Learning Briefing 5

Chloe

Case summary:

Chloe was aged 13 at the time this review was undertaken. She is a young person who had been subject of a child protection plan and at the time had recently been accommodated under an Interim Care Order (ICO) due to concern that the child protection plan was not keeping her safe. Chloe was frequently going missing and there was concern about her mental health and risk of child sexual exploitation (CSE).

The period of the case review was very time specific. The review was undertaken as it was felt there could be learning for the Police, Children's Social Care and Health, to improve communication, joint working and planning for children in situations of particular crisis.

The family provided their views for this review.

Areas for Improvement/Concerns within the timeframe of the review:

The Police did not feel that they, or the plan for Chloe, was safely containing her as she was repeatedly missing and sometimes would run within moments of being returned. This resulted in Chloe spending time on police premises as the police did not agree, on occasion, to follow the social care plan for her and return her to her placement.

Different parts of the police force dealt with different aspects of Chloe's case and not all information was shared amongst the different departments. Officers of the Police force are not always aware of social care legal terminology, which meant at times, police action taken was against the order of the Family Court.

Procedures were not followed regarding the missing episodes, in particular the need to hold risk management meetings; they appear to have been overlooked due to the ongoing 'crisis' and care planning that social care were trying to implement.

Senior managers were not always called upon at times when they should have been regarding decisions about where Chloe should reside after missing episodes.

The management of Chloe in one placement following a number of missing episodes, lacked consideration and thought about the impact on others in the placement.

A suitable placement for Chloe was delayed due to the lack of a Mental Health assessment and it was not possible to get CAMHS to provide this.

Good Practice/Positives within the case:
Communication between the Police Safeguarding Team and the Social Care Team was good.

All decisions made by parties had Chloe's best interests at heart.

Chloe had been engaged in school until the making of the ICO and the school had adapted her timetable to meet her changing needs.

The Police response to reports of missing episodes was good. Information regarding possible CSE concerns was also able to be obtained and was being investigated.

Recommendations:

There were a number of recommendations for the Police regarding ensuring the right and up to date information about vulnerable young people was recorded on the right systems so it is accessible to communication and response staff. In order that this is effective Police and Social Care need to; ensure the timely sharing of written information regarding strategy meetings and actions; that the Police understand social care terminology and legal duties relating to Family Court Orders. All of these factors being in place should lead to better collaborative working relationships.

Police and social care need to understand from CAMHS (AWP) who to escalate accessing a MH assessment out of hours and how to escalate this if they are not getting the response they need.

Social care need to do some work with their commissioning team about better arrangements for working together and reduction in paperwork when Secure Placements are needed in an emergency; also to decide who searches for these placements.

Out of hours work: 1) Social care need to identify an 'on call' consistent manager should similar situations arise in the future so there is consistent oversight of decision making and all necessary information shared will be up to date, 2) EDT to look into having access to legal advice 3) social care need to ensure a system of free flowing essential information and decisions about cases, so these can be adhered to out of hours.

Missing Protocol: this needs to be reviewed and updated to ensure that there is a standard format for risk management meetings and clear guidance about when they should be considered as well as when a missing episode warrants a strategy discussion.

Consideration of a bespoke school attendance plan in similar situations; for Chloe allowing her to come in for short hours each day, at least meant she was seen daily by someone in the professional network.