South Gloucestershire Children's Partnership
Practitioner Learning Brief
SCR: Georgia February 2020

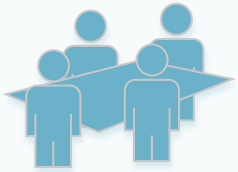
Background Summary

Georgia* is 15 years old and a looked after chid. She took an overdose, which was serious and life threatening. She had been living with her father in another local authority many miles away when this incident occurred.
There had been safeguarding concerns about Georgia since she was a baby including time on a CP plan.
An independent reviewer was commissioned to work with a group of local professionals to undertake the review. Georgia, her father and the foster carers were also involved in the review.

*Georgia is not the real name of this young person, but is the name chosen by her for the SCR

The full SCR has not been published to protect the young person

Learning



15 agencies across 2 LAs took part in the review

Georgia told the lead reviewer that children who take a first overdose need support afterwards 'to stop them trying again'.

Learning has been identified regarding:

- training and support for connected foster carers
- meaningful information sharing about a child's history and when they move area
- handovers when a social worker leaves
- recording expectations
- education provision following a move, including the role of the Virtual School
- timeliness of assessments
- therapeutic support for children in care
- the professional response to an episode of deliberate self-harm

There is a need for children in care to receive timely and specialist support when there are identified issues such as vulnerability to exploitation, substance misuse, and self harm

Key Finding:
Professionals were overly optimistic about a fresh start

IROs must focus on a child, regardless of the pressures that professionals working with the child are experiencing

Improvements in recording are required in the Looked After Children social work team, the Virtual School team and the Looked After Children nursing service

When a change of allocation occurs, a meaningful and thorough handover is essential

ABE interviews should take place as soon as possible after a strategy meeting. There should be timely & robust challenge from those working with the child if this does not happen

Foster Carers require training that is trauma informed

GP records should be flagged to show that a child is in care

Georgia's advice for professionals working with children in care:

'Stay in touch with children in care, ring when you say you will, and visit as promised.'

There should always be an 'out of office' message when a practitioner is off sick, with clear instructions of how to access cover arrangements

Find the Resolution Of Professional Differences (Escalation) Policy here

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What Needs To Happen?

Recommendations

1.The Children's Partnership should request a review of the assessment, training and support for connected foster carers, taking into consideration the learning from this review regarding information sharing and the impact of a child's history and trauma on placement stability.

2. The Children's Partnership should request assurance from the relevant agencies regarding compliance with recording expectations, including filing email correspondence, use of 'out of office' on email, and in ensuring notifications to other areas are acknowledged.

3. The Children's Partnership should request that a multi-agency audit be undertaken to consider practice and processes when a child in care is placed outside of area.

4. The Children's Partnership should consider how they can assure that children who deliberately self-harm receive appropriate and coordinated support, following assessment in A&E, to prevent a further incident.

5. The Children's Partnership to seek assurance that professionals in all partner agencies are using appropriate formal processes to challenge other professionals if they are concerned about the plan for a child, or if they do not receive information that is required.

6. A request should be made to the Partnership in the area where father lives that they consider the learning from this review, including recommendations 4 and 5

7. The Children's Partnership should receive copies of the single agency action plans developed from single agency learning and updates on their progress until completed

The first overdose should have led to a coordinated response from professionals in both areas

There has been excellent cooperation with this review from the partner agencies in both areas, which was essential in establishing the learning from this case

Self Harm Training is available by clicking here

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