she wanted a fresh start and was resolute about this, Lilly wanted to follow her sister and so both moved to live with their birth father in West Sussex where they attended a local secondary school. Extensive support was provided to Hazel and Lilly by the school. The onset of the coronavirus pandemic impacted on the services provided over the following period. Hazel and Lilly were identified as vulnerable by the school and could have continued attending school during this time, but their father was concerned about the pandemic and therefore they accessed

[3]A Team Around the Child/Family is a network of practitioners who work together to agree a plan and delivery of support to meet a child or young person's assessed needs – this is usually provided by universal services.

remote learning.[4] School staff stayed connected with the girls and their father when no significant concerns were noted.
Twelve months after Hazel and Lilly's move to West Sussex, concerns emerged about Hazel's mental health. She was noted by her school counsellor to have deliberately self-harmed, and Hazel spoke about thoughts of suicide. Hazel was taken to the local acute hospital by her father where she was reviewed by CAMHS and discharged to the care of her father. Risk assessments and safety planning took place, and a referral was made to West Sussex Children's Social Care (WSCSC). Over the following month both school and WSCSC provided services to the family; a child and family assessment was completed; the school continued to be actively involved in providing support; the CAMHS duty team were involved in reviewing the risks and in safety planning. An appointment for Hazel to see a CAMHS psychologist was scheduled to take place six weeks later. On a number of occasions, school staff, CSC and the family asked for this appointment to be brought forward due to Hazel's ongoing distress and plans to end her life. Two days before her death, the school made a referral to the West Sussex Integrated Front Door[5] due to significant concerns that Hazel had planned to take her life that night. The following day in school Hazel appeared more optimistic about the future, the next morning she took her own life.

Findings

1. Understanding & responding to the risk of suicide as a safeguarding concern

Hazel took my idea (to kill herself) – *she got there before me* (Lilly)

It would be difficult to find more factors/risks in cases of suicide (panel member)

Hazel and Lilly's lived experiences

- Hazel and Lilly's parents separated when they were young – this separation was acrimonious – it was described by father as *a traumatic end to their relationship*. Hazel and Lilly did not see their father for many years – this was a living loss.
- Hazel had a high level of medical needs when she was young requiring hospital admission and significant medical intervention.
- Hazel and Lilly spent much of their childhoods in the care of their mother who suffered with myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).
- Hazel and Lilly were young carers of their mother and Hazel described being a carer for Lilly.
- Concerns about neglect were investigated by Children's Social Care and resulted in a short period of involvement.
- As a young adolescent, when she was living with her mother, Hazel was known to the local child and adolescent mental health services - she self-harmed and had expressed thoughts of suicide.

[4] When reading this report, Lilly was keen to point out that she was not aware that she could have continued to attend school at this time - this was important to her.
[5] The Integrated Front Door (IFD, formerly MASH) aims to provide a single and consistent point of access to advice, guidance and decision-making about the right level of help needed to keep each child safe or achieve change.

- Hazel described extensive bullying at the school she attended in LA1.
- Hazel was fourteen and Lilly was twelve when they found their mother unconscious at home. She later died of sepsis – her death was unexpected.
- Hazel and Lilly later went to live with their father and his partner some distance from their maternal family home. The girls left behind trusted relationships with maternal family, their stepfather, peers, and school staff – they also left behind beloved pets - these were living losses.
- The new parenting couple struggled to meet the emotional needs of Hazel and Lilly – the girls behaviour was indicative of trauma. Father's view was that the neglect they had suffered was the cause. The girls felt they were not understood and were not able to grieve the loss of their mother - relationships within the family home were difficult.

Research Note: NCMD[6]

62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and "living losses" such as loss of friendships and routine due to moving home or school or other close relationship breakdown.

Of the 91 children who died from suicide between April 2019 – March 2020 common background factors were identified[7]. Out of the top 10 factors (out of a possible 15 factors in all), Hazel and Lilly's life experiences suggests that all these factors were present.

- Household functioning 63 (69%)
- Loss of key relationships 56 (62%)
- Mental health needs of the child/young person 50 (55%)
- Risk taking behaviours 45 (49%)
- Conflict within key relationships 41 (45%)
- Problems with service provision 32 (35%)
- Abuse and neglect 29 (32%)
- Problems at school 27 (30%)
- Bullying 21 (23%)
- Medical condition in the child/young person 21 (23%)

Multi-agency involvement. Five months after mother's death, Hazel was referred to the Child and Adolescent Mental Health Service (CAMHS) in LA1 by her GP as Hazel was experiencing 'low mood' and she asked to be seen by CAMHS. After discussion with the GP and Hazel's stepfather, and review of the information available, CAMHS concluded that this was a normal grief reaction to a bereavement that should not be pathologized – local

[6] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021.
[7] NCMD stress that it is important to note this data represents a minimum number due to underreporting and limitation of information available to Child Death Overview Panels.

bereavement services were identified. The GP was advised to monitor and re-refer if concerns remained/escalated – this was in line with practice and procedure at this time.

Hazel and Lilly received a high level of support from their school; team around the child (TAC) meetings took place and counselling was provided. Lilly's perspective was that she was not provided with the support she needed at this time, she was suffering from low mood and had thoughts of self-harm, but this only resulted in her being directed to self-help websites on line which she felt did not provide her with the support that she needed.

LA1's Children's Social Care were told of mother's death, but there had been no involvement from this service since being closed following an initial assessment in March 2018 and as *there were no safeguarding concerns* no role for this service was identified.[8]

When Hazel and Lilly moved to live with their father in West Sussex, the school in LA1 promptly passed the information to the new school – but as *there were no safeguarding concerns* and no statutory social care service involved – no referral was made to West Sussex Children's Social Care (WSCSC). School continued to support Hazel and Lilly and provided opportunities for Hazel and Lilly to speak with trusted adults.

Approximately one year after Hazel and Lilly's move to West Sussex, WSCSC commenced an assessment after Hazel was assessed at hospital after expressing suicidal thoughts at school. WSCSC continued to remain involved and provided support. One month later, school referred to the Integrated Front Door[9] when concerns about Hazel were escalating. This referral was not regarded as a safeguarding matter that met the threshold for a multi-agency strategy meeting.

Learning from panel members & practitioners. Panel members have been keen to emphasise that these concerns would not have met a threshold for providing a child protection response. The question that has arisen is – if these concerns had been regarded as a safeguarding/child protection concern, which required statutory multi-agency intervention under Sc47 of The Children Act 1989[10], would this have made any difference to Hazel and Lilly?

Services provided under Sc47 of the Children's Act positions the scale and speed of multi-agency intervention at one of the highest threshold levels of intervention; there are strict time frames for intervention; no consent is required to share information; tried and tested processes bring together the multi-agency network into a series of meetings to share information and plan interventions and often galvanises the network to provide a timely structured response. It is not normal practice to regard children at risk to themselves as a result of mental ill health as sitting within this statutory framework although more recently,

[8] Family members were clear that there were safeguarding concerns prior to mother's death – this is discussed in finding five.

[9] The Integrated Front Door (IFD, formerly MASH) aims to provide a single and consistent point of access to advice, guidance and decision-making about the right level of help needed to keep each child safe or achieve change.

[10] A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

in some parts of the country, the response to children at risk of serious youth violence/criminal/sexual exploitation has adopted this route for the reasons set out above.

The view of practitioners at the learning event was that responding to Hazel and Lilly's needs under Sc47 would not have made a difference to Hazel and Lilly (particularly given the recent changes in the services provided by West Sussex CSC when responding to children with mental ill health who are at a high risk). Evidence suggests these recent developments have resulted in significant changes to how the needs of these children are responded to. These changes are discussed later in this report.

However, these changes do not address the service response to children who move from one area to another who are receiving services below the child in need (Sc17) and child protection (Sc47) threshold. At the time of Hazel and Lilly's move, the children were receiving services at the universal threshold of intervention; support was provided through schools in LA1 and West Sussex and there was prompt information sharing across these schools. At the time of mother's death, and later when the children moved, there was no intervention by CAMHS or Children's Social Care (CSC) in LA1. Therefore, no referrals were made to services in West Sussex - this would fit with accepted practice and procedure in relation to children receiving universal services. Over a year later, when concerns about Hazel were escalating, referrals were received by West Sussex CAMHS and CSC from the school and the acute hospital.

A subject of debate within the panel has been about the timely sharing of information. In the view of West Sussex CSC, had information about Hazel and Lilly been shared with West Sussex by LA1 CSC at an earlier point there would have been an opportunity to intervene early instead of at the point of crisis. LA1 CSC have rightly said that when West Sussex requested information this was shared promptly but at the time of Hazel and Lilly's move, as they were receiving universal provision, there was no need or authority for information to be shared with West Sussex CSC at this time - this is in line with established procedure and accepted practice.

Learning from Lilly. In discussion with Lilly and Lilly's half-sister (Jodie) as part of this CSPR, it was clear that timely information sharing, and communication, was important to Lilly. Improving communication amongst professionals and across services was the first and last point Lilly raised as areas she most wanted to see change. She spoke about how often she was asked to retell her life story about things that had happened to her and Hazel, and how important it was for services and practitioners to share the sisters' story and communicate with each other *….our files weren't passed on to the next service* (Lilly).

Learning from Jodie and Alan. The views of Jodie and Alan are that Hazel and Lilly's needs should have met a threshold for immediate safeguarding action under Sc47. From their perspectives, the multi-agency view that Hazel and Lilly's needs did not meet a child protection threshold was arbitrary – the lack of an urgent response has left a legacy of indescribable grief.

Multi-agency service developments. Whilst it is accepted that there are considerable challenges and ethical questions about use of Sc47 when a child is at risk to themselves as a

result of mental ill health – it is an approach that can work well by achieving prompt sharing of information and communication across service and geographic boundaries to enable a child to be responded to in real time.

The research mentioned above by the National Child Mortality Database was not available at the time Hazel and Lilly's mother died, at the time of their move to West Sussex, or when concerns about Hazel were escalating. Practitioners at the learning event were keen to emphasise that as this research was not available, the risk factors were not widely understood. The question that arises is what would happen now? It is clear that the changes in West Sussex would result in a different response at the time of concerns escalating – what is less clear is how the risk of suicide could be identified at an earlier point to enable information sharing and communication especially at a time when a child moves across geographic boundaries. This is particularly relevant to all services, including schools, who may be providing early help services to children.

Recommendation 1. West Sussex and LA1 Safeguarding Children Partnerships to seek representation from local services, including early help services, to understand how the risk of suicide and the impact of related factors are now understood and what service changes are in place that prompts a timely safeguarding response to children in real time. This should include consideration of how information sharing and communication across geographic boundaries between services can be achieved.

2. Safeguarding children across multi-agency boundaries

Multi-agency involvement. As previously outlined, Hazel received Team Around the Child (TAC) services from the LA1 school throughout her attendance at this school and she received services from LA1 Child and Adolescent Mental Health Services (CAMHS) before her mother died. On occasions, CAMHS referred to LA1 Children's Social Care (LA1 CSC) expressing concerns for Hazel. LA1CSC concluded there was no ongoing role for this service on the basis that there were no safeguarding concerns about parenting. The school described positive communication between CAMHS and the school when CAMHS were involved, they were the only service involved at the time of Hazel and Lilly's move therefore there was no dialogue between services about the possible needs of the girls/possible risks posed by their move out of area.

In West Sussex, school were keenly aware of Hazel and Lilly's emotional wellbeing and were concerned about Hazel's mental health - counselling was swiftly provided. As a result of the Coronavirus Pandemic, national lockdown was in place shortly after Hazel and Lilly's move to West Sussex. Seven months later, at the start of the new term in September 2020, pupils returned to school and concerns about Hazel's mental ill health gradually emerged. As these concerns were not regarded as safeguarding concerns that would meet a threshold for CSC intervention, a referral to West Sussex CSC was not made. Equally, as the school's experience was that concerns such as these would not meet a CAMHS threshold, a referral was not made at this time. In January 2021 when the second national lockdown commenced, the school counsellor continued to support Hazel. In March 2021, pupils returned to school and increasing concerns emerged about Hazel's mental ill health. Hazel

spoke freely to her counsellor about self-harm and about taking her own life. School staff asked Father to take Hazel to hospital.

Hazel was reviewed by CAMHS A&E liaison; a safety plan was completed and follow up by community CAMHS was requested. The hospital referred to the Multi-Agency Safeguarding Hub (MASH)[11]. Information was gathered by MASH and a decision made to progress to a Child and Family Assessment. CAMHS A&E referred to community CAMHS where the referral was triaged by the referral panel and passed to duty CAMHS for follow up. A letter was promptly sent to Hazel offering an appointment with a psychologist (which was to take place approx. 6 weeks later) but there was no active involvement by the community CAMHS team with Hazel and her family or with the multi-agency safeguarding network. The relevant Serious Incident Review, examining the services provided by CAMHS at this time, identified a culture of *what cannot be done rather than what can be done* and of *pushing back to the network.*[12]

The school were not informed of the assessment outcomes or about the safety plan that had been agreed with Hazel and her father. There was no communication with the acute hospital in response to the referral that had been made to MASH. At a subsequent home visit by the social worker, Hazel talked about suicidal thoughts and plans to end her life – this was not communicated to CAMHS.

It was critical that joint working across the multi-agency network was in place – school were actively communicating their concerns with services. Services gathered information and there was some communication by WSCSC with school. However, there was little evidence of joint working across CAMHS & CSC, CAMHS and the school or with the acute hospital. Sussex Police, British Transport Police, the GP and the School Nursing service were not part of any safety planning. In effect, school and father were left holding the risks.

Learning from research and national reports

Research Note: Multi-agency working. Research, inspections, and Child Safeguarding Practice Reviews, have identified the importance of multi-agency working with children who have mental ill health. However, it has been identified that this multi-agency working is not in place across the country for these children.

CDOPs[13] 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….[14]

[11] The MASH provides a single point of access to advice, information and support services for professionals working with vulnerable and at-risk children and young people.
[12] A Serious Incident Review (SIR) has been completed since Hazel's death which thoroughly examines service provision at this time and identifies significant gaps in service provision at this time and learning to be taken forward.
[13] Child Death Overview Panels are established in local areas across the country and have a statutory responsibility for reviewing information on all child deaths, looking for possible patterns and potential improvements in services, with the aim of preventing future deaths.
[14] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021

Children's mental ill health cannot be addressed by any one agency working in isolation. Partners need to come together at a strategic level, alongside those who use the service, and develop a joined-up and coherent approach and ensure that services are delivered in an integrated way at the frontline.[15]

There is currently no national approach or framework that supports multi-agency services to provide a joined-up approach to children with mental ill health. A great deal of national activity has taken place in the last few years in response to the growing concerns about children who are at risk of harm/are harmed through criminal and/or sexual exploitation. Multi-agency service provision and associated guidance[16] has not focussed on children who have significant mental health needs, despite the high risk of harm. The recent JTAI inspection,[17] reviewing services provided to children with mental ill health, identified that multi-agency collaborative work *can be really effective when professionals work to a shared practice model* and that local partnerships have an important part to play in developing this work.

Learning from the panel: Assessment under the Mental Health Act 1983: A question posed by the panel was why a mental health act assessment[18] did not take place/was not requested by involved services. There was a view that this assessment was needed during this critical period when Hazel was demonstrably unwell/actively talking about ending her life. There was also a view that the grounds for detention under this act were not met and that detaining Hazel in an inpatient mental health unit would have potentially negative consequences for Hazel. Research about the detention of children in inpatient units[19] supports this view.

A number of issues arise. Firstly, the panel were keen to ensure that multi-agency practitioners and families were aware of the process by which an assessment under the mental health act can be requested. Secondly, whilst it is accepted that detention in an inpatient unit should be avoided wherever possible – there appeared to be few good options available to support Hazel and her family in the community; Hazel was waiting to see a psychologist, there was no active involvement by community CAMHS; there was no offer of a community based mental health support package and little mental health guidance was provided to practitioners who were in contact with Hazel and her family.

Learning from Jodie and Alan. The view of family members is that whilst they understand, and agree, that admission to inpatient units should be avoided where possible and that long

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

[16] Working Together to Safeguard Children 2018 HMG.

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

[18] In summary, a Mental Health Act Assessment is an assessment to decide whether someone should be detained in hospital under the Mental Health Act to ensure medical treatment for their mental ill health is provided and risks to self are safely managed.

[19] Such as *: 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/

periods of admission have negative consequences, Hazel was at immediate risk at this time and required admission – the consequences for Hazel, Lilly and family members have been infinite.

Service developments in West Sussex: It is clear that there have been important service developments since Hazel's death. It is understood that these changes have been made as a result of learning from the tragic deaths of other children in the local area. As discussed above, the lack of joined up multi-agency working in response to children with mental ill health is a national concern. West Sussex have responded to the learning identified in Hazel's case, and in other similar cases in the local area; £1.4 million has been invested in service developments and these developments have progressed. The main changes that have been made include:

- Training addressing suicide prevention has been provided to 200 social workers and training in respect to relevant children and mental health legislation has been made available to social workers.
- Children's Social Care have formed a new team: The children's mental and emotional health team. A service manager and three mental health managers have been recruited to this team and lead on the mental health response over the next 2 years within Children's Social Care.
- A multi-agency triage team was formed in October 2021 and continues to date. This team supports schools to consider the needs of children with complex mental health presentations, ensuring they are receiving a timely and comprehensive response. Since its commencement over 1000 children have been triaged by this team.
- Children and Young People have co-produced a new safety planning format, the 'My Wellbeing Plans'. The three versions of this plan offer a preventative and graduated response to promote active coping, and resilience while maintaining safety. Plans are co-created with the young person and routinely reviewed. Schools are included in implementation of the plans and the plans are shared with the partnership.
- Trauma informed practice training has been commissioned and commenced in January 2023 with an intention to increase understanding of the ways in which present behaviours and difficulties can be understood in the context of past trauma, in order to support the partnership to respond and intervene using a trauma informed approach.
- Children's services managers have been provided with questions to ask in respect of concerns relating to mental health if they are experiencing any uncertainty and in order that they are able to fully understand the rationale for decisions made if this is not immediately apparent.
- The expertise provided by the children's mental and emotional health team provides staff with the opportunity to reflect on and consider partner agency decisions and recommendations, whereby further discussion and (where necessary) professional challenge is encouraged.

- The relationships between senior leaders in CAMHS and Children's Social Care have been strengthened significantly in the past 12 months as a result of regular meetings to discuss key concerns and challenges, to formulate shared service planning and through a facilitated problem-solving event in March 2022.
- Structures have been developed to ensure response to suicide and concerns relating to mental ill health contagion. These have been enshrined in the Pan Sussex safeguarding procedures.[20]
- An aim of West Sussex Local Authority is to create 'a suicide aware system' through the work of public health by raising awareness of suicide, addressing the risks posed by social media platforms and upskilling the children's workforce to have difficult conversations about the subject of suicide with young people which is felt to still carry a stigma/remains a taboo subject.
- Reducing waiting times continues to be an ongoing workstream within Sussex CAMHS. The establishment of CAMHS duty and liaison teams across Sussex form part of the support available to children and young people awaiting assessment by CAMHS.
- Sussex CAMHS paediatric liaison teams aim to provide a rapid mental health assessment for young people who need help in the Emergency Department (ED) and for people who are inpatients in hospital. Sussex CAMHS duty holds the lead practitioner status for any child or young person who is on the waiting list with no current lead practitioner.
- The Integrated Care Board [21] Foundations for our Future work programme and the Children and Young People Mental Health and Emotional Wellbeing local transformation plan[22] clearly sets out children's mental health as a key priority.

Learning from best practice in West Sussex. The significant developments detailed above are a testament to the commitment across multi-agency services in West Sussex to improving the service response to children requiring support with their emotional wellbeing and in providing a swift response to children at risk as a result of their mental ill health. Of particular note is the establishment of the Multi-Agency Mental Health and Education Triage[23] which is managed through the Children's Mental and Emotional Health Team embedded within West Sussex Children's Services.

Learning from practitioners and panel members. It is acknowledged by West Sussex CSC that the investments made in services are significant and that since the coronavirus pandemic there has been an increasing demand to respond to the mental ill health and emotional wellbeing of young people, as a result the demands on services remain acute.

20 https://sussexchildprotection.procedures.org.uk/yzkystl/self-harm-and-suicide/responding-to-a-potential-cluster-of-suicides-for-children-and-young-people-aged-under-18

21 Formerly known as NHS Sussex

22 Improving children and young people's mental health - Sussex Health and Care (ics.nhs.uk)

23 Multi-Agency Mental Health and Education Triage (MAMHET) brings together professionals to help identify and respond to presentations of children in school which might point to progression to a mental health crisis and potential suicide.

There remain problems in West Sussex, and nationally, for children who are waiting too long (often on acute general hospital wards) for inpatient mental health provision. It is accepted that inpatient provision is not a panacea, and should be avoided whenever possible, but it is equally accepted that services focussed on preventing emotional troubles becoming acute mental health difficulties are at the early stage of development in the local area. In addition, the lack of resources available to Child and Adolescent Mental Health services over time, coupled with the recent growth in young people with mental ill health,[24] means that other services such as CSC are compelled to act to fill the gaps. It is unclear how long these newly developed services in West Sussex can be sustained.

Recommendation 2. West Sussex Safeguarding Children Partnership to seek assurances about the sustainability of the new provisions detailed above and consider how the work of the partnership will be linked with the Foundations for our Future and the Children and Young People Mental Health and Emotional Wellbeing local transformation plan.

3. Schools know children best.

The voice of schools is not sufficiently heard by safeguarding partners.[25]

Other cases have shown that schools understanding of the risks to a child are not taken seriously enough.[26]

Multi-agency involvement. A comprehensive package of support was provided to both Hazel and Lilly at their school in LA1 and as soon as they started attending the secondary school in West Sussex. Trusted relationships were established and nurtured with members of staff and peers once Hazel and Lilly started at their new school in West Sussex. Hazel spoke freely to staff about her circumstances, the close trusted relationships enabled her to speak openly about her feelings. Staff at school knew Hazel well. In their opinion, Hazel would take her own life – it being a matter not of if, but when. Despite raising these concerns with multi-agency partners, the risks were not taken seriously enough by involved agencies. An urgent request made by school staff to CAMHS in West Sussex, for Hazel's appointment with the CAMHS clinician to be brought forward, was recorded by CAMHS but did not result in the timing of the appointment being changed. In a later contact, when Hazel's heightened distress and daily suicidal thoughts were reported, an urgent request was made for the appointment to be brought forward. CAMHS stated they were unable to change the date of the appointment, the member of staff from the school stated: *this will be too late*.

Three days before Hazel took her life, school referred to the Integrated Front Door[27] detailing explicit concerns about Hazel's distress and her plan to take her own life that night.

[24] Growing problems, in depth: The impact of Covid-19 on health care for children and young people in England. Nuffield Trust February 2022
25 West Sussex Panel Members
26 West Sussex Panel Members
[27] The Integrated Front Door (IFD, formerly MASH) aims to provide a single and consistent point of access to advice, guidance and decision-making about the right level of help needed to keep each child safe or achieve change.

The Emergency Duty Team responded by safety planning with father, but no strategy meeting took place. Two days later, Hazel was hit by a train and sadly died from her injuries.

Learning from practitioners and panel members. A member of school staff from Hazel and Lilly's school in West Sussex described staff as *screaming as loud as they could that Hazel would take her life – they were not listened to – the response was all too slow.* Questions have been raised about whether more could have been done to escalate these concerns at the time. There is a Sussex Dispute Resolution and Escalation Protocol[28] that could have been used that may have prompted a different response, it is unclear why this was not followed. The view of panel members was that a pattern had emerged in West Sussex of not listening to the views of schools - *who often understand the risks and know a child better than any other agency.* The changes set out in the previous section are aimed at addressing this issue.

Panel members were of the view that the support provided to Hazel and Lilly by the secondary schools in LA1 and West Sussex was excellent. This support included the well-researched benefits of providing children with opportunities to form trusted relationships with adults. This can provide a platform on which to build resilience for children who have experienced trauma. However, Lilly's view was that the support provided to her at the school in LA1 was not enough to help her cope with her emotional troubles. It was recognised by panel that it is simply not possible for schools to carry and respond to these levels of risk in isolation.

During the practitioner learning event, practitioners from schools and children's social care in LA1 and West Sussex were represented. It was felt that whilst this was an extreme example of a lack of joint working/response, other examples of schools in West Sussex not being heard by multi-agency colleagues (about the risks to children as a result of their mental ill health) were cited. It was understood that, in responding to the findings of local CSPRs, a great deal of work has happened in West Sussex to raise awareness of the pan Sussex Dispute Resolution and Escalation Protocol but there remain concerns about its effective use. A recent example of a swifter multi-agency response led by West Sussex Children's Social Care was given by a school at the learning event although overall it was felt that it is still early days in seeing a consistent multi-agency response in West Sussex in these circumstances.

The experience of LA1 schools seemed to be different. LA1 schools were reported as holding responsibility for and being the lead professional in 75% of Team around the Child (TAC) cases. Relationships between Children's Social Care, CAMHS and schools were described as good. School representatives described being well supported in their work with children. An 'open door policy' operated during the period covered by this CSPR, which enabled schools to have easy access to social workers and managers in Children's Social Care, and a pre-CAMHS service[29] works with schools to support the emotional wellbeing of children.

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[28] Dispute Resolution & Escalation Protocol November 2018 https://sussexchildprotection.procedures.org.uk/assets/clients/1/Documents/Pan%20Sussex%20Escalation%20Policy%20Aug%2018.docx

[29] Healthy Minds (LA1)

Recommendation 3: West Sussex Children's Services to review the recent service changes with school representatives to consider their experiences of the new service developments and identify any gaps/inconsistencies in approach. West Sussex Safeguarding Children Partnership to be informed of progress.

Recommendation 4: West Sussex Safeguarding Children Partnership to review use of the Pan Sussex Dispute Resolution and Escalation Protocol and consider what may be the barriers to using this effectively across services with a particular focus on schools.

4. Caring for traumatised children

Hazel and Lilly were young carers; they cared for their mother who suffered from Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) - a debilitating condition that has significant physical and psychological impacts. This would have significantly influenced the care they received: *I feel like I wake up with a mattress on me most mornings. When I wake up with post-exertional malaise, there is an elephant sitting on the mattress. He stays there for days. He steals my words and fills my brain with wet cotton wool and wraps his trunk around my neck, so I struggle to swallow.*[30] No research has been found about the specific impact on children of a care giver suffering from this condition. However, there is established research about the impact on children of being a young carer.

Research note: Research by Carers Trust and the University of Nottingham found that almost a third of young carers surveyed (29%), reported that their own physical health was 'just OK', whilst 38% reported having a mental health problem.[31]

…..almost 60% of those interviewed said that their caring role had a significant impact on their mental health.[32]

Learning from Lilly, Hazel and Lilly's Birth Father and Jodie. It has not been possible to establish from agency records the day to day lived experiences of Hazel and Lilly when they were in the care of their mother and stepfather or about the consequences and circumstances of their mother's death on their emotional wellbeing/mental health and the impact of living losses when they moved from their kinship and community.

Lilly and Jodie spoke at length to the Lead Reviewer about their experiences of maternal care. Lilly described in detail the demands placed on Hazel and Lilly and the frequent *screaming and shouting* by mother, she gave several examples of neglect and emotional harm. Lilly was clear that her mother *acted as a victim* and manipulated services – *she knew how to get round them to get what she wanted. We were afraid of the consequences if we spoke out about what was really happening at home.* Research suggests these traumatic events would have had a significant impact on Hazel and Lilly. Hazel and Lilly moved to live with their birth father a few months after mother's death. They had no contact with their birth father during the majority of their childhood, despite requests by birth father and both

[30] Action for ME Supporter
[31] https://carers.org/
[32] Young Carers Well-being. The Children's Society

sisters' to do so. The change in family circumstances resulting from this new arrangement would have been very significant for Hazel and Lilly, their birth father and his partner. As described, apart from the school, there were no agencies involved in providing support to the family at this time.

Hazel and Lilly talked about difficult family relationships whilst in their birth father's care and spoke about not feeling understood by the parenting couple. Birth father spoke to school about how difficult he found it dealing with Hazel's feelings *…. he said it had been difficult since his daughters had moved in – they barely knew each other, and the country was in lockdown soon after…….. he felt that Hazel's self-harm was as a result of the neglect she had experienced in her mother's care but was at a loss as to how to deal with this.* Jodie has said that although birth father had the best of intentions for his daughters – *Hazel and Lilly had been brought up by an abusive mother – they were traumatised – they did not know how to be parented and father did not know how to parent – he needed support.*

Research Note: Children who have been exposed to on-going trauma, over a prolonged period of time, carry brain and body responses consistent with their traumatic experiences. A growing body of scientific research supports this by identifying the way in which the neuro-biological impact of early abuse affects children resulting in traumatised children developing different neurological patterns to their non-traumatised counterparts[33]. Exposure to stress chemicals such as adrenaline and cortisol can also have a long-lasting impact on traumatised children's ways of understanding themselves and the world around them. In addition, the intersubjective way in which children make sense of the world means that traumatised children develop 'mirror neuron patterning' that influences their understanding of the intentions of the adults who are caring for them; in effect they may interpret the positive intentions of safe and loving parenting figures as potentially abusive and threatening.[34]

Research[35] [36] [37] shows that the impact on parents of parenting a child who has experienced trauma can be similar to that of the child's response to trauma. Living with a sad, angry, sometimes aggressive child who is clearly in pain, who is regularly engaged in self-harm and making attempts to end their lives, is traumatic.

Professionals must work to understand the profound and pervasive impact of abuse on children and the impact on families. Teaching parents about neurobiological impact of trauma is also important alongside respecting the critical place parents occupy in being the key repair agent in their child's recovery. [38]

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[33] *Neuroscience and the Future of Early Childhood Policy: Moving from Why to What and How.* J. Shonkoff & P. Levitt 2010). Neuron. Science Direct Volume 67, Issue 5, v9 September 2010, Pages 689-691.

[34] *Grasping the Intentions of Others with One's Own Mirror Neuron Systems.* Iacoboni, Molnar-Szakas, Gallese, Buccino, Mazziotta, Rizzolatti (2005) Available at http://www.plosbiology.org/article/info

[35] *Reparenting the Child Who Hurts.* C. Archer & C. Gordon. Kingsley Publishers, London.

[36] *The Cost of Caring: Secondary Traumatic Stress.* Fostering Communications 2004.Vol. XVIII No.3.

[37] *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat The Traumatized*. C.Figley Routledge Psychosocial Stress Series.

[38] *The Trauma of Parenting Traumatised Children.* Adapt Scotland, Scottish Attachment in Action. C. Gordan, K. Wallace 2015

Multi-agency involvement. Members of school staff in West Sussex were concerned about the limitations of the emotional support at home. The Child and Family Assessment by West Sussex CSC concluded that whilst the parenting couple completed practical parenting tasks and were engaged with services – they struggled to provide emotional nurture and containment. For the first time, Hazel and Lilly openly discussed with the social worker their childhood experiences in maternal care and the difficulties in the emotional care they received whilst living with their birth father and stepmother - this was detailed in the good assessment that was completed by CSC. The dilemma for CSC was in identifying available services that could provide the support that birth father and his partner needed.

CAMHS often offer family therapy in these circumstances, and this was offered in LA1 on several occasions, but Hazel was resistant to this being provided as she was concerned about her mother's response. In West Sussex, Hazel was waiting for a CAMHS service therefore this was not available to the family. As discussed, CSC and CAMHS services in LA1 were not involved at the time the girls moved to West Sussex. Although aware of mother's death the extent of the possible support services from CSC and CAMHS that were needed were not predicted. By the point West Sussex multi-agency services were involved, the family were in crisis.

Learning from practitioners and panel members. During the learning event practitioners spoke about the challenges in engaging families in these circumstances: *Families may feel services to be intrusion into family life and/or there can be a perception that they are doing something wrong and are seen as a failure by services.* It was also recognised that preventative services are not well developed: *when families may ask for help, the message that can be received is that the problem is not bad enough for service intervention* and that children and families can get *bounced around the system* (when services may assess and refer on to another service on the basis that 'the problem' does not meet a service threshold). In addition, practitioners spoke about the risk of services 'medicalising' a child who has mental ill health – *we look for a diagnosis and a treatment plan which can lead to perceptions in families that the child needs to change, and families may not be encouraged to think about the secondary trauma involved in caring for a child in significant emotional distress.*

Multi-agency service developments. There have been some recent service developments in LA1 and West Sussex indicating that the possibility of families experiencing secondary trauma is beginning to be understood. These developments include a recent trauma informed course being established in West Sussex for practitioners. In LA1, the Complex Care Needs Service and the Adolescent Service was established in 2019; a trauma informed approach is being adopted in services and a trauma informed course is available for parents to access. In West Sussex, two psychologists have been employed within CSC to promote trauma informed approaches with families (and in certain circumstances a parental group is available to offer support to parents). These are promising developments which need to become embedded within the service offer to carers of adolescents who have mental ill health/emotional troubles and should be underpinned by an important message to parents

of adolescents that, in the vast majority of cases, it is they who are the critical repair agent in their child's recovery – statutory services can support families but are rarely the solution.

Recommendation 5. West Sussex and LA1 Safeguarding Children Partnerships to seek representation from agencies about how a trauma informed culture across the multi-agency partnership is being implemented (and the impact achieved) including how parents/carers of children are supported to understand the impact of trauma on the child and family.

5. The importance of family: *Unblocking the potential of family networks*[39]

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.[40]

Multi-agency involvement. Hazel and Lilly had contact with a wide maternal kinship in LA1. The full extent of this kinship was unknown during the period of service involvement - it is now believed to include maternal aunts/uncles and a half-brother, half-sister (Jodie) and her partner (with whom Lilly now lives). Hazel and Lilly visited family members and spoke about wanting to see more of them – the pandemic limited face to face contact and this was upsetting for Hazel and Lilly. Within this kinship were adults they trusted. It is clear that trauma informed work took place with Hazel and Lilly, and this included attempts to understand sources of safety, but Hazel was reluctant to engage in this work with the social worker in West Sussex.

Mapping family (including extended family members) and kinship is critical to children; it can nurture identity and a sense of belonging, establish sources of safety and identify potential risks. It is understood that LA1 were aware of some kinship members and there had been communication with Jodie by LA1 CSC when they were involved.

Learning from Lilly, Jodie and Alan. Jodie described her childhood as abusive. She said she grew up in the maternal household and remembers the birth of Hazel and Lilly and of caring for her sisters. Both Jodie and her partner (Alan) described being very involved in the lives of Hazel and Lilly and said that they often stayed with them in their home, and when Hazel and Lilly were living in West Sussex they would stay with them – it was a familiar safe haven.

Overall, the descriptions family members provided during this CSPR were of neglect – many examples were given. They said they were worried about raising concerns about Hazel and Lilly directly with services as they feared mother would not allow them to have contact with the girls. As a result, they encouraged Hazel to talk about what was happening at home with LA1 CAMHS and school staff and said there was an occasion when they raised concerns directly with LA1 CSC and on other occasions with the school.[41] Hazel was described as

[39] *The independent review of children's social care*. Chapter 4. Josh Mc Alister May 2022
[40] Croydon Safeguarding Children's Board Vulnerable Adolescents Thematic Review 2019
[41] It has not been possible to triangulate family perspectives, agency records available in this CSPR do not detail the concerns that were raised.

courageously speaking about her experiences of maternal care to CAMHS, but she told Jodie that the consequences of her mother's anger made her afraid to speak out again. Jodie and Alan's perspective was that they were not listened to by services – they spoke about not being believed when they raised concerns. They spoke about being left with a feeling that they are unable to trust services (although spoke positively about the current involvement of the SW from LA1 CSC and CAMHS).

Learning point – exploring intergenerational patterns. Going forwards, Jodie and Alan urged services to change the way they treat concerns raised by family members – *to triangulate any concerns* raised and *to reflect on whether the history of the family was indicative of a pattern of unresolved concerns about neglect*. They keenly felt that exploring and understanding intergenerational patterns of child care/parenting was vital in assessing risk to children.

A wide family network existed who were willing and capable of working alongside professionals to support Hazel and Lilly and mitigate the risks. In West Sussex, there appeared to be no attempts to engage extended family members in LA1 in making plans for Hazel and Lilly or in risk and safety planning by practitioners/services prior to Hazel's death.[42] There did not seem to be a demonstrable understanding of the truism that it is simply not possible for services to safeguard children without the engagement of family and kinship.

Engaging Fathers - multi-agency involvement. Birth father was present in the family when Hazel and Lilly were infants. Following what birth father described as *a traumatic separation,* he moved away from the area. Hazel and Lilly spoke about wanting to see their birth father but there were allegations made by him about the neglect of the children by birth mother and counter allegations made by birth mother. Jodie described birth mother as *manipulating memories* (of the sisters) *about their father*. There was no contact with their birth father for a number of years.

LA1 CSC described stepfather as *the key link* with the Team Around the Child (TAC) at school, he cared for Hazel and Lilly after mother died for several months and was engaged with services when Hazel and Lilly lived in LA1. During this CSPR Lilly spoke with affection about her stepfather although acknowledged that she felt he was, at times, manipulated by mother/in fear of her.

There was engagement with stepfather by LA1 when Hazel and Lilly were living in the local area, and with birth father once services were involved in West Sussex. However, there was no attempt to engage birth father by services in LA1 and no attempt to engage stepfather once Hazel and Lilly moved to West Sussex.

In terms of the involvement of birth father by services in LA1, it is understood that mother did not support contact with birth father whilst she was alive, and this provides a partial explanation as to why there was no engagement. However, services need to be more

[42] Extended family members are now well engaged in caring for Lilly and planning for the future.

inquisitive about the place of fathers in children's lives; be curious about an estranged parental narrative (more often maternal) about the 'absent parent'; and give the same opportunity to fathers as services give to mothers - to enable fathers to be the best parent they can be.

Research Note: Engaging fathers

Many of the issues explored here reflect deeply engrained roles, stereotypes and expectations about men, women and parenthood in our society. Notwithstanding major social changes, women continue to be regarded as the prime and sometimes only protective carer for their children…… The report also takes stock of how well safeguarding and other services engage with men. It sets out systemic weaknesses in the way that universal and specialist services operate. Too often, even if unwittingly, they enable men to be absent.[43]

A cultural shift is needed: Cultural change is never easy to achieve. It means taking an organisation-wide approach to including fathers and working with other agencies and joining up principles; it means starting with a belief that fathers matter too, and engaging them in the early years sector, schools, social services and health services.[44]

Learning from national reports. There are limits to what can be done to nurture a child's relationship with estranged parents (more often fathers) in circumstances where consent underpins service provision. However, as identified by the Child Safeguarding Practice Review Panel, the importance of understanding the place of fathers/father figures in the lives of children can often be overlooked by services.

It is understood that birth father felt his concerns about the children whilst in the care of mother were not believed/treated with the seriousness warranted – this perspective was important to understand when working with father and may provide insight into how trusted engagement with services by fathers, and by services with fathers, can be facilitated. The importance of building trusted relationships with family members has been highlighted in recent national reports.[45]

Learning from practitioners and panel members about service developments. Practitioners at the learning event referred to recent developments in LA1 to try and *consciously do more to involve absent fathers*. Assessments by social workers are regularly reviewed and returned for further work if it is identified that there has been a lack of contact with fathers and a 'Separated Parents Policy' is in development which emphasises inclusive work with parents – *not at the expense of one or the other*. Additional developments have focussed on; including family and kinship in assessments and future planning, finding and building a

[43] *"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

[44] www.fatherhoodinstitute.org- The risks of excluding fathers.

[45] *The independent review of children's social care*. J. Mc Alister 2022. *Child Protection in England.* The Child Safeguarding Practice Review Panel 2022

network by utilising the Network Matrix Tool from the Signs of Safety[46] approach, utilising tools from Social Pedagogy[47] and reviewing the importance of cultural genograms.[48]In West Sussex, the Family Safeguarding Model[49] has recently been adopted which aims to work alongside families to support children living at home by building strengths and co-designing care and support plans by bringing the family together in family network meetings.

A further issue highlighted in this section relates to concerns about children raised by family and kinship. It is important to acknowledge that it is not possible to triangulate the perspectives of family members. However, as identified in a recent national review[50], it is an important contemporary issue that requires the attention of multi-agency safeguarding partners.

Recommendation 6. West Sussex and LA1 Safeguarding Children Partnerships to seek representation from services about how wider family and kin-networks feature in safeguarding activity including involvement in safety planning. Support and challenge to be provided to partners in reviewing how the recommendations set out in relevant Child Safeguarding Practice Review reports[51] are being implemented.

6. Understanding a child's world - paying attention to the language we use

Realities are socially constructed, constituted through language, and organised and maintained through narrative - *Communication is the creation and exchange of meaning.*[52]

Learning from practitioners and panel members. Panel members felt it was important to pay attention to the language used when recording what children say – when Hazel and Lilly may have expressed sadness, helplessness or worthlessness, and Hazel spoke about wanting to die, what did this mean to them in their day-to-day worlds? Whilst school records were explicit about what this meant, this was not replicated across the services involved. Panel views were that children's words are recorded but it is often difficult to see how far what a child says is explored with the child, or what lies beneath these words …….*its important to get beneath the words to understand a child's lived experiences.*[53]

Learning Point: The use of language used by professionals to describe a child/their experiences is important. If the language used is professional language/ does not get beneath the words to understand the uniqueness of the child and their day-to-day

[46] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.
[47] Social pedagogy describes a holistic and relationship-centred way of working with people across the course of their lives.
[48] The cultural genogram is a creative, practical tool that assists in understanding a child's family and cultural context.
[49] Family Safeguarding is a strengths-based model and a new way of working with families to promote families staying together, and children remaining safely at home.
[50] *Child Protection in England.* The Child Safeguarding Practice Review Panel 2022
[51] *"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. *Child Protection in England*. The Child Safeguarding Practice Review Panel 2022
[52] From the work of M White & D Epston
[53] Panel members

experiences, it has the potential to minimise trauma and vulnerability and shape service response.

Learning from national reports. The Child Safeguarding Practice Review Panel (CSPRP) identified five key practice themes in their first annual report[54] - understanding a child's lived world is one of these key themes. The CSPRP has repeated an urgent need to understand this in their most recent report,[55] and it is echoed in the recently published national review of children's social care.[56] The question that arises is why it remains such a stubborn issue. Both these national reports highlight that the lack of multi-agency/multi-disciplinary work means that a child's story is fragmented. *The child's story is often held by multiple people in multiple places, the detail of which is constantly evolving. This means that it can be extremely difficult to build and maintain an accurate sense of what life is actually like for a child…*[57] and the independent review of children's social care additionally highlights the lack of time available to social workers to complete direct work with children*: Social workers have told the review that rather than spending time with children and families they spend most of their working day on administration.*[58]

Learning from Lilly, practitioners and panel members. Lilly was clearly affected by what she described as the constant retelling of her story to different agencies and different practitioners and urged agencies and practitioners to communicate with one another – to effectively share information to avoid the painful retelling of her life story. Practitioners at the learning event spoke about the importance of listening to people who see a child every day and know them best (such as school staff). They spoke about how *everyone has good intentions of hearing the voice of a child* but also said that *it can be difficult to hear the level of distress a child may be feeling.*

Representatives from LA1 spoke about use of the Signs of Safety[59] model embedded within practice and the tools in use that supports practitioners to elicit a child's life experiences. Public Health Services in West Sussex spoke about tackling what they described as a *widespread culture of avoidance* due to the *shame and stigma* that continues to exist in our society about suicide. The new suicide strategy is currently in development stage, amongst other issues detailed in this strategy there is an ambition to give practitioners confidence to ask about thoughts of suicide.

Finally, it was felt important to acknowledge the impact of secondary trauma on the children's workforce. Practitioners can experience the trauma of a child's experiences vicariously.[60] In other words, repeatedly seeing, hearing and reading about the experiences

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[54] *Annual Report 2020 Patterns in practice, key messages and 2021 work programme*. The Child Safeguarding Practice Review Panel. 2021
[55] *Child Protection in England.* The Child Safeguarding Practice Review Panel 2022
[56] *The independent review of children's social care*. J. Mc Alister 2022
[57] *Child Protection in England.* The Child Safeguarding Practice Review Panel 2022
[58] *The independent review of children's social care*. J. Mc Alister 2022
[59] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.
[60] Developing and leading trauma-informed practice. Leaders Briefing. Research in Practice https://www.researchinpractice.org.uk/all/

of a child who is hurting can lead to anxiety and has an emotional cost – a cost that may lead to unconscious defences[61] being constructed. These defences can provide an individual and collective buffer within a system that faces the unbearable reality of a child's suffering especially when there are few viable options to provide meaningful help. This may provide an explanation for why certain language is used – it may sanitise a child's experiences and thereby make the unbearable bearable.

Lilly's point about communication across service and geographic boundaries is an important practical point about how the voice of a child may be better heard and may reduce the possibility of re-traumatisation. As raised by a panel member, if all practitioners are being encouraged to be curious about a child's life story this may risk what Lilly raises about being retraumatised by the re-telling.

The point made by practitioners about listening to those trusted adults who know children best does not seem at odds with Lilly's wish that she and Hazel did not have to keep re-telling their story. The view expressed by panel members that practitioners need to *get beneath a child's words to truly understand and reflect a child's lived world* is a commendable aspiration. In order to achieve this, attention must be paid to the support needed by practitioners to routinely bear the emotional cost of their work. And, as highlighted in the recent national report[62], social workers need to be freed from bureaucracy to enable them to have time to build trusted relationships with children and families.

An additional point raised at panel was the question about how far the national qualification training provided to social workers/teachers/nurses, and other members of the children's workforce, equips them to work with adolescent mental ill health and wellbeing. The view of panel members was that these practitioners often have to *learn on the job.* This presents significant challenges to practitioners and services and, in the view of panel members, does not support and equip practitioners to recognise and cope with the inherent secondary trauma they will face as part and parcel of their work.

Multi-agency service developments. West Sussex and LA1 Safeguarding Children Partnerships have made service changes and provided support to practitioners in trauma informed practice, a relevant recommendation to promote this work is made in section 4. However, as identified in the relevant national reports, resolving several of the issues identified requires fundamental changes at a national level and it is understood that these changes are currently the subject of review by members of government. An area that does not appear to be covered in these national changes is the final point raised about post qualifying support and training in adolescent mental ill health and wellbeing.

[61] Jacques, E. (1953) On the dynamics of social structure: a contribution to the psychoanalytic study of social phenomena deriving from the views of Melanie Klein, in E. Trist and H. Murray (eds) 1990 27 Menzies, I.E.P. (1960) 'Social systems as a defence against anxiety: an empirical study of the nursing service of a general hospital', in E. Trist and Murray (eds), 1990. The Unconscious at work: Individual and Organisational Stress in the Human Services. The Members of the Tavistock Clinic Consulting to Institutions Workshop: Eds: Obholzer & Roberts 1994

[62] *The independent review of children's social care*. J. Mc Alister 2022

Recommendation 7. West Sussex and LA1 Safeguarding Children Partnerships to consider what changes may be needed in practice to promote an approach that enables the sharing of a child's story across services to minimise re-traumatisation and promotes how nominated trusted adults in a child's life might be supported to understand a child's lived experiences.

Recommendation 8. West Sussex and LA1 Safeguarding Children Partnerships to make representations to the relevant national qualifying authorities raising the importance of the training and support provided to practitioners in understanding and responding to adolescent mental ill health and wellbeing, and the impact of secondary trauma.

7. The Coronavirus Pandemic as a systems dynamic

Multi-agency involvement. At the start of 2020, Hazel and Lilly moved to live with their father and his partner in West Sussex and transitioned to the new secondary school. These moves took place at the time of the Coronavirus Pandemic when there was significant media reporting about the virus and significant fear and anxiety about the implications. Within a few weeks of starting at their new school, the first national lockdown was in place. Schools transitioned to remote learning – Hazel and Lilly accessed this remote learning from their home with father. Over the following months various changes to service provision were made in response to the pandemic with the country moving in and out of various levels of lockdown. All West Sussex reports to this CSPR have identified that the pandemic had a significant impact on the family and on the services provided. Including:

- The lack of face-to-face contact with trusted adults and peers.
- Limited opportunity for services to build a comprehensive picture of Hazel and Lilly's needs and family functioning.
- Fathers view that – *we barely knew each other – then lockdown started.*
- Services faced significant staff shortages.
- There were limited opportunities to properly induct new staff leading to a lack of understanding about relevant policies/procedure/practice and remote working impacted on communication, information sharing and supervision.
- Organisational flux including a redesign of service provision.
- Limited opportunity for social connection/recreation.
- Isolation of children and families and financial hardship for many.
- Societal fear and anxiety – loss and bereavement.

Research Note: Whilst it has been reported[63] that there has not been an increase in suicide during the pandemic, the Nuffield Foundation[64] reports the following:

[63] NCMD – A study of suicide during the Coronavirus pandemic
[64] *Growing problems, in depth: The impact of Covid-19 on health care for children and young people in England*. Nuffield Trust February 2022

The sharp increase in children and young people with mental health problems is a serious concern. Services are facing unprecedented levels of demand, and young people are waiting longer to receive mental health care. ….. Community services have not escaped the pressures of the pandemic, and children's services are facing significant backlogs…. The challenges that mental health services are facing are currently unsustainable and should be prioritised with a high level of urgency.

Children and young people have been severely impacted by the pandemic, and more support and funding for services should be put in place in order to avoid disadvantaging a whole generation of people. Without further action, the impacts of the pandemic will be compounded and will be felt for a long time to come.

As reflected in the title of this section, the Coronavirus Pandemic was a systems dynamic that had widespread consequences across the world. Local services have learnt a great deal from these unprecedented events. However, learning from the pandemic, and uncovering the long-term consequences, are issues that largely sit within the national domain.

Conclusion

Hazel and Lilly experienced childhood adversity, multi-agency services were provided at various points in their life in an attempt to support them. Without doubt, the impact of the Coronavirus Pandemic and resulting restrictions influenced their quality of life, particularly at a time of vulnerability when they moved to live with their father. There have been many practitioners involved in providing services, these practitioners were committed to providing the support that Hazel and Lilly needed. The greatest support they received was from the schools they attended. Overall, the care provided is a testament to the excellent work that schools carry out every day to improve children's outcomes. This CSPR has highlighted the commitment of multi-agency services to learn, adapt and evolve in response to children's needs. WSSCP and LA1 SCP are committed to implementing the recommendations made in this report in order to support their journey of continuous adaption in response to changing demands, and in seeking excellence in the services provided.

Lilly has been committed to make a difference to children's lives by sharing her experiences, her courage has been deeply humbling. WSSCP and LA1 SCP are extremely grateful for the involvement of Lilly, Jodie and Alan in this CSPR.