Sophia's Safeguarding Practice Review

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1. INTRODUCTION

1.1 Introduction to Sophia[1]

My name is Sophia; I was 13 years old when my safeguarding practice review[2] started. I am female and White British. I have always lived in England and English is my first language. I do not have a disability but I have an education health care plan (EHCP).[3]

People that know me now say I am bubbly and confident; they regularly see me smiling and giggling. They say I like to try new things and I want to have as many new experiences as possible. I love shopping, make up, clothes, swimming, cycling and taking photos with my camera. I also enjoy being able to go to school.

1.2 Introduction to my family

The people in my family are identified through my review by their relationship to me. My family tree is included in Appendix A.

1.3 Introduction to my review

In March 2023 I went to hospital. I was unresponsive. I had very low blood sugar, bone marrow failure and malnutrition that the paediatricians said was "not seen in the UK". I was 13.8kg/2 stone 1 pound.[4] The paediatricians caring for me were worried I would not survive.

At the time, I was attending appointments with the Children and Young People Service[5] and I was registered with a general practitioner (GP). I was on roll at a special school and my EHCP was monitored by the special educational needs and disability (SEND) team.[6] The Education Welfare Service (EWS)[7] was also involved.

When I was in hospital, I told hospital staff and police officers about some of my experiences at home. They were worried about what I said. Police Protection, under section 46 of the Children Act 1989, was used so I had to stay in hospital until police officers asked lots of questions to understand what had happened.

The Northumberland Children and Adult Safeguarding Partnership (NCASP) was really worried about me. They sent a serious incident notification (SIN) to the Child Safeguarding Practice Review Panel (CSPRP).

The NCASP also arranged a meeting called a rapid review.[8] The people at the meeting said there was learning to be identified from what happened to me and they recommended a local child safeguarding practice review (LCSPR) was completed. The CSPRP agreed with the decision.

[1] I chose this name for my review.
[2] This is called this a review throughout the report.
[3] The children with special educational needs and disabilities guidance (DfE 2015) outlines an EHCP is for children and young people aged up to 25 who need more support that what their school or college can usually provide. It identifies the educational, health and social needs of the child and sets out the additional support they will get to meet those needs.
[4] This is an extremely low weight for a 13-year-old child. The average weight of a 2-year-old girl is 11.5kg/1 stone 8 pounds.
[5] CYPS is a service within CNTW which provides a specialist service to children and young people aged 0-18 who have mental health difficulties (CNTW, 2023).
[6] The SEND Team is responsible for co-ordinating Education Health and Care Needs Assessments and managing the EHCP process including attending and processing annual reviews (NCC 2023a).
[7] Education Welfare fulfils the local authority's statutory duty to identify, safeguard and re-engage children who are missing education (NCC, 2023b).
[8] CSPRP (2022a) explains a rapid review is a multi-agency process to consider the circumstances of a serious incident. The purpose is to identify and act upon immediate learning and consider if there is additional learning which could be identified through a Local Child Safeguarding Practice Review (LCSPR). There was a delay in NCASP submitting the SIN within the required timescale, but this did not place me at risk as appropriate actions had already taken place so I was safe. An explanation was provided for and accepted by the National Panel on 22 May 2023.

2. MY REVIEW

2.1 Scope[9]

Actions taken by workers who were involved with me between 1 June 2020 and 2 April 2023 have been considered in my review. Significant events in my life before June 2020 have also been thought about. Information was not gathered about the other children in my family, my parents or my wider family members.

2.2 Parallel processes

The police spoke to lots of people between April and September 2023. They ended their enquiries in October 2023. Nobody was charged with a criminal offence.

The Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW) also spoke to lots of people in their services between March and July 2023 as part of something they called a serious incident review (SIR). This ended in September 2023 with an action plan.

2.3 My involvement

I did not meet the lead reviewer because when my review started I was getting used to lots of changes in my life. Instead they asked someone I know to support me when I received their letter that explained what my review was, why it was being completed and to ask if I wanted to be involved.

I said I did and I was supported to share my answers to their questions in October 2023. The lead reviewer sent me a thank you letter. They said my answers were important and that they hoped people would be able to understand what I was thinking and feeling during my review period. They also said they hoped people would think more about what they say and do when they work with children and families in the future. I was really pleased.

2.4 My family involvement

When my review started the police were still speaking to lots of people, so the lead reviewer did not want to affect their enquiries. So they wrote separate letters to my mum and dad in August and September 2023 to explain what my review was and why it was being completed. My mum and dad received another letter in November 2023 with an update about my review and to ask if they wanted to be involved.[10]

The views and experiences of my mum, maternal grandma and maternal aunt have been included.

2.5 Methodology

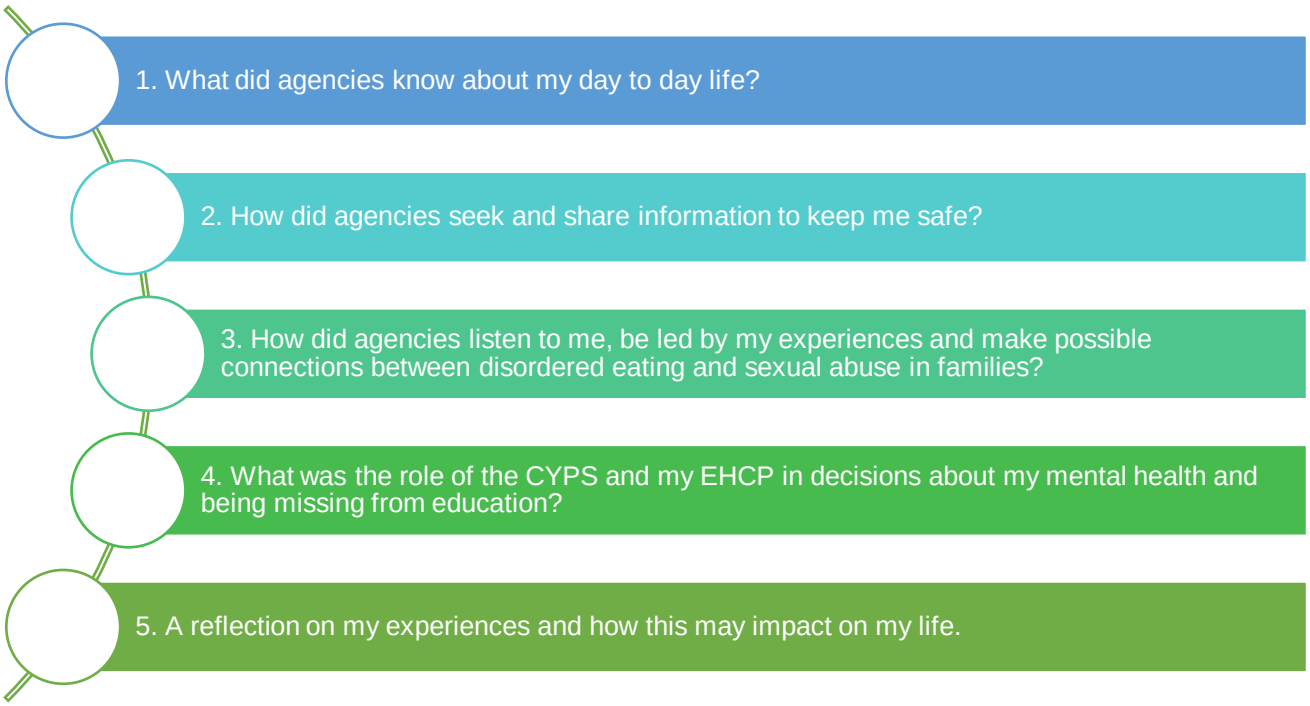
Reviews like mine are an opportunity for workers and agencies to reflect on what has happened, to learn about and to develop how people[11] can and should work with children[12] and their families or carers. To do this well, thought needs to be given to including the celebration of successes, achievements and what is already working well.[13]

My review has followed an Appreciative Inquiry (AI) approach.[14] This focused on identifying strengths and successes to support people to learn from what happened to me. This approach helped people to think about all the things that were happening at the time that made working with children and families possible or more difficult. This is called a system and strength-based approach. The key steps of my review are explained in Appendix B.

[9] My review's scope was presented within its Terms of Reference. This was agreed by the NCASP executive group in July 2023.
[10] They were offered a face to face or virtual meeting, or an opportunity to respond in writing or to the questions prepared by the lead reviewer to understand their experiences of working with workers and services.
[11] Practitioners, managers and leaders throughout the NCASP, unless a specific role has been identified.
[12] Throughout my review this refers to unborn children and children and young people aged between 0-18.
[13] Carter (2006).
[14] Cooperrider and Srivastva (1987).

2.6 Key lines of enquiry (KLoE)[15]

Five areas were identified for the lead reviewer to consider in my review.



3. ANALYSIS

The lead reviewer thought about different theories to understand events and experiences that are identified in my review. This is what they thought was important to know.

There are lots of parts of a child's development. How we learn what feelings and emotions are, understand them and why they happen, recognise our own feelings and those of others, and develop ways to manage these feelings is called emotional development. How we learn and develop skills and behaviours to help us interact with others is called social development. How we grow and develop is called physical health and our thoughts, feelings and behaviours are called mental health. These areas of development were all important in my review.

The attachment theory explains a child's emotional and social development are influenced by their relationship (or attachment) with the main person that comforts and protects them. These people are called a caregiver. A child's attachment is an important part of their survival and influences relationships throughout their life.

Experiences during childhood can have a huge impact on how children develop.

A traumatic experience is a very stressful, frightening or distressing event that is difficult to cope with or is out of our control. It can be one incident or an ongoing event that happens over a long period of time.[16] These experiences in a child's early life can affect how they develop and are called adverse experiences.[17] However, they can affect children differently and do not always lead to poor consequences.[18] Adverse experiences can be managed if they are understood and there are things in place to help the child deal with what happened more effectively. These are called protective factors.

[15] The KLoEs were initially developed in my rapid review meeting in May 2023, updated at a review briefing in July 2023 to include the CSPRP suggestions and then agreed by the NCASP executive group the same month. They reflect the define phase (see Appendix B).
[16] Mind (2023).
[17] Loveday et al. (2012).
[18] Public Health England (2022).

People that work with children and their families should always make sure their responses are based on an understanding of trauma and its consequences. This is important because a child's behaviour is often about keeping themself safe; it is how they have learned to cope. This is called a trauma informed approach (TIA). So TIA requires people to look beyond "behaviours" to ask what does the child need? rather than what is wrong with them?[19]

Shame is always a response to a traumatic experience. To understand shame in my review the lead reviewer has considered the shame containment theory (SCT).[20] The term trauma is not used because this would suggest shame is only caused by a traumatic event. This is not the case because shame is a human response and everybody will experience it.

The SCT explains shame is part of people's attachment system and is produced when a child's connection with their caregiver is broken. Its purpose is to protect; it makes a child change their behaviour so this connection is repaired. If this does not happen the shame is stuck or contained. If a child experiences repeated broken connections that are not fixed the feeling of contained shame intensifies which makes them feel inadequate or unworthy of love. To avoid feeling contained shame the child, or adult in later life, will develop shame containment strategies.

3.1 April 2020 and before

I first became known to the police and children's social care (CSC) when I was two years old. Somebody called the police because my mum and dad were shouting in our house. I was staying with my maternal aunt at the time so I did not see or hear what happened. My mum and dad explained to the police officers that nothing had happened. However they later told a court they were both victims of domestic abuse in their relationship.

My mum told to the lead reviewer her relationship with my dad was "volatile and turbulent." She said she was "beaten up every weekend" when he drank alcohol and that there was lots of shouting. My mum explained that she was aggressive towards him too, in self-defence. My mum said domestic abuse consistently happened before and after I was born, until I was two years old, and that I was usually in bed.

When my mum and dad were fighting and shouting the lead reviewer said their focus would have been on each other so I may not have always been given the attention I needed. They thought I might have seen or heard what was happening, and I could have felt scared, unsafe or confused. My mum thought that I would have seen her with a black eye, when she was upset or the damage in our house.

Children that live with domestic abuse sometimes feel responsible. The lead reviewer said my shame experience would have convinced me to think I was 'bad' because domestic abuse would not have happened if I was 'good'. So I would have started to think if I was 'good' the shouting and fighting in our house would stop, people would not get hurt or upset, and I would get the consistent attention I needed as a small child from my mum and dad.

The lead reviewer said violence in my mum and dad's relationship could have been an example of a shame containment strategy. People that are violent often feel powerful because they can present themselves in a different way to their contained feelings of shame that are either known or unknown. It can also be a way that their vulnerabilities are never seen.

They also said I could have taken on my mum and dad's shame as my own. This is called vicarious shame. If this happened I would have felt powerless. My mum and dad were unable to keep me safe so I would have felt I needed to do this myself. However, this would not have been possible as I was too young so I could

[19] Office for Health Improvement and Disparities (2022).
[20] Etherson (2023). See Appendix D. SCT will be used to understand shame throughout my review and to show how it can be used to work with children and families. This understanding will be highlighted from the points of view of me, the people in my family, and workers/agencies.

have experienced a feeling of failure that would have reinforced my thoughts that I was 'bad', and that I needed to be 'good'.

When my mum and dad separated I lived with my mum and brother. I still spent time with my dad and the other people in my family.

CSC received several concerns about me during this time. When I was two years old a housing officer and a police officer saw dog faeces, used nappies, clothes, toys and rubbish on the floor at our house. The lead reviewer said this would not have been a clean or safe space for me to eat, play or sleep. Advice, guidance and support were offered to my mum by CSC and my health visitor over the next six months. The home conditions improved and CSC ended their involvement with our family.

When I was three years old, a member of the public found me early in the morning, in a nappy, wandering the street alone. I do not know how I responded to the stranger but my mum did not know I was not in the house until I was returned. At the time, the social worker was also worried our house was untidy and recorded that there was rubbish all over the floor. Three weeks later police officers found me wandering the street alone early in the morning, wearing my night dress. The police used Police Protection to take me to hospital as a safe place.

The lead reviewer said these experiences probably made me feel scared and I could have been hurt.

At hospital I met a paediatrician who said I was unkempt, with matted hair, in a dirty night dress and I had poor speech. They observed I was overfamiliar with adults, even if I did not know them. When my mum arrived at the hospital, staff could smell alcohol on her breath. My mum told the lead reviewer she had been drinking the night before but that she was not drunk. The social worker at the time recorded my mum was "loving and warm" towards me in the hospital and at home, but they were still worried our home was dirty, there was very little food in the house, there was no clean bedding and toys were all over the floor.

The police spoke to my mum about child neglect; she was not charged with any criminal offence.

The lead reviewer said my "overfamiliar behaviour" could mean that I was trying to find people to make me feel safe and protected. They thought I would have done this to change the parts of me that I thought were 'bad' from when I experienced shame when I was younger, because it would have reinforced to me that I needed to be 'good'.

Not being aware I had left the house, not being clean and not having clean clothing could have been examples of my mum withdrawing from her role as my caregiver. The lead reviewer said this could have been a shame containment strategy or a re-containment strategy if my mum had feelings of uncontained shame that were unbearable.

The lead reviewer said being consistently interested in me, able to care for me and to keep me safe could have been affected by the experiences in my mum's life including those within the relationship with my dad. My mum now recognises that she was struggling at the time being a newly single mum with two small children. She told the lead reviewer there were times where she lost concentration, like the times when I was wandering the streets. My maternal grandma also remembered that it took my mum a long time "to sort herself out" after the relationship with my dad ended.

My mum's partner[21] came to live with us when I was about three years old. When I was four years old somebody contacted CSC because they were worried my mum was drinking too much alcohol when she was caring for me and my brother and they said her partner was a "bad influence". The referrer was concerned

[21] He is now my step dad.

we had cut our hair several times and we had been climbing on the kitchen benches because nobody was watching us to make sure we were safe. The referrer said we were dirty and sometimes smelly.

At the time, the social worker was worried my mum had "put her own needs first" and our house had become dirty and untidy again. They saw lots of beers cans on the bench, clothing and toys on the floor and we had no clean bedding. The lead reviewer said these experiences could have made me feel scared or that I could have been hurt. Advice, guidance and support were offered by CSC and the health visitor. The home conditions improved and CSC ended their involvement with our family after 10 months.

If my mum was drinking alcohol when she was caring for me the lead reviewer said she would not have always been available to look after me, keep me safe or give me the attention I needed as a small child. This would mean my thoughts that I was 'bad' from when I experienced shame when I was younger would have been confirmed again. So I would have thought if I was 'good' I would receive the consistent love and attention from my mum that I needed.

The lead reviewer also said adults can use alcohol as a shame containment strategy because it can make the negative feelings they have about themselves go away for a short time. This could have also been a re-containment strategy if my mum's feelings of uncontained shame were unbearable.

When I was five years old I told a teacher my mum's partner had physically hurt me and my brother. CSC moved us to live with our dad, his partner, her son and daughter. Agencies assumed this would provide me with the safety and security I needed. My records were not clear about the roles and responsibilities within our dad's house although they said my dad has parental responsibility, but my step mum was the main person that looked after me. It was recorded that my brother was very protective of me at the time. For example, that he always made sure I had food and initially he told our dad how to care for me.

The police spoke to lots of people about the physical abuse. My mum's partner was not charged with any criminal offence.

The same year I told my step mum I had been sexually abused by my mum's partner the year before. The police spoke to lots of people about this including me. My mum's partner was not charged with any criminal offence.

The lead reviewer knows when a child has been physically and/or sexually abused they can feel responsible for what happened. This can feel worse if they think that they must protect themselves because they have not been protected by adults in their life. The lead reviewer said I was too young to understand that shame is a protective response. Instead the thoughts that I was 'bad' from when I experienced shame when I was younger would have been confirmed again. So I would have thought if I was 'good' the bad experiences would not have happened and if I was 'good' they would not happen again.

My mum told the lead reviewer she was concerned when I said I had been physically and sexually abused but she was worried I had used language that was not "what little girls come out with" and she was worried these were other people's words. She explained that she spoke to her partner on both occasions and he said it was not true. My mum believed him because she had never seen him shout, be aggressive or inappropriate with children. My mum said the police were involved at the time and that it was their job to investigate what had happened, but that she followed a plan that was put in place by workers.

The lead reviewer said my mum placed responsibility on to the police and CSC to decide what had happened to me, which could have been a shame containment strategy.

There were important and frequent events in the first five years of my life where my connection to my mum and/or dad was broken. The lead reviewer said it is almost impossible to be a parent and for there not to be any broken connections with a child. However, these connections can and should be repaired as quickly as

possible. It was not clear that any repairs took place with me so the lead reviewer said I would have experienced a lot of contained shame.

My parents probably did not know the effect of their behaviours at the time. The lead reviewer said this highlights the importance of working with parents and carers to help them identify and understand their shame containment strategies and how they may affect children.

That year a court decided I should live with my dad[22] and spend regular time with my mum. The judge said I was not to spent time with her partner. I spent time with my mum for about 12 months, but I did not spent face to face time with her or my maternal family from the age of seven.

My mum explained to the lead reviewer this decision was made by my dad who told her I no longer wanted to see my maternal family. She said she did not want to force me to see her if this was what I had said. She remembered speaking to CSC to ask for support but she did not feel that anybody listened or helped because of the events that happened when I was younger. The lead reviewer said this could have been an indicator of my mum's contained shame; she felt that she was seen as a 'bad' person and that workers were unable to see past information that had been recorded about her when I was younger.

Between 2014 and 2019 my dad, step mum and workers from CSC, my school and CNTW shared concerns about my "emotional wellbeing and behaviours". They recorded I scratched my face, pushed my fingers in my eyes, banged my head, cut and pulled out my hair; I was physically aggressive at home and at school; I was very active and hypervigilant with poor sleep; I had urinary or faecal incontinence; and that I avoided activities in the bathroom. Workers recorded these behaviours happened because I had been neglected and abused when I was younger and were examples of how I was trying to cope with my experiences.

The lead reviewer said it was not clear from my agency records what happened before each of these events but they thought these behaviours could have been my response to feeling uncontained shame, even if I was not aware of it. This is because my shame experiences when I was younger would have made me think I was 'bad' so I could have been hurting myself and keeping people away from me with my poor hygiene so it would not come as a shock, and I would not experience uncontained shame if someone else told me I was 'bad'.

Assessments at this time said I had complex PTSD (Post Traumatic Stress Disorder) symptoms, secondary to trauma, and a disorganised attachment disorder.

My agency records said with support from CNTW and changes at school I was able to "progress academically, working towards age-appropriate attainment levels, as well as interacting with peers". My progress was recognised by other people too. My family and workers saw "a reduction in self-harm behaviours and improvements in emotional wellbeing".

When I was seven or eight years old I no longer needed a social worker and my school agreed to be the lead professional to encourage my family, my school and CNTW to meet regularly and talk about how I was doing. Then when I was eight or nine years old I no longer needed to work with CNTW because they said my "mental health was more stable, I was attending school and [my] weight was also being maintained". It was not clear what the changes were but the progress I made could have meant that my shame was successfully contained.

Within my agency records it was recorded my "behaviour is extreme, and it is a concern that she regularly will claim that she has been hit and then retract often with a smile." People at my rapid review said this comment has influenced how agencies thought about me and how they have responded to the things I have shared since, like the time I said my step mum kicked me in 2016, when my step mum said I had a cut to my head in 2019 or what I told hospital staff and police officers in 2023.

[22] A Child Arrangement Order was granted by the court.

The lead reviewer said my records indicated an assumption that I was lying or being manipulative but they thought this could have been a shame containment strategy. I had had lots of experiences of telling people that bad things had happened to me but there were no consequences. In 2016 and 2019 I could have been trying to tell someone again that something bad had happened.

The lead reviewer thought this must have been scary and it could have made me feel unprotected because I had reported concerns before and because I was sharing information about my step mum, the person who was looking after me. So they said smiling and retracting my words could have been my way of protecting myself from the thought of not being believed again and the shame that would have come from not being heard. Or it could have been a re-containment strategy if I became frightened and thought I should not have shared the information.

3.2 My review period: April 2020-April 2023

My review period has been broken down into five periods. In each period there is an explanation of what agencies did and why, or what could have happened and how. Identified learning and reflections are explained as *could*- an action that was possible, *would*- a possible situation and *should*- the best thing to do. Each period ends with reflections from my learning event and any developments that have since taken place.

Period one: 1 June to 31 October 2020. I was 11 years old.

Who was involved?

I was on roll with school 2 and had a special educational needs and disabilities (SEND) officer, then I transferred to the roll of school 3. I was registered with a GP and the children and young people service (CNTW) read information about me.

What happened and why or what was possible and how?

During the pandemic I was identified as a vulnerable learner by school 2, as expected, because I had an education health care plan (EHCP). The working restrictions at the time meant places to attend school were offered to children who had a parent/carer that was a key worker. This did not include me.

This changed to include all children if their parent/carer requested their child attended school. However, my school was not open during the pandemic because it needed some repair work. The headteacher, my class teacher and my parents[23] decided I would not manage attending a different school because I would have been in a different building, with different children and I would not have the support of my trusted adults as they were not in school or they were isolating at home.

So from March 2020 I accessed my education from home. School 2 supported me with on-line learning and education work packs. They monitored my progress through weekly telephone calls to my parents and provided feedback about my work when they delivered my new works packs and saw me face-to-face at home.

School 2 started to think about my move to school 3 in June 2020. This is called transition planning. School 2 shared important information about me that they thought would help like me needing a trusted person as a point of contact, the people in my friendship groups, the things I needed to learn and feel supported, and what helped me when I did not feel I was coping well with new or difficult situations.

At my learning event the two schools said the education recording system supported their planning because documents about me and how I learned were available. They used these documents when they spoke on the telephone to think about what needed to be in my transition plan. The two schools said this worked well because they both understood the tasks that needed to happen, why and who would do them.

[23] I called my dad and step mum my parents, so this has been used throughout my review.

As part of my plan, school 2 asked me to create a transition booklet for school 3. This was so that school 3 could understand information about me, from my point of view. During my learning event school 2 said this was a really important activity to help me understand and accept I was leaving school 2, which they knew would be difficult because I trusted and liked my teachers.

Teachers at school 2 tried to stay in touch with me when I was learning at home, but this was more difficult because of the pandemic rules and the teacher who was supporting me became unwell. School 2 thought I understood the teachers cared about me and that the school was still trying to support me, but they said these things made it more difficult for me to accept I was leaving.

On 1 September 2020 I transferred to the roll of school 3. This usually involved a home visit, a visit to see the pupil at their school, a visit at school 3 then a face-to-face parents' evening. Due to the pandemic, all new starters at school 3 were offered a virtual parents evening and a tour of the school. At the parents' evening, school 3 explained their expectations about my attendance and this important message continued through their termly attendance letters to all pupils.

School 3 understood this was a difficult time for me because I missed teachers from school 2 and I had not attended a school building since March 2020. They tried lots of creative and flexible things to support me. For example, they arranged visits and video calls so I could see the building, they sent me letters from my friends and a booklet that had photographs and social stories about school activities and the staff, including the people I would spend time with.

School 3 said at my learning event they hoped I understood the staff were trying to make me feel wanted and welcomed. They now accept they could have asked me what I thought was most helpful about everything they were doing at the time so that they understand if these things were working and how.

The staff at school 3 said that they were trying to support me and asked my step mum lots of questions on the telephone or sometimes by email. This included the school intervention team, my new class teacher or my teaching assistant. School 3 appreciated the information my step mum shared about what I needed and what some of my behaviours told her about how I was feeling. School 3 said this helped them to understand more about me and how they could support me when I was ready to attend school.

There were two school visits arranged for 4 and 9 September 2020 that were cancelled or rearranged by my step mum because people in our family were unwell. When I visited on 11 September 2020, staff from the intervention team and the deputy head teacher recorded that I was unable to leave the car and I repeatedly banged my head off the car windscreen, shouted, screamed and swore. School 3 understood this was my way of communicating how I was feeling because of the things they had read about me and what my family and other workers had said.

The lead reviewer said this could have been an example of uncontained shame. It was not clear what happened in the car but they know there is always a trigger. Uncontained shame would have been intolerable so hurting myself and presenting with anger, fear and stress would have been how I was trying to re-contain it. The lead reviewer thought I could have been hurting myself because it would not come as a shock and I would not experience uncontained shame, if someone else also told me I was 'bad'. Or I could have been trying to move the hateful feelings of shame I had about myself onto my step mum or my teachers to make me feel seen and less vulnerable.

School 3 tried to be flexible to build a relationship with me. At the time they thought about the different things they could do to help. For example, they did not want to pressure me to visit school because they understood from my behaviour and my step mum's feedback that I was scared and anxious. They also did not want to rely on video or telephone calls because my step mum said this made me think about difficult events in my life when I was younger, like family time with my mum. So school 3 suggested outdoor home visits, because

they wanted to see me, build a relationship and to give me feedback about my work in person. See development 1.

During a home visit on 17 September 2020, my class teacher and someone from the school intervention team recorded that I did not like them being in the garden. I shouted "no" loudly when they asked me about attending school. However, my teachers also asked me lots of open questions about the things I liked and disliked, to try and build a relationship. So, we had a conversation about my friends from school 2.

At this time it was unclear why I did not want to go to school but the lead reviewer said there must have been a good reason. They thought this could have been a shame containment strategy so I did not experience the terrifying feeling of uncontained shame.

I had not attended school for 20 days in a row, so school 3 quickly identified I was a child missing from education (CME).[24] School 3 had to send a report to the Education Welfare service (EWS) with details of my school attendance, including the reasons why and what they were doing to support me back into some form of education. They did this every month, as expected. This worked well and meant the EWS monitored how I was doing and could consider what I needed to support me back into some form of education.

During another home visit on 28 September 2020 I did not go to the door because it was too cold, but I shouted out the answers to my class teacher's questions about the work packs I had completed and I told them about the activities I had enjoyed. The class teacher told me they noticed I had spent a lot of time and effort on my work. At my learning event school 3 said they thought I would have been pleased with this feedback, but it could have been helpful if my class teacher had recorded my response so they were confident they understood how I felt.

I was supported by my step mum to attend school 3 on 1 October 2020. My class teacher said they could tell I enjoyed seeing my friends from school 2 from my facial gestures. They said I looked happy when I said hello and I tried to say goodbye to my friends before I left. This was the last time I visited school; the next few school visits were rearranged by my step mum due to her car breaking down, the poor weather conditions and events discussed later in this period and the next.

School 3 understood from their early observations and my step mum's feedback that visits to school 3 had a negative impact on how I felt and how I was able to cope. This made school 3 worried about how much I would want to engage with staff if the visits continued. School 3 thought about the best ways to show they understood they needed to keep me safe, to keep in touch with me, and to support me to access some form of education whilst I was not in school.[25] So, they agreed with my step mum that weekly work packs would be sent in the post with a telephone call to 'check in', like what happened when I was at school 2.

My class teacher visited me at home on 23 October 2020 and they saw bruising to my left eye. My step mum explained that the day before we had spoken about going to school and I had hit my head off a breakfast bowl which caught the bridge of my nose and caused the bruising. I was not spoken to about this. Although school 3 had known me for eight weeks, the lead reviewer thought this could have been possible, or a record made of the reasons why a discussion did not happen. If I was spoken to, the lead reviewer said it could have been an opportunity for school 3 to understand more about me, how I was feeling, what I was thinking or what was happening in my life at the time.

The lead reviewer thought this could have been an example of uncontained shame. It was not clear what was said in the discussion between me and my step mum about attending school, or how it was said, that

[24] Reflected in the children missing education (DfE 2016) and NCC (2023c) guidance. The local authority has a duty to identify and engage with pupils who are not receiving their entitlement to full time education.
[25] Reflected in Keeping Children Safe in Education (DfE 2023a), Working Together (DfE 2018) guidance, and section 175 of the Education Act 2020.

may have been a trigger. The lead reviewer identified hurting myself and presenting with anger, fear and stress could have been shame re-containment strategies because uncontained shame is so unbearable.

During the visit, my step mum also told my class teacher I found it difficult to trust others, that I would smear or eat faeces depending on how I felt, and when I said I felt "fizzy" I was not coping well. She was concerned services and workers did not always understand me because I was "very complex". My learning event identified that the focus of the visit moved away from me and my needs and focused on the needs and issues of the adults in my life. This included a discussion about the relationship between my parents becoming difficult, which my step mum said involved my behaviour; there being a limited support network because of some difficult family relationships; and stress from debt related to legal costs when children's social care (CSC) were last involved, who my step mum said had "scapegoated" my parents.

My learning event thought this could have been an opportunity for my class teacher to follow up my step mum's comment by asking open questions to explore the meaning of feeling "scapegoated", or it could have helped to explore and/or reduce her concerns about CSC involvement with my family. They identified if my class teacher had recorded the questions they asked or how they responded to my step mum's comments, this could have also helped people to understand how the conversation happened.

The lead reviewer thought feeling "scapegoated" could have indicated my step mum's contained shame because she did not trust CSC and she felt blamed by workers. They said it was also possible that my step mum's request for support from services could have reflected feelings of failure, leading her to have a more defensive and critical shame containment strategy. So the more shame my step mum experienced the more defensive and critical she would become and the more criticised workers would feel. If my step mum felt she was being shamed by workers or services she would have needed to relieve that shame. The lead reviewer said I would have been the obvious person to direct this towards because she would have thought it was me that was causing her to feel inadequate.

My step mum's feelings of blame could have been possible if workers had used the shame containment strategy of being conscientious. The lead reviewer said this would place the worker in a position of never being called out because their work is so good. However, this can lead them being more critical of others or more prone to blaming. They know this strategy can prevent workers from being self-reflective or considering learning and it can lead them to defend any wrongdoing by placing it onto others.

The lead reviewer is aware many families can experience feelings of shame and stigma when there is involvement from a service. However, if these feelings are not acknowledged or understood as early as possible, they can create barriers to a family and the worker being able to work together in a positive way.

It was not clear in my records if I heard the conversation between my class teacher and my step mum during the visit, but I was in the house. The lead reviewer said children that hear conversations like this can go on to have negative views and feelings about themselves, where they think they are responsible or they could feel guilt. So, they identified workers should be mindful who is present when sensitive conversations take place.

My class teacher discussed the home visit with the headteacher/Designated Safeguarding Lead (DSL)[26] the same day, as expected. Together they considered information recorded by school 2 on 17 June 2020. This gave a clear explanation of some of my behaviours like what my step mum had described during the visit, and how she had assessed situations in the past. Using this information, school 3 decided the bruising explanation was reasonable and they did not need to do anything else. They agreed the intervention team at school 3 could start a referral to CNTW for me to access support if my parents agreed.

[26] The DSL is the person that takes the lead responsibility for safeguarding issues in a school.

The class teacher spoke to my step mum about the referral on the telephone but she was not sure I would work with somebody new or what CNTW could offer that was different to when I worked with them the last time. However, a referral had already been made to CNTW by school 2 when I was still attending the school and my step mum had shared concerns about my eating, weight, self-harm and behaviours.

At the time there was a delay in referrals being looked at by CNTW. When my referral was considered, CNTW did not identify a role for their service but suggested the Education Other Than at School (EOTAS) health needs team[27] might be able to support me back into a form of education if that was the main concern. EOTAS did not receive a referral for me.

Due to the working restrictions and reduced admin support at the time, there was a delay in CNTW sending their outcome letters. So school 2 was unaware of the outcome of their referral to CNTW. The lead reviewer said this meant they did not have an opportunity to understand this decision based on what they knew about me, or if they disagreed, they did not have a chance to ask questions to understand how this decision was made.

School 2 acknowledged at my learning event this has been addressed and CNTW outcome letters are now received in a more timely way. CNTW identified that different questions could have been asked when the referral was triaged. They felt this may have been an opportunity to explore my views, thoughts and feelings as part of deciding what needed to happen next to support me. They also said my records did not explain why the referral to CNTW from school 2 was not accepted at the time. CNTW said could have helped to understand if the referral from school 2 was not accepted based on the service criteria or the quality of the referral from school 2. This is something CNTW are working to address now.

When my CNTW outcome letter was sent I had already moved to school 3. School 3 said after such a short period of time on roll they could not have tried all the options to support me back into school, so a referral to EOTAS would not have been appropriate. They also explained a referral to EOTAS could not have been made without the support of an assessment from CNTW. Although workers recognised I needed support at the time, there was confusion about what support I needed, who could offer it and how. So my circumstances did not change.

My learning event identified that referrals should include information about why things are a strength or a worry, what support is needed and why it could help. It was also highlighted that a better understanding of EOTAS, including how and when to make a referral, could have helped CNTW at the time. School 2 or 3 could also have also considered an early help assessment (EHA)[28] and team around the family (TAF)[29] meetings.

The lead reviewer said there were several issues in this period, like me being a child missing from education, worries about how I was feeling, how I was communicating through my behaviours, and how my family was coping. Although the EHA/TAF could have been declined, they said it could have offered support in a co-ordinated way and been an opportunity for the important people in my family like me and my parents, the relevant people from school 3 and CNTW to come together to talk about and agree a plan of support for me. See developments 2 and 3a-d.

Reflection

People were asked to identify their most important learning from this period.

[27] A team that fulfils the local authority's duty to provide education for those young people who are of statutory school age but are unable to attend school full time due to a diagnosed health condition or medical need.
[28] This assessment identifies a child and family's needs and strengths, to plan the right support and services to address those needs.
[29] This is a group made up of family members and relevant people working with a family. TAF meetings should take place to review the child's plan.

The need for the important people in a family and the relevant professionals to come together when there is more than one issue that makes people worried, to talk about what needs to happen next.

The need to have a plan that explains what is expected to happen and how.

The need to share and listen to relevant information in a regular and co-ordinated way to understand what has changed or what still needs to happen.

What has changed since?

Development 1	School 3 has updated their process when a pupil is absent for more than 10 days. A home visit is now completed on day 10 so the pupil can be seen. The school attendance recording system identifies when a home visit is needed and this is monitored daily by the DSLs so visits are completed promptly. School 3 needs to evaluate the difference this change has made over time.
Development 2	Since October 2022 there has been an early help education worker (EHEW) aligned to all schools in Northumberland. The role supports schools to identify a pupils needs early by initiating an EHA, and leading TAF meetings to monitor progress. The EHEW also works with family help co-ordinators to support schools with a strong early help offer. The manager who oversees this role said there is evidence it is having a positive impact because schools have reported they feel more confident to identify their pupils' needs earlier and use an EHA/TAF to manage the identified issue(s). The next step is to understand the roles impact on the quality of EHAs that are recorded.
Development 3	The NCASP thresholds of need document was updated in December 2022. It is available on the NCASP policy and procedures platform. Feedback about the changes were positive for example the clear language and the inclusion of relevant and useful information for workers. The document now includes: a) How child development should be considered. This includes physical, emotional and mental health which were important in my situation. b) How family and the network should be considered. This includes boundaries, understanding and expectations which were important in my situation. c) How worries about a child should be managed, including information sharing and consent. This now highlights that workers need to explain to families what information would be shared and why, so they can make consent-based decisions about a referral to services. d) Expectations of how people work with children and families in Northumberland. The NCASP needs to evaluate the difference the document has made.

Period two: 1 November 2020 to 31 July 2021. I was between 11 and 12 years old.

Who was involved?

I was on roll at school 3, I had a special education needs and disabilities (SEND) officer, I was registered at the same GP and I was discussed in their multi-agency practice meeting. I met lots of people at hospital 1 and 2, and hospital 2 spoke to lots of people outside of the hospital about me. My step mum had contact with a duty worker from the children and young people service (CNTW) and I had a CNTW keyworker from January 2021. The dietician service and Education Welfare service (EWS) became involved and read information about me, and the police and children's social care (CSC) also heard information about me.

What happened and why or what was possible and how?

In November 2020, my step mum spoke to people about me on the telephone because I was unwell. They talked about me not going to school, my mental health, my eating and my weight. They sometimes talked about how she was feeling too, as the person that looked after me.

On 2 November 2020 my step mum told my class teacher she struggled to trust services and workers and felt she did not have anybody to ask questions or talk to about what support was available for me. The leader reviewer explained feelings of struggle, lack of trust and isolation could have indicated my step mums' thoughts about herself, how others perceived her and her contained shame.

During the conversation with my teacher, my step mum also said I could not hear or use my legs. She said she did not know if this was true because I had responded to her questions that day, and it had happened before when I felt anxious about attending school. The conversation ended when my class teacher agreed to send information about elective home education (EHE) and my step mum was asked to consider seeking evidence from CNTW to say I was not ready to access any form of education because I was unwell.

My learning event identified this could have been an opportunity for my class teacher to involve a health agency when concerns about my physical health were raised. However, it was highlighted that workers often find it difficult to identify children's physical health needs and/or risks. It was agreed having more knowledge about healthy child growth and development and asking different questions at this time would have supported a better understanding of the concern or to identify if any additional actions were required, like speaking to the GP.

On 3 November 2020, my step mum contacted the GP and CNTW about me; they both said I needed to go to hospital.

From the discussions, the GP wrote in my record I had "extensive mental health problems, a history of self-harm, problems with eating" and I was not attending school. My step mum had explained my weight had improved over the last few weeks, but I had loose stools, was tired, lethargic, shaky and appeared locked in myself. CNTW wrote in my record I used eating as a "tool" against my parents. For example I stopped eating or I was sick if I did not want to do something and when I was anxious, I lost my appetite.

The lead reviewer said it was unclear what had happened to trigger my self-harming behaviours, but they could have been an example of a re-containment strategy if I was experiencing uncontained shame. They explained the comment about food being used as a "tool" may have been my step mum's way to place responsibility for the situation onto me as a way of denying her shame experience was present, which would be a shame containment strategy.

My step mum was worried what the hospital would say because I had self-harm bruising to my eye and I had had a social worker in the past. This response could have indicated her contained shame. The lead reviewer identified this comment described her concern about what workers would think of her and how well I was cared for. This could have been influenced by her experience when I was removed from my mum's care and the media's negative portrayal of social workers.

CNTW proactively contacted my step mum again on the telephone, to check I had been taken to the hospital. My step mum had taken me to an emergency department (ED) (hospital 1) the same day. The lead reviewer said Hospital 1 was thorough in their assessment to understand what I needed. They gathered historical information from my step mum and recorded that I had disordered eating,[30] a sleep disorder, I did not go to school, and I was abused when I was younger. The hospital then explored the concerns that led to me attending the ED. My step mum explained I had been tired and unsteady on my feet for a few days.

Hospital 1 observed I had swollen hands and feet; I was pale with purple marks to my right temple and over my eyelids. I also had bruising on my eye and forehead, a cut lip and bites inside my mouth. My step mum explained I did this to myself when I felt frustrated. The leader reviewer said it could have been clearer in my hospital record if the doctor agreed with my step mum's explanation. They thought I could have been hurting

[30] Disordered eating is food and diet related behaviours that do not meet the diagnostic criteria for an eating disorder but negatively affect somebody's physical, mental or emotional health.

myself as a shame containment strategy because it would not come as a shock and I would not experience uncontained shame if someone else also told me I was 'bad' or it could have been a re-containment strategy if the feeling of uncontained shame became too unbearable.

Hospital 1 tried to speak to me. I opened my eyes when they said my name but they recorded I was difficult to wake up. Tests at the time confirmed I had pancytopenia[31] but hospital 1 did not know why. I had to go to a different hospital, so my medical records were updated with all the tests completed and doctors spoke to people at hospital 2 on the telephone.

I was transported to hospital 2[32] in a special ambulance.[33] On the way, I told the ambulance crew I was very hungry, and I asked for some food. They shared this information in their report with hospital 2. At my learning event, hospital 2 said this information was added to my medical record but it was not escalated as a concern because it was not considered significant at the time.

My medical record said when I arrived at hospital 2 I was "confused, agitated, hallucinating and very unsettled". The lead reviewer said this was probably because my weight was recorded as 20.5kg/3 stone 2 pounds.

My class teacher continued to communicate with my step mum on the telephone during the initial days when I was in hospital. Sometimes there was no answer or a call back. When they did speak, my step mum shared what tests hospital 2 had completed. Occasionally my step mum was upset and my class teacher tried to offer her reassurance.

At first, hospital 2 did not know why I had pancytopenia. So, lots of different people and services were involved. Hospital 2 spoke to my parents about the tests they completed and explained what the results meant. For example, on 4 November 2020 my parents were made aware of potential concerns with my blood, like leukaemia. On 10 November 2020 my dad was spoken to about disordered eating and that I would need follow up appointments with a community paediatrician and a dietician. Finally, on 11 November 2020 my parents were told my blood tests identified malnutrition was the cause of my pancytopenia. The lead reviewer said it was not clear what their response was to these discussions or how they were managed.

On 11 November 2020 somebody from the eating disorder intensive care team (EDICT) completed a thorough assessment and said I did not have an eating disorder. I was involved in my assessment and my parents were also spoken to. My parents shared concerns that I had been discharged too soon from CNTW in 2019. The lead reviewer identified this was different to what my step mum told school 3 in September 2020, when they explored a referral to CNTW, but the EDICT would not have known that. The EDICT agreed to make a new referral to CNTW so I would be supported with my mental health when I left hospital.

The lead reviewer said my disordered eating could have been an indicator of chronic uncontained shame.

On 13 November 2020 my step mum spoke to a dietician from hospital 2 to provide a diet history for me. My learning event thought I could have been spoken to, but I was not. The dietician recorded they were "surprised my weight was so low based on my diet history". At my learning event hospital 2 said this information was not escalated because it was not an unusual observation for a child in my situation. My learning event said there was an assumption made that this would be followed up by a community dietician.

Hospital 2 said it was standard practice in their Trust to speak to children as part of assessments and during their time in hospital. When I first went to hospital 2 I was confused, agitated and hallucinating, so staff were unable to communicate with me until around 10 November 2020. However, hospital 2 identified I was rarely

[31] Pancytopenia is a serious condition where a person has too few red blood cells, white blood cells and platelets.
[32] Hospital 2 is in a different Healthcare Trust.
[33] This was a specialised ambulance transport service for critically unwell patients.

spoken to about my views, thoughts or feelings although there were opportunities during my last week in hospital. This could have helped hospital 2 to understand my views, thoughts and feelings, or helped me understand what was happening at the time. See development 4.

People were worried about me in hospital 2. An internal cause for concern was sent to the safeguarding team on 4 November 2020. This was because the hospital was aware of previous concerns about me and the concerns at the time that I was self-harming and that I had not been eating. This was reviewed and my hospital record was updated. No further action was taken. A doctor also shared concerns with ward staff that my admission could have been caused by the care I had received before I went to hospital. They used the word negligence for this. I do not think this information was shared with the safeguarding team in the hospital but it was written in my medical record.

Hospital 2 considered a referral to CSC for me but my parents had made negative comments to staff about their past experiences of social workers so they felt they would not work with a social worker or family help again. My parents were not spoken to about this. The lead reviewer identified if this happened it would have been an opportunity to understand their views and feelings.

The lead reviewer said my parents' negative comments could have been a shame containment strategy if they were not accepting of their shame and pushing its distressful feeling onto others so they were seen and so they felt less vulnerable. Likewise, hospital 2 not speaking to my parents about their comments when they were worried about me could have been a shame containment strategy because it was a difficult conversation to have and not having it would avoid a shame exposing experience for the workers and my parents.

Hospital 2 spoke to lots of colleagues within the Trust, to their safeguarding leads and to people that had worked with me before I went into hospital. From these discussions they decided I had experienced anxiety for a long time which caused me to have issues with food. Hospital 2 said this explained the level of malnutrition I presented with which caused my pancytopenia. The discussions highlighted CNTW were working with me which they felt was the most appropriate service to support me when I went home.

Considering all the information hospital 2 had, it did not think the threshold was met to make a referral to CSC. Hospital 2 felt their identified plan when I left hospital could support me and prevent me from returning to hospital. This plan included a follow up appointment with a paediatrician the following week and then in January 2021; a planned referral to a community dietician for follow up care and monitoring; and support from CNTW with my mental health.

Hospital 2 followed its Trust policy for discharging children. I was discharged on 17 November 2020 following two consecutive weight gains. A summary of my time in hospital and my health plan was send as a letter dated 23 November 2020, to my parents, the GP, the community dietician, CNTW and the Designated Doctor in Northumberland. Within the letter, hospital 2 requested to be notified if I was not taken to my follow up appointments, or a referral to be made to CSC.

My learning event identified there was evidence my circumstances at this time had a significant impact on my growth and development. For example, I was seriously unwell and that resulted in me needing to be in hospital, I needed to be transported between hospitals in a specialist ambulance and tests confirmed I had malnutrition. People thought if staff had asked why and how I had become so unwell this should have identified that a referral to CSC was required and that I needed a co-ordinated multi-agency plan to address all my developmental needs. See development 3.

The lead reviewer explained workers' or agencies' shame containment strategies can include not being willing to show other professionals how they work or what they have done because this could leave them feeling vulnerable to criticism which can lead to uncontained shame. This strategy will prompt workers to be closed and not to share with others, but this can lead to things being missed or issues continuing without being addressed.

There were some relevant details in the hospital summary letter, however the lead reviewer felt it only focused on my physical health and this was an opportunity for my plan to be strengthened. My learning event identified this should have been achieved through a formal discharge planning meeting, face to face or virtual at the hospital, or when I returned home. This would have involved my family, people from hospital 2 and the relevant workers in the community like the dietician service, CNTW, my school and the GP.

My learning event thought a formal planning meeting would have been an opportunity to explore my parents' comments together, which may have reduced their concerns about CSC involvement or identified what the concerns were. It would have also been an opportunity to share and seek information about me from my family and relevant agencies, and to use the skills and knowledge from all the people that would be working with me in the community, to develop a multi-agency plan to manage all my developmental needs.[34] My plan would have included the key issues at the time like my physical and mental health as well as my education and social needs because I was missing from education and that I was not having contact with friends and children my own age.

I continued to access education from home when I left hospital 2 through weekly work packs. My step mum told my class teacher I was doing a little bit of school work each day.

I was seen by the consultant paediatrician face to face at the end of November 2020, as planned. It was unclear in my records if I was spoken to in this appointment but the consultant paediatrician recorded that they were happy that my weight gain was "very good" and a referral to the community dietician service had been made. The consultant explained to the lead reviewer a referral to a community paediatrician was not needed because they did not feel further physical health input was required and an appointment with a community dietician had been scheduled for February 2021.

The community dietician service confirmed it had received a referral from the hospital dietician with information about their assessment of my needs when I was still in hospital. This was then followed up by the written referral from the consultant paediatrician at hospital 2. The referral outlined my weight loss and that my pancytopenia was due to malnutrition. It also said my experience of abuse had "driven some abnormal eating and vomiting patterns" but that my eating had improved when I had been in hospital. The lead reviewer identified the referral did not mention other services involved in my care.

In December 2020, I was asked by CNTW if I wanted to work with my previous keyworker again. I said I was happy to and it was agreed with my step mum that she would speak to a duty worker until my keyworker returned to work in January 2021. They decided I would not cope with a new worker for a short period of time. The lead reviewer identified I was not asked about this, but if I had been then my views could have been considered. CNTW explained at my learning event this allocation could have been different, to reflect my physical and mental health needs at the time.

The same month my step mum told the CNTW duty worker that I was aggressive towards her. A referral to CSC for support was explored. The lead reviewer said it was unclear how this was explained but my step mum did not agree and said she did not want any additional support. She expressed worry about the last time CSC was involved with our family and how I would manage the introduction of a new worker. On 10 December 2020 my step mum also shared concerns with my class teacher about me being aggressive and said that I had "severe meltdowns", I hit her, and I pulled her hair out causing injuries.

It was not clear what happened to make me behave aggressively towards my step mum, but the lead reviewer explained this could have been a response to uncontained shame. They know people who experience uncontained shame need to move from this state as quickly as possible because it is terrifying. If this was

[34] The North and South of Tyne Safeguarding partnership manual (2021) refers to the assessment framework triangle: a child's development, family and environmental factors and parental capacity.

happening, they thought I could have been trying to push the distress of shame away or trying to move the hateful feelings of shame I had about myself onto my step mum.

My class teacher and CNTW discussed the worries on the telephone, as expected. They considered child to parent violence and abuse (CPVA) and after speaking to my step mum decided no further action was needed. The lead reviewer said it was not clear what questions school 3 and CNTW asked, how they challenged their own assumptions or what they did to feel confident this was the best decision for me. The lead reviewer identified I was not seen or spoken to about this because there was nobody that had direct contact with me at the time, because I was not attending school. They thought this could have been an opportunity to ask my views or to observe my relationship with my step mum to understand the situation from a different perspective.

The NCASP CPVA pathway could have been considered by school 3 and CNTW. The CPVA gatekeeper, a role in place since March 2019, could have provided useful advice and guidance. The risk screening tool could have identified if further information was needed, or if a more in-depth assessment or a referral to CSC or adult social care (ASC) for multi-agency involvement was required. Using these resources could have been an opportunity to explore the information further whilst sensitively recognising the possible effects of CPVA on me and my parents. The lead reviewer highlighted this was also learning in Aaron's review in 2021 and a domestic abuse multi-agency audit completed in November 2023 too.

School 3 used this discussion with CNTW as an opportunity to review if I was ready to access a form of education. The CNTW duty worker felt confident I would be supported back into school when my keyworker returned in January 2021. They agreed to send a letter to confirm that any pressure or attempts to engage me in any form of education was "not in my best interests, because contact with or from new or unknown people caused me significant distress". This included attending school, visits from school and support from EOTAS. My school received the letter on 15 December 2020.

CNTW acknowledged the decision that I would not engage with other people other than my keyworker was inaccurate and that this affected how well agencies were able to identify and review my needs and risks at the time and throughout my review period. See development 5.

Before the letter was prepared, the lead reviewer thought consideration could have been given to how my views could have been gathered, directly or indirectly, that would not cause me distress. There should have been a virtual or face to face meeting between my family, CNTW, school 3 and possibly the EWS to discuss the circumstances, the potential risks of reducing the network of people that would see and speak to me and the longer-term consequences of me not attending school or accessing an education. The decision may not have been different but it would have been based on all the available information, everybody's opinions and an agreement about when and how it would be reviewed so that it remained the best decision for me.

My class teacher and step mum continued to speak on the phone between January and May 2021. The records indicated they mainly talked about my CNTW appointments and if I had attended, rather than my education.

I started to see my CNTW keyworker again. Between January and February 2021 I was taken to five of the six appointments offered to me.

In January 2021 school 3 explored a referral to EOTAS with my step mum to support me back into school. The lead reviewer said the views of CNTW and the EWS could have been considered if there had been a virtual or face to face multi-agency meeting. This would have made sure decisions about me were based on all the available information, everybody's opinions and an agreement about when and how it would be reviewed again.

On 25 January 2021 I was not taken to my follow up face to face appointment with the consultant paediatrician at hospital 2. Usually a letter would have been sent to a family informing them that they could make another

appointment. Or if the child no longer needed to see a paediatrician from hospital 2, they would be followed up by community services. The letter would also be sent to the child's GP and any relevant community health services.

As I had been so unwell in November 2020, the consultant paediatrician from hospital 2 proactively contacted my step mum the same day on the telephone to see how I was doing. It was not clear if my step mum was asked why I had not been taken to my appointment but she told the consultant paediatrician CNTW was involved and seeing me regularly. The consultant paediatrician from hospital 2 followed this up, as expected. There was no record of this discussion in my CNTW records. The lead reviewer said this was probably because the consultant paediatrician did not speak to a specific worker to confirm I was being seen regularly. This information was shared by a secretary who would not have been able to comment on the detail of my appointments, specifically how my height and weight was being monitored.

The consultant paediatrician at hospital 2 decided to discharge me because they assumed there was a plan in place with follow up appointments with CNTW and a community dietician. The lead reviewer said this would have been clearer if a named person had been spoken to in CNTW or if there was a multi-agency plan in place that explained how my physical health would be managed. Knowing this information would have informed their summary letter dated 15 February 2021.

The summary letter identified hospital 2 would offer support to the GP or CNTW "as necessary" but it was not clear what this support could or would be. The letter was sent to my parents, GP and CNTW. School 3 and the community dietician were not aware of this information.

Hospital 2 reflected if my appointment had been face-to-face as planned it could have been an opportunity to identify a concern sooner.

The referral to the community dietician service was made by hospital 2 to assess and monitor what I was eating and how this affected my health. Health workers call this dietary intake and nutritional status. The dietician would have checked my weight and height and reviewed the supplements I was taking to decide if any advice or changes were needed to keep me healthy. The service would have spoken with other health workers and my school if I was attending, to share information about my progress and it would have welcomed feedback from others working with me at the time. They would have offered follow up appointments and made a referral to other services if I needed any additional support, or if they were concerned about me.

However, I was not taken to my first appointment with the community dietician on 9 February 2021. My GP was informed and hospital 2. Hospital 2 was no longer involved but the dietician did not know this at the time. The community dietician service said it would have been useful to receive the February 2021 summary letter from hospital 2 about the change in oversight of my paediatric care so the relevant people were notified about my appointments. A new dietician appointment was sent to my parents in a letter, as expected.

School 3 and CNTW were not aware of this information about me. The lead reviewer said if I had a multi-agency plan, not being taken to important appointments would have been discussed at my review meetings. This could have been an opportunity to explore if my parents understood the importance of my appointments or if they needed additional support, so I was consistently taken to my appointments to access the support I needed to stay healthy.

On 23 February 2021 my GP practice talked about my family in their practice meeting. Usually, these meetings are represented by the 0-19 service, midwife and the GP safeguarding lead. They are an opportunity to discuss families where there are concerns and any notifications of children who have not been taken to important appointments. The people at the meeting said I was being supported by CNTW but there was no letter from CNTW with an update at the time in my GP records.

School 3 was still worried I was not attending school and the EWS was monitoring my monthly CME returns, as expected. My school attendance was 0% and authorised because of the letter from CNTW in December 2020. The EWS and School 3 respected CNTW's decision making as a specialist service that was supporting me with my mental health. They were mindful the letter stated "contact with new or unknown people caused me significant distress" which they wanted to avoid.

As part of their monitoring, the EWS identified there were times when school 3 had not always been able to speak to my parents, so from March 2021 the Lead Education Welfare Officer (LEWO) began to offer school 3 advice to try and support me back into a form of education when it was agreed I was ready, because they understood the importance of me maintaining a relationship with school 3. Options that could have been considered included continuing with school work packs, support from EOTAS which would include online or face to face learning and eventually working towards attending school.

There was a meeting called an EHCP review[35] on 8 March 2021. My last review had been in November 2019. The SEND team explained the delay could have been because during the pandemic my paper records were moved to an electronic system, making some documents more difficult to find. Additionally, I had had several SEND officers[36] because of the EHCP process at the time. Some of the information in my EHCP was out of date or incorrect, like when it said I had a Care Order but at the time my dad had a Child Arrangement Order.[37]

I was not at my EHCP review, but school 3 said my views were shared by my step mum and CNTW. Usually pupils are supported to share their views using a pupil feedback form before their review. As I was not attending school and school 3 did not want to distress me, School 3 said my views were taken from what I had shared about my education with the people I had contact with at the time.

In the meeting, School 3 said my step mum was worried I was encouraged to attend school, which she thought made me unwell so she was not sure the school was the best option for me. The decision about people visiting me and me accessing education from the letter in December 2020 had not been reviewed so the lead reviewer identified it was unclear if it was still the best decision for me. School 3, CNTW and the SEND officer agreed I needed support to accept my time at school 2 had ended, to feel able to attend school 3.

After the meeting, school 2 said a 'goodbye visit' with my trusted teachers had been arranged. However, due to the working restrictions and how I felt at the time, I said I did not want to go. CNTW and school 3 discussed this and agreed a visit did not need to happen if I did not want it to. My wishes were respected, and the goodbye visit was not rearranged or discussed again. The lead reviewer said if the information about my goodbye visit was gathered before my EHCP review then alternative next steps for me could have been discussed in the review meeting to avoid delay.

An EHCP explains what support a child will receive when they are attending school. The review of the EHCP is expected to consider information about the developmental needs of a child within the context of their education. But the lead reviewer said my needs at the time were more than being missing from education. School 3 reflected there is often an expectation that it is a schools responsibility to update a child's EHCP. However, as I did not have direct contact with school 3 at the time this was difficult. This was an opportunity for the people involved with me to work together to update my EHCP or to create a multi-agency plan to address my developmental needs at the time, including how I would be supported to access a form of education and a return to school.

[35] A child's EHCP must be reviewed at least once every 12 months. It involves parents/carers, the child and everyone who is providing support. Views are recorded on what is working well and what is not working so well. It should focus on how well the support is working to help the child move towards the outcomes in their plan. It should look at any changes that need to be recommended or if the plan is still required.

[36] When I moved to school 2, I received a new SEND officer. This changed again when I moved to school 3, and again when I went into year 9 at school 3.

[37] This is a court order that explains where a child will live, when they will spend time with each parent, and when and what types of contact will take place. A Care Order is when the local authority shares parental responsibility for a child.

My learning event said an EHA/TAF could have achieved this, to encourage more co-ordinated and frequent information sharing and the review of a plan that addressed all my needs at the time. The multi-agency plan could have also supported the EHCP and its annual review cycle. See development 6.

I was not taken to my rearranged community dietician appointment on 23 March 2021. The dietician was proactive and telephoned my dad the same day to check our contact details because he said the appointment letter had not been received. Our contact details were confirmed as correct. My dad was asked to make a new appointment and a letter was sent about how to do this, which my GP and hospital 2 also received. Hospital 2 was not involved at this time, but the dietician service would not have known that. School 3 and CNTW were not aware of this information about me.

Hospital 2 confirmed they received the letter from the community dietician but because they thought CNTW was involved, they did not follow this up. The lead reviewer said it was unclear what the GP did with the information. My dad did not rearrange my dietician appointment and at the time the administration support in the dietician service was on maternity leave and I got lost in the system. So, another appointment was not rearranged or followed up by the service. See development 7.

There was a record of my weight on 15 March 2021 as 19.5kg/3 stone 0.5 pound. The lead reviewer identified this was lower than my weight when I left hospital in November 2020.

My learning event said if I had a multi-agency plan that was being regularly reviewed, not being taken to important appointments or the change in my weight could have been identified in my review meetings. This could have been an opportunity to explain what the role of a dietician was and to talk about how important it was for me to be seen regularly so I made progress like I did in hospital. It would have also been an opportunity to review the decision from December 2020 about school 3 visiting me or how I could have been supported to access some form of education, to make sure not attending school or being visited by school was still the best decision for me. The lead reviewer explained this could have been an unconscious shame containment strategy by workers not to challenge this decision.

Home visits were not completed by school 3 and the EWS because of the advice they had received from CNTW. So my class teacher or a teaching assistant and step mum continued to speak weekly on the telephone, during March and May 2021. The conversations were focused on my CNTW appointments and if I attended, rather than my education.

In June 2021 sometimes the telephone calls were not answered, and sometimes school 3 did not receive a call back. Although there was an agreed plan for weekly telephone calls, the lead reviewer said it was unclear if the time and day was set or if the calls were made when the teacher was available which highlighted the importance of planning and communication.

I was taken to two of the nine appointments offered by CNTW between April and June 2021. Reasons given to CNTW or school 3 by my step mum included I had a "meltdown", it clashed with her dental appointment or there was a teacher training day. Often a reason was not recorded.

On 21 May 2021 CNTW wrote in my record they were worried my step mum may have been overwhelmed with responsibility. My keyworker spoke to her about a referral to CSC and stressed I needed to be taken to all my appointments to receive the support I needed. The lead reviewer said it was not clear how this was explained. My step mum did not agree for the same reasons she had explained before and she told my keyworker she was managing ok.

The lead reviewer explained my step mum could have withdrawn from the offer of support from CSC because she was worried she was being blamed or that she would be blamed for me not being taken to my appointments or not coping. This would have caused her to feel uncontained shame, based on the thoughts she already had about herself and how workers perceived her.

In June 2021 sometimes telephone calls to my step mum from school 3 were not successful, and they were not always returned. So my class teacher contacted my dad. On 25 June 2021 he shared I had started to pull my hair out when I was spoken to about attending school. The lead reviewer identified it was not clear what questions school 3 asked or how they analysed the information to feel confident this was happening. On 29 June 2021 my class teacher phoned my dad again to explore reasons why my step mum may not have answered calls or emails since 24 June 2021, but he did not know.

The lead reviewer explained these could have been shame containment strategies. I could have been hurting myself because it would not come as a shock and I would not experience uncontained shame, if someone else also told me I was 'bad'. Based on her thoughts and feelings of being blamed in the past, my step mum could have been withdrawing from telephone calls with school 3 to limit these feelings from happening again.

In June 2021 I told my CNTW keyworker I had suicidal thoughts and my keyworker recorded "I did not like myself at all". The lead reviewer said this comment was an indicator of my contained shame because it explained what I really thought about myself.

It was not clear if the NCASP self-harm and suicidal behaviour pathway was considered. The lead reviewer identified this should have been an opportunity to complete a baseline risk assessment to identify if a more in-depth assessment or a referral to CSC for multi-agency involvement was needed. See development 8.

There were also changes in the relationships within my family at this time. Later in July 2021 my step mum told CNTW there was "conflict" between her and my dad. This was the third time a referral to CSC was explored. The lead reviewer identified it was not clear how this was explained but my step mum said she did not want other agencies to be involved for the same reasons she had explained before.

The lead reviewer explained my step mum's shame containment strategy may have been to withdraw from the offer of support from CSC because she felt blamed for not supporting me to all my appointments or for the arguments in the house. This could have caused her to feel uncontained shame and to worry about being blamed again, based on the thoughts she already had about herself and how she thought workers viewed her.

In another CNTW appointment in July 2021, somebody said there had been increased arguments in our house about my brother which made me feel distressed and unsafe. My keyworker offered me a joint appointment with my brother to talk about it. It was not clear if this was accepted. My learning event thought through discussions with colleagues, this could have been a prompt for my keyworker to identify that I needed a multi-agency plan. This would have identified the tasks to keep me safe and well, by who and by when.

The lead reviewer highlighted if there was more regular and co-ordinated communication between CNTW and school 3 at the time important information they both recorded could have been considered as part of decision making the same month when my parents reported my brother missing to the police on 27 July 2021. The police spoke to my parents and the police officer recorded the information in a child concern notification (CCN).[38] All the children in our family were included and the CCN was shared with CSC, as expected. This was looked at by a social worker and a police officer in the daily CCN meeting.[39] However, the focus of the discussion was only my brother, and they decided no additional action was required.[40]

[38] This is the way police officers record a concern about a child, which is stored on their system and shared with CSC. This should document what the child experienced, the impact but if this is not possible then the reason should also be recorded, and any ongoing risk towards the child.

[39] This is a process that agrees the outcome of CCNs received into CSC. Those present included representatives from the police, CSC including education, early help and the adolescent service. They are asked to check their recording systems and populate a decision-making sheet with relevant information including any further actions to consider. The decision-making sheet is then reviewed by a CSC manager and police officer and the outcome is recorded on the child's record for CSC and the police.

[40] There are several outcomes: no further action, progress to Early Help, triage or MASH. There are circumstances where the CCN is shared with other agencies. For example, where there is a child under five years old involving domestic abuse. This is shared with health colleagues. When the threshold is not met for social worker involvement and the victim of a domestic incident. This is shared with the MASH independent domestic violence advisor (IDVA).

School 3 was not aware of this CCN or the concerns at the time. My learning event identified that information held within CSC front door[41] is important to share with a school, college or alternative provision - these are called education provisions - so they can safeguard children on their roll.[42]

The SST (School's Safeguarding team) are represented at the CCN meetings and have access to education recording systems. However any direct contact with an education provision about a CCN must have prior permission from police and CSC. This could have been an opportunity where a process supported better information seeking and sharing.

In August 2021, I was observed by my CNTW key worker to be underweight. We spoke about this and I said the main issue was my relationship with my brother. My learning event identified this could have been an opportunity to contact the GP, or consultant paediatrician at hospital 2 for support like they offered.

The lead reviewer said at this time there was evidence the circumstances in our home had an effect on my social, educational, emotional and physical needs. There were opportunities for my family and the workers involved to identify and explore the issues together. This would have shown things were not working and a multi-agency plan was needed to identify tasks to keep me safe and well, by who and by when. However, agencies managed issues alone, within their agency objectives and through single agency decision making. The lead reviewer said this could have been an example of workers containment strategies to avoid criticism and the experience of uncontained shame.

My learning event acknowledged this period was probably a very difficult and overwhelming time for me, my family and workers.

Reflection

People were asked what this period had taught them about their skills, or the skills workers needed to manage the key issues for me.

- The need to use clear and simple language that everybody can understand.
- The need for people in a family and workers to have the same information to avoid miscommunication.
- The need for co-ordination through a multi-agency plan so expectations are clear to everyone.
- The need to be aware of a child's physical health and development in their assessments and reviews.
- The need to avoid making assumptions that information is correct or that tasks will be or are progressed.
- The need to use the support available within their professional networks to access advice and/or reassurance.
- The need to be confident to ask questions to understand the meaning and impact of situations.
- The need to see a child and seek their views, thoughts and feelings through words or observations of behaviours and interactions.

[41] CSC 'front door' arrangement is represented by three teams. Triage: screening of information and referrals. Multi-agency Safeguarding Hub (MASH): the management of referrals where there are concerns about significant harm. Assessment: the completion of child protection enquiries and Child and Family assessments.

[42] This is outlined in Working Together (DfE 2018), the revised Working Together arrangements, Promoting the education of children with a social worker (DfE 2022), Keeping Children Safe (DfE 2023a), a prominent narrative within the National Review of Star and Arthur (CSPRP, 2022b), the independent review of CSC (McAlister, 2022) and the Stable Homes Built on Love consultation paper (DfE 2023b).

What has changed since?

Development 4	In October 2023, hospital 2's Trust updated its children's safeguarding policy to make a clearer focus on the importance of people understanding the day-to-day experiences of children. This included updating the level 3 children's safeguarding training to include a greater emphasis; the internal cause for concern submission form with a mandatory section; and a new electronic admission form is being created to prompt staff to seek and record this information too. Its impact needs to be evaluated over time by the Trust.
Development 5	The findings from the CNTW significant incident review are identified in their agency action plan. The plan identifies learning and key actions, which was endorsed by the CNTW SIR panel in September 2023. An Assistant Director has oversight of the plan and its progression. Its impact needs to be evaluated over time by CNTW.
Development 6	Leaders with responsibility for the SEND team and CSC have recognised apprehension amongst some agencies and workers to start an EHA for a child who has an EHCP. Acknowledging they are separate but interlinked processes, work is now underway to review the EHCP process. This will work towards an alignment of a child's EHA/TAF with a child's EHCP/annual review which will strengthen the assessment and review of a child's needs and risks.
Development 7	In October 2023 the dietician service reviewed its appointment system. This now includes a weekly appointment report that identifies if a child does not have a follow up appointment scheduled or if they have been formally discharged from the service. This means that if a parent/carer does not contact the service to rearrange appointments, then a follow up appointment will automatically be made. If a child is not taken to their follow up appointment, the process now includes actions to ensure they remain visible to clinicians. For example, speaking to other health services involved with the child or making a referral to CSC. Its impact needs to be evaluated over time by the dietician service.
Development 8	The NCASP updated its self-harm and/or suicidal behaviour pathway in January 2023 in response to the Isla review. This has been promoted through a 7-minute guide which is also available on the NCASP policy and procedure platform. Its impact needs to be evaluated over time by the NCASP.

Period three: 1 September 2021 to 31 March 2022. I was 12 years old.

Who was involved?

I was on roll at the same school, I had a special educational needs and disabilities (SEND) officer, and the Education Welfare service (EWS) was still involved. I was registered at the same GP and I was discussed at their practice meeting. I had the same keyworker from the children and young people service (CNTW), a CNTW manager heard about me, and my brother's CNTW keyworker heard and shared information about me. I was still known to the dietician service. Workers in the multi-agency safeguarding hub (MASH) read information about me, then the police, children's social care (CSC) and children's safeguarding health spoke about me. A CSC advanced practitioner was involved with me and their manager and senior manager read information about me. A social care manager and call handler heard about me, and another CSC advanced practitioner read information and spoke about me.

What happened and why or what was possible and how?

My class teacher and step mum started weekly telephone calls again in September 2021 after the summer holidays. The focus was my CNTW appointments and if I attended, rather than my education.

I was taken to one of the two appointments offered by CNTW. My step mum explained I was self-isolating for the other. My keyworker was worried that they did not have consistent contact with me to complete work that would support me. They were then off work, so the information was not shared.

My GP practice discussed our family at their practice meeting on 16 September 2021. They said they had not received an updated letter about me from CNTW for a little while. The lead reviewer identified it was unclear how the GP followed this up. CNTW said they expect an update is shared after at each planned review. See development 5.

There was an emergency EHCP review meeting for me on 30 September 2021 because during the previous 12 months I was on roll with school 3 there had been no progress to support me back into any form of education. This was because there was no updated information about me to review. Usually a pupil's feedback form would be sent to parents/carers with the meeting invitation letter. At the time I found it difficult to speak about school, so school 3 did not share the feedback form. They wanted to reduce any distress it may have caused me based on information shared by CNTW and my step mum at the time. See development 9.

I was not at my review. My step mum, school 3, the EWS and SEND officer were at the meeting but my CNTW keyworker was still off work and the service could not send a report. School 3 felt they could not meet my educational needs at the time, and my step mum, school 3, the EWS and SEND officer decided I needed regular and detailed input from CNTW to address my "extremely complex needs". So it was agreed a new education placement was needed so I could feel safe and listened to.

My EHCP would usually have been updated based on observations and assessments completed in school but I had not attended school 3 and the teachers last saw me in September 2020. They continued to be worried this would distress me, because that is what the CNTW letter in December 2020 said. The lead reviewer said this decision had not been reviewed so it was still unclear if this was the best decision for me.

School 3 identified it was their responsibility to update my EHCP. It had been partially updated with information from my step mum in September 2021, but because I found it difficult to work with school 3, school 3 identified it could have been an opportunity to update my EHCP by another agency. For example, if there was representation for health and social care at all review meetings or if there was a multi-agency plan in place that was being reviewed, the available information from multi-agency meetings could have been used. This would then have been the responsibility of everybody working with me.

There were some missed telephone calls to my step mum from school 3 in October 2021, but they kept trying to make contact either by telephone or emails.

Since April 2021 school 3 had sent 10 emails to CNTW to seek an update on how I was doing which were not responded to. School 3 was worried they were unable to review if I was ready to return to any form of education, so they escalated their concerns to a CNTW manager who offered to provide support where possible. The lead reviewer said it was unclear what actions then took place. See development 10. They identified if I had a multi-agency plan, supporting me to access a form of education would have been regularly discussed at my review meetings. This could have included a discussion about the decision that I would not engage with other workers or that visits would cause me distress.

My brother went to live with our paternal grandma this month because my parents said they struggled with his behaviour and attitude, which caused lots of arguments in our house. My parents told his CNTW worker, and they explained the information had to be shared with CSC because of the possible risks to me (and my paternal half-sister). My step mum agreed. The lead reviewer said it was not clear what was different on this occasion, but my step mum told CNTW the referral made her feel extremely nervous because of past experiences with CSC. They explained this could have been an indication of my step mum's contained shame and the thoughts she had about herself and how she felt she had been treated by agencies in the past.

On 20 October 2021 CNTW made a telephone referral to CSC. The lead reviewer said the agreed multi-agency referral form (MARF) could have been considered, see developments 3d and 11, however, the

referral details clearly identified what the concerning behaviours were and the impact on the whole family, some of my brother's lived experiences, the reason for CNTW involvement, and his response to the concerns.

A CSC triage manager reviewed and summarised the referral information as concerns and impact in their management oversight in my CSC record. They recorded the threshold for a multi-agency safeguarding hub (MASH) episode[43] was met to create a safety plan and risk assessment for my brother. My learning event said this decision could have considered me (and my paternal half-sister), but I was included in the MASH episode so this could have been a recording issue.

On the same day the CSC MASH manager identified the police, safeguarding health, children's social care (family help and statutory social work), mental health services, education, adult social care, and housing as agencies that held relevant information to consider our safety. They were asked to consider the referral reason and return relevant information, including a recommendation to increase our safety and a scaling[44] of the situation.

There was no response from education due to adoption leave in the SST and no capacity to cover at the time. Positively, this had been communicated in advance so the CSC MASH manager tried to contact my brother's school directly, although information was not received within the timescale of the MASH episode. See development 12.

The CSC MASH manager reviewed the agency responses and decided a strategy discussion[45] was needed. They recorded that this was because information from my brother's school had not been received and the nature of the referral concerns. See development 13**.**

My learning event identified my school was not contacted as part of the MASH episode, although other agencies had shared information about me in their information return. The lead reviewer identified this could have been an opportunity to identify a possible link between the concerns about my brother's behaviours and attitude, and my behaviour or how I might have felt at the time.

The strategy discussion took place over the telephone on 21 October 2021 between the police, safeguarding health and the CSC MASH manager. There was no invitation for education. Within the strategy record it was recorded "other agencies were not invited because it was to decide about threshold". The lead reviewer said this could have been clearer because it was different to the decision the CSC MASH manager recorded in my MASH episode.

The strategy discussion focused on my brother, but it should have considered all the children in our house. The recommendation was a child protection enquiry (s47)[46] and child and family assessment (C+F)[47] for all the children in our house, and to include information from education. A CSC manager identified the focus for the assessment was my brother, to develop a family network and to consider if he needed any specialist support. My learning event said this could also have considered if I (or my paternal half-sister) needed any support because of the circumstances, however the assessment included us both so it could have been a recording issue.

[43] MASH is a function within CSC front door arrangement, that gathers information to make an assessment when there are concerns that a child has or is likely to suffer significant harm. It has representation from family help, statutory social care, police, safeguarding health, education, adult social care, mental health services and virtual links with housing, probation and domestic abuse agencies.
[44] Scaling is used in the MASH as part of a judgement about the impact of a situation on a child/young person. This is between 0-10, where 10 is there are no issues and there is confidence the child/young person is safe and well and 0 is there is evidence of serious impact on the child/young person.
[45] When information gathered during a referral or an assessment means the social worker suspects that the child is suffering or likely to suffer significant harm, a strategy discussion/meeting should be held to decide whether to initiate enquiries under section 47 of the Children Act 1989.
[46] This is completed under section 47 of the Children Act 1989 to assess if there is the risk of significant harm to a child(ren).
[47] This is completed under section 17 of the Children Act 1989 to identify the needs of the child and ensures the family are given the appropriate support to safeguard and promote the child's welfare.

If education had been involved in my MASH episode or the strategy discussion, my learning event said this could have been an opportunity to think about all my developmental needs and vulnerabilities especially as a child missing from education. My learning event did not think this information would have changed the decision making in the strategy discussion, but it would have given more focus to my s47 and C+F assessment. The 0-19 health service also identified a referral for my paternal half-sister could have been made into their 5-19 mental health and resilience pillar. This could have offered more support to my family, as well as an opportunity to understand everyone's needs from a different perspective.

An advanced practitioner (AP)[48] in the CSC assessment team was allocated my s47 and C+F assessment on 22 October 2021. They completed one home visit on 28 October 2021, but the lead reviewer said the practice handbook identified a visit should be completed within five working days of a referral or sooner. This was the first time a worker had been inside my house during my review period. I was spoken to with my paternal half-sister. The AP recorded I did not like how my brother behaved and he was very nasty to our parents. I explained I was really upset by some of the things he had said to me which made me feel like I did not want to see him anymore and I wanted him to stay with our grandma.

The AP recorded "positive relationships in our house, with interactions that were loving and with lots of affection". They said the children in my family "presented as very happy and comfortable" around my parents'. The AP also spoke to my step mum who said I was a quiet girl, who really enjoyed baking, especially cakes, and I had thought about being a baker in the future. The lead reviewer noted these were the first positive comments recorded about me.

Historical information was considered as part of my assessments. The AP recorded in my s47 the impact of my early year experiences led to me "struggling with emotions" but there was no link to my situation at the time of the assessment. They wrote any immediate risk was reduced by my brother not being in the family home. The recommendation was my assessment continued to consider whether I needed emotional support and if it was, it could be managed with a Child in Need (CiN) plan.

A CSC assessment manager completed a day four discussion with the AP, as expected, on 28 October 2021. Usually, the day four discussion considers progress on actions from a strategy meeting/discussion to decide about what level of support a family needs. The day four discussion was reviewed by the senior manager the same day, as expected. The senior manager acknowledged my emotional and psychological health and agreed an initial child protection conference (ICPC) was not needed. My s47 was authorised by a CSC manager on 4 November 2021.

The AP wrote in my assessment I was not attending school, but this was managed with an EHCP and that the worries about my mental health were managed by CNTW. However, the lead reviewer said the assessment did not explain what my educational or mental health needs were at the time, or how they were being managed by an EHCP or CNTW involvement, so it was unclear how this decision had been made.

Based on what was recorded in my CSC record, my learning event thought the AP could have spoken to me alone to hear and explore my experiences in more depth. To do this they might have considered different ways to gather this information, see development 14, or if there were difficulties in doing this the reason could have been recorded. It is unlikely detailed information would have been gathered in the one visit completed. However, at my learning event the CSC manager said the AP was able to provide a lot of detail that was not recorded, for example the length of time they spent speaking to people in my family and the positive interactions they observed.

The lead reviewer said it was not clear from my C+F assessment who the AP had spoken with to reach their recommendation because information was provided by my step mum or based on historical information in my CSC record or from my MASH episode. They explained this may have influenced the decision making at

[48] Advanced practitioners are experienced social workers.

the time, rather than my developmental needs. CSC managers identified factors at the time that may have made this more difficult, like time constraints, workloads and the narrow focus of my assessment.

The AP recommended I did not need any further support from CSC. A CSC manager agreed based on the information recorded and my involvement with CSC ended on 22 December 2021, although several actions from the strategy discussion had not been completed. The CSC manager recorded there were no safeguarding concerns for me, because there was a safety plan in place with my brother living outside of the family home. To be more confident about this decision making, the C+F assessment could have evidenced how my plan had been tested to know it would work if the concerns happened again or if my brother returned to our home, like the CSC practice handbook identifies.

My learning event said the C+F assessment and its authorisation could have benefited from enquiries into wider issues about my development, rather than the concerns identified within the original referral that only focused on my brother. The C+F assessment could have been an opportunity to gain a better understanding of my emotional, educational, physical health and social needs by exploring these issues with me and to seek relevant information from agencies that were involved with me and my family at the time.

The lead reviewer also identified information shared by agencies within a MASH episode should not be relied upon to complete C+F assessments; social workers should make enquiries with relevant agencies or workers that know a child as part of a child's s47 and or a C+F assessment. This is an identified area of development in the service.

Workers felt different questions from the AP or their manager could have highlighted the concerns about me at the time. For example, information available from CNTW, school 3 and the EWS would have challenged the assumption that my mental health needs were being managed and an EHCP was managing concerns about me not attending school. Available information would have prompted further enquiries within the C+F assessment before it was finalised and identified ongoing involvement was required. For example, it was known that I was discharged by CNTW in December 2021 because I was taken to 10 of the 24 appointments offered between January and December 2021 and my last EHCP review was an emergency review because school 3 and the EWS had been unable to make progress over 12 months to support me back into any form of education. See developments 15, 16 and 17.

The CSC authorising manager reflected on events and said there was reference to my school in my C+F assessment which made them think school 3 had been spoken to. They identified that relevant workers and agencies should be spoken to as part of any assessment, as well as the child, parents and carers and network members. This is an area identified for development in the service. See development 18.

In their review CNTW identified that safeguarding concerns were not escalated as expected and referrals were not made when there were concerns about me not being taken to appointments. Using the supports within CNTW now or considering the thresholds of need document would support future decision making in this situation. See developments 3a-c and 5.

My learning review identified this was the second time school 3 was not aware of important information about me, or that a s47 and C+F assessment had been completed. People said this information should have helped school 3 and the EWS reconsider their approach or conversations with my family and been an opportunity for them to share important information they held as part of my CSC assessments.

Usually, if a child remains open to CSC, there is a face-to-face meeting with the family and the relevant agencies where the outcome of the assessment is shared and a plan for the child is agreed. CSC managers acknowledged this process is less established when involvement with a child or family ends following an assessment. Time and workloads were identified factors in social workers struggling to always share assessments with families and agencies, although there is an administration process that could support this. A clearer process to share an assessment or its outcome is an area identified for development in the service.

My step mum contacted the GP on 6 January 2022 requesting supplement drinks for me. The GP recorded I was known to mental health services for disordered eating and that I had had periods of better eating patterns. My step mum reported I needed to be stopped from vomiting and my weight was approximately 21kg/3 stone 3 pounds. The lead reviewer said this was one pound heavier than when I was taken to hospital in November 2020.

The GP reviewed my CNTW discharge letter and asked my step mum why I had not been taken to my appointments. She said this had been agreed with my CNTW keyworker, so I was not "stressed out". It was not clear if this was checked with my keyworker. The GP asked permission to speak to other agencies, as expected. They also explored with my step mum a referral to CSC, to access additional support.

It was not clear how this was explained but my step mum said she did not need extra support. My step mum had previously explained she felt blamed, so the lead reviewer explained she may have withdrawn from the offer of support from CSC to limit her feeling again to avoid uncontained shame. This could have been an opportunity to explore the worries my step mum had expressed, reduce her concerns about CSC involvement or to identified suitable support for me and my family, based on our needs at the time. See development 3b.

The GP was proactive and requested to speak to me on the telephone to gather my views. I told them I was "a bit iffy" with food but I named lots of food I liked. They asked me to attend the practice so I could be weighed and seen. I said I did not want to, and I ended the conversation. My step mum also declined stating it could cause me to not eat because it would increase my anxiety. The lead reviewer said my step mum and I could have withdrawn from the GPs requests to protect ourselves from experiencing shame if we thought concerns about my growth and development would be identified.

I do not know if the GP considered my capacity to make decisions and it was not clear what the GP did next or what the arrangements were for my weight and height to be measured again. The lead reviewer identified communication on the telephone may have limited the GP's opportunity to fully assess my developmental needs. To avoid being too reliant on the information that was being reported by my step mum, the GP could have considered alternative ways to see me to achieve an accurate measure of my height and weight. For example, a video call, a home visit or to contact another agency that was working with me. My capacity to make decisions, unwise or not, could also have been considered.

My step mum told my class teacher she had spoken to CNTW about my discharge and that it had been an error. At the same time, the GP tried to speak to CNTW on 7 and 11 January 2022. They also spoke to their safeguarding lead for advice and support, as expected, but I am not sure what the outcome of this was. The GP clearly recorded their actions including the outstanding tasks with a reasonable timescale. On 20 January 2022 a CNTW manager contacted the GP by telephone and said my CNTW keyworker would support me again when they returned to work.

There was no record of a discussion about a plan for my height and weight in either my GP or CNTW records.

In March 2022 my mum received a photograph of me from a friend. She told the lead reviewer she knew she had to report her concerns because she was worried about my appearance. She wanted a worker to visit me, to check I was ok.

On 7 March 2022 my mum contacted a CSC locality manager[49] who was working with my brother at the time. Within the conversation my mum explained she had received a photograph and was concerned because I looked "very skinny and small". She shared the photograph via WhatsApp for the manager to see and to show why she was worried. My mum acknowledged she had not seen me for six years but was unable to

[49] When an ongoing need is identified following an assessment, a family transfer to a CSC locality team.

speak with my dad about her concerns. Her concerns were acknowledged by the manager and my mum was told to make a referral to OneCall[50] if she was concerned, which she did.

A CSC triage manager reviewed the information and recorded there was no role identified for CSC because my mum had not seen me in person and there were no other concerns raised at the time. However, the lead reviewer highlighted I was not attending school and I had not been seen by school 3 since October 2020.

On 8 March 2022 the CSC locality manager confirmed with the CSC triage function they had seen the photograph of me. They explained I appeared as a much younger child, I was very slim, but due to my clothing in the photograph it was difficult to make a full assessment. The photograph was not recorded on my CSC record. The information was reviewed by a CSC triage AP on the same day as expected and my mum was contacted by telephone. She reconfirmed her concerns about my weight and me not attending school.

The CSC triage AP considered the historical information in my CSC record and recommended no further action was needed. The recorded rationale was a C+F assessment had been finalised in December 2021 which said I was not attending school, so this was not new information, it identified no concerns about my care at home and I had been seen and spoken to.

My mum told the lead reviewer she did not feel her concerns were listened to and that she was "passed from pillar to post" being asked to speak to lots of people and to repeat her concerns. She said she felt like "I was in the way and creating work for people". She wondered if she was treated this way because she had shared concerns about me before or because she thought workers had blamed her for being 'bad' based on events when I was younger.

My mum said she did not know what the AP did or their decision, so she was left wondering what had been done and if I was safe. This made her feel upset and annoyed that she had not been taken seriously. My mum explained she hoped I would understand one day she was trying to help because she was worried about me and she thought contacting CSC was the "right thing" to do.

The lead reviewer said this explained my mum's contained shame; it is a description of how she thought agencies viewed her as 'bad' so she was not taken seriously or listened to and how this made her feel. Her feeling of blame could have been possible if workers had used the shame containment strategy of being conscientious.

At my learning event the CSC triage manager said there is now a greater awareness and understanding of children missing from/out on education and school as a protective factor for children. See development 19. The information from my mum could have been an opportunity for a better analysis of my developmental needs and my situation at the time. See development 20. The photograph could have been recorded on my CSC record and reviewed by the people making important decisions about me, or with consent the CSC triage AP could have spoken to my dad, my school, the GP or CNTW.

My learning event identified if different questions were asked at the time, it may have been established that I did not have a plan or a plan that was working. For example, had my weight decreased since I was seen in October 2021? What was the detail of my plan to address my physical health needs or how were my appointments progressing? These questions may have challenged the assumption my weight was being reviewed and that the previous CSC decision making in December 2021 was appropriate.

A difficulty identified by the CSC triage manager was the different perspectives of what being underweight meant. They reflected that it would have been helpful to understand my actual weight or to understand this using a weight chart to appreciate how underweight I was. They said this is now something triage social

[50] The point of contact for all adult social care, children's services and community health enquiries in Northumberland.

workers consider when there are concerns a child is underweight or overweight; information is put into context with actual weights and the use of weight charts.

School 3 and CNTW were not aware my mum had shared these concerns about me. My learning event felt this could have informed their approach or conversation with my family or it could have been a prompt to start a multi-agency assessment and co-ordinated plan of support for me.

Reflection

People were asked to think about the systems, processes and procedures in place during period three, to identify what could be used or developed in the future.

The full-time education representation in MASH which can share information with education provisions.

The decision-making to and within the MASH which can bring agencies together to share the decision making responsibility.

Being confident to share information with agencies, so children and young people are safe and well and systems support this.

Having more representation at strategy discussions/meetings so all the developmental needs of a child are considered at the right time.

What has changed since?

Development 9	Since September 2021 the NCASP has offered a quarterly caring about adversity, resilience, and empowerment (CARE) multi-agency training course. The sessions are designed to build awareness of adversity, trauma, and approaches to building resilience and protective factors when trauma is experienced to work. Evaluation feedback about the course and other trauma informed courses has been positive.[51] There is an aspiration to build awareness, confidence and skills amongst workers to make trauma informed practice part of everyday practice. The trauma-informed principles of creating safety, trust, choice, and empowerment through collaboration, are now threaded throughout the multi-agency learning programme. Workers and managers are supported to consider these principles and their use of language to identify what trauma-informed means when they are working with children and families.
Development 10	School 3 has now introduced a 'safeguarding check system' which identifies when follow up actions are required. This could be after an interaction with a family member or another worker. This ensures follow up actions are completed within a set timescale. This system is accessed by the DSLs so there is sufficient cover to monitor and respond. This system has helped school 3 feel more prepared when working with other agencies, to challenge actions or responses, and to escalate concerns when required, so responses are received and actions are achieved.
Development 11	CSC launched its multi-agency referral form (MARF) in April 2021. The objective was to align referrals into the service with its chosen practice model. It was also to share accountability to identify strengths and safety, worries about a child and actions required to increase their safety or wellbeing. The MARF was then aligned with the updated NCASP Thresholds of Need document in December 2022. The quality of referrals into CSC remains variable, however the MARF is a way to streamline information in the same form. Its impact needs to be reviewed by CSC First Contact (see development 18).
Development 12	There has been a full-time education presence in the MASH since January 2022. The SST feel this works well because information from a child's education provision contributes to a

[51] Evaluation feedback is requested 3-6 months after the course to understand the difference that has been made to the work completed with children and their families.

	response within a MASH episode and they are made aware of significant harm concerns when a referral has been made by another agency. The SST speak to education provisions directly to gather appropriate information, which is supported by their knowledge of how they work with families, and they have access to the relevant education recording systems. CSC recognised education provisions usually see children and see the role of the DSL as vital to sharing information as well as progressing agreed actions. The Virtual School (VS) completed an initial review of this alignment in August 2023, however the Virtual School Headteacher (VSH) has requested this to be repeated in more depth, recognising the importance of collaboration between social care and DSL colleagues, including the role of the SST.
Development 13	The information sharing process within the MASH was developed in April 2023 so agencies can now see all the information that is returned as part of an active MASH episode. This was the result of discussions within the MASH strategic group. This development has helped to inform agency recommendations, scaling and supports CSC social workers to analyse information. CSC explained the biggest difference it has made is helping agencies to prepare for a strategy meeting/discussion, which has improved multi-agency decision making, rather than it being the responsibility of the CSC MASH manager. This is more aligned to the intended purpose of the MASH. Its impact needs to be evaluated over time by the MASH strategic group.
Development 14	CSC introduced the talking toolkits in 2019. The purpose is to establish expectations for interaction and interventions with children; to provide practical resources to support solution focused and trauma informed work; and to strengthen evidence of lived experiences being elicited and to support how this information is recorded. The value and impact of the toolkit has been recognised within CSC, and nationally in 2023. The focus now needs to be consistency of use. This needs to be understood further by CSC.
Development 15	When the CSC First Contact assessment team end their involvement with a child or a family, managers have started to seek evidence of scaling and a rationale from family members and the relevant workers involved at the time. This was introduced to support stronger decision making that is not reliant only on the views of a social worker. Managers in the service said they felt confident to return assessments that did not include this information and it is practice that the service is trying to embed. Its impact needs to be evaluated over time through the quality assurance framework (see development 18).
Development 16	As part of ongoing developments within the SEND service awareness workshops are now being offered across CSC teams. The objective is to provide an understanding of SEND, SEND services, the expectations of schools and education settings including the responsibility to assess, plan and review a child with SEND needs. This started in August 2023 within family help teams, and will eventually include all services within the children, young people and families directorate. The impact needs to be evaluated over time (see development 18).
Development 17	CSC launched its practice framework and expectations handbook in March 2021. This was then updated in July 2022. This sets out what is expected of social care practitioners, managers and leaders and what good practice should look like. CSC leaders acknowledged the handbook has made some difference to practice, although this is mainly with new workers, but the hope is that it will provide a more consistent approach to practice. CSC know that this is an area of development.
Development 18	CSC reviewed and launched its quality of practice framework in May 2023. This outlines its approach to understanding how well its services are doing, by evaluating their impact and learning from the findings. CSC leaders said progress is being made to embed the principles across all services. Their hope is for the implementation and understanding of the framework to be evident across the whole workforce. CSC knows that this is an area of development to understand the difference its services make to children and families.

Development 19	Support from the Virtual School (VS)[52] to children's social workers has had a high profile since June 2022 through its new duty.[53] This has included providing advice and guidance and making training and resources available. The duty was initially addressed through a 12-month project plan, which demonstrated a commitment to change that integrated the work of social care and education using a child centred approach. The structures are now in place to evaluate the impact through the quality of practice framework (see development 18).
Development 20	Following the national review publication in 2022[54] the CSC First Contact service explored the response to referrals and worries from family and friends during a team away day in November 2022 and as part of group reflections. CSC managers indicated this was positive to supporting workers to consider historical information, to be more curious about information that is shared, to think about how information can be triangulated with other sources and to appreciate that family, friends and network members often know children and their families the best.

Period four: 1 May 2022 to 31 January 2023. I was between 12 and 13 years old.
Who was involved?

I was registered at the same GP. I had the same keyworker from the children and young people service (CNTW) who was speaking to other people in CNTW about me. I was on roll at the same school, I had a special educational needs and disabilities (SEND) officer, and the Education Welfare service (EWS) was still involved. Police officers met me. Another police officer and people in children's social care (CSC) read information and spoke about me. Social workers in the emergency duty team (EDT) read information and spoke about me. The information advice and support service (IASS), and a charity were also speaking to my parents about me.

What happened and why or what was possible and how?

My class teacher or a teaching assistant continued weekly telephone calls to my step mum throughout May 2022. My step mum said she was struggling, and she did not feel CNTW was making any progress with me. My step mum also said she had spoken to the SEND information advice and support service (IASS), about a personal budget to access a home tutor for me.

The SEND officer at the time told my parents they could access support from the IASS to see if a personal budget would be helpful. If it was agreed this would mean an education package could be put in place for me that reflected what I needed. This would have been an opportunity for my parents to identify education provisions and send the information and costs to the local authority to consider.

I was taken to the two appointments offered by CNTW this month. My CNTW keyworker recorded observations of "low weight and self-neglect". Positively, they spoke to their colleagues in the eating disorder intensive care team (EDICT) for advice as expected. EDICT asked my keyworker to monitor my physical health so that my needs and risks could be identified and reviewed. The lead reviewer said this could have also been an opportunity to contact the consultant paediatrician at hospital 2 for support like they offered or the dietician service.

[52] The VS has supported raising the profile of education in safeguarding arrangements for children in Northumberland. This has been reflected in representation of education in the 'front door' arrangement since 2017 providing advice and sharing information about safeguarding in schools, with case level involvement where appropriate. A Schools' Safeguarding Team (SST) delivers services through the VS to DSLs and the safeguarding partnership. The Virtual School Headteacher (VSH) has chaired the NCASP Safer in Education Group since May 2023, which drives the improvement of safeguarding standards in schools, including an education safeguarding training programme.

[53] From September 2021 the role of the VSH was extended to include all children who have or have had a social worker including children in need (CiN), and those subject to child protection plans (CPP).

[54] CSPRP (2022).

On 24 May 2022 my maternal aunt reported concerns to the police when she saw me with my step mum in the community the previous week. She told the lead reviewer she felt "devastated" when she saw me because she remembered me being much healthier when she saw me several years before. My aunt explained there was a delay in her contacting the police because she was concerned there would be consequences for my mum, like referrals to CSC because this had happened before, or people thinking she was being malicious.

I had not seen my aunt for six years but she told the police call handler I looked like a seven-year-old child, malnourished, in a pushchair and unable to walk due to muscle waste. My aunt told the lead reviewer the caller handler was "amazing" because they listened to her worries and asked what she wanted to happen; she confirmed she wanted me to be visited to make sure I was ok.

The police used the Thrive model,[55] as expected, when they received the telephone call. Two police officers from the Neighbourhood Policing Team (NPT) attended our house within 50 minutes to complete a welfare visit. They are trained to respond to a concern 'through the eyes of a child' and to establish if a child is affected by an incident and to ensure they are safe and well. A parent or appropriate adult does not need to be present for a police officer to speak to a child.

Through a discussion with my brother, the police officers understood I was out with our dad and that I was not in school due to concerns about my mental health. They tried to contact my dad on the telephone but there was no answer. My dad returned the call and the police officers returned to our house. They explained the purpose of their visit was to check I was ok because concerns had been shared about me.

My dad reported that he had expected a referral due to a difficult relationship with maternal family members. The police officers said my parents "engaged well and appeared to be open and honest about me". A police officer recorded I had complex mental health issues including anorexia. The lead reviewer said it was unclear if these were the words my dad used or the police officer's understanding. My dad told them I was abused when I was younger which was why I was in his full-time care. He explained I was working with CNTW and a psychiatrist, who I saw regularly.

The police officers said I looked unwell and I had the appearance of being much younger than my age, but they understood this was due to my low weight and small height. They spent time talking to me and I told them I would like to return to school in the future. The police officers described me as "pleasant, engaging and in good spirits". They said the house was also "clean and tidy". The police officers explained they were not concerned about me from the conversations they had and felt I was appropriately supported by my family and medical workers.

It was recognised at my learning event whilst the police officers had spoken to my dad and I, they did not have a full understanding of the support that was being provided by CNTW. There may have been an assumption that because a specialist service was involved support was in place. Questions could have been asked like what the support CNTW and the psychiatrist were offering to understand this further or CNTW could have been contacted directly.

The police officers provided an update to my maternal aunt and said she was unhappy and that she said she would make a complaint. My aunt told the lead reviewer she felt angry because the police officer spoke to her "harshly" on the telephone and the information they shared did not reduce her concerns. She said she was told I was "fine" and there were "no concerns." She felt they could have been more understanding that she was upset and concerned about me or they could have considered a face-to-face discussion. My aunt explained she was left wondering what had happened during the visit, if I had been seen and if I was really "fine".

[55] The THRIVE (threat, harm, risk, investigation, vulnerability and engagement) model is used by the police to assess the most appropriate response to a call for service. It allows a judgement to be made about risk and places the individuals needs at the centre of the decision.

The lead reviewer identified it could have been more reassuring to my aunt if details about what had happened during the visit, for example that I had been seen and spoken to and what was discussed could have been shared. It is not clear why the officer did not share more information. The lead reviewer explained workers containment strategies can include conscientiousness which places them in a position of rarely being challenged so they are more critical of others and prone to blaming. This can mean they are more closed and do not share what they have done with others to avoid criticism, but this can lead to things being missed or issues not being addressed.

A summary of the officer's enquiries were recorded on a CCN which was shared with CSC, as expected. This was discussed at the CCN meeting on 25 May 2022. It was decided there was no role identified for CSC because support from CNTW was already in place for me. However, at the time I had not always been taken to my appointments with CNTW, so the support CNTW could have offered was not consistent and there was no oversight of my physical health at the time. The police officers and CSC did not know that.

My learning event identified if I was so unwell that I needed a pushchair, this showed impact on my health and development. If workers felt confident to question or make enquiries about my physical health, this might have prompted a health review for me. This could have involved a discussion with the GP to gather a medical opinion about my height and weight. The GP may have then identified that I needed more specialist support, like the involvement of a dietician or the consultant paediatrician at hospital 2. Or information could have been gathered from CNTW which may have identified the challenges with me being taken to appointments to access consistent support.

This was the third time school 3 was not aware of important information about me. The lead reviewer said this could have been an opportunity where a process supported information seeking and sharing between agencies and services. If this happened school 3 and the EWS could have reconsidered their approach or conversations with my family or it could have been a prompt to review the CNTW decision not to visit me at home made in December 2020. It could also have been an opportunity for school 3 and the EWS to share their worries about me being missing from education, not seeing me since October 2020 and why, and sometimes not being able to speak to my parents or CNTW to understand how I was doing at home. The focus of meetings between CNTW and education had always been on my physical and mental health needs, to understand how my learning and social needs could be met too.

My learning event identified positive arrangements where information is shared with education provisions as part of Operation Encompass and Operation Endeavour, so it was considered if this could be replicated for all CCNs. It was also identified agencies are often asked to provide information as part of a CSC referral triage, strategy discussions/meetings, MASH episodes etc. but they are not always informed of the concern or the outcome. It was recognised at my learning event that this process could be strengthened, by including the reason why information was requested. This would provide a sense of urgency and increase the relevance of information that is returned by agencies, to inform the decisions made about a child's safety or wellbeing. This is an important area of development that needs to be addressed.

There were some telephone calls between my class teacher and step mum in June 2022; some were missed and not returned.

There was a meeting on 22 July 2022 between my class teacher, CNTW, my step mum and a new SEND officer. It was not clear what type of meeting this was but I was not there. School 3 said it could not meet my educational needs and a personal budget for me was discussed. School 3 recorded that CNTW said I was not emotionally or physically ready to access any form of education. On the advice of a specialist service, a plan for me to access a form of education was postponed because my physical and mental health needs were identified as a priority at that time. I was not spoken to about it.

I was taken to my appointments with CNTW in July and August 2022. In July 2022 I told my keyworker I did not want to go outside or meet people because I was too self-conscious about my height and weight. Progress

with my weight gain was discussed at my appointments during August 2022. My step mum reported my weight had increased to 17.1kg/2 stone 7 pounds. However, the lead reviewer said this was a 4kg/6 pounds reduction since my last recorded weight in January 2022 and lower than my weight when I went to hospital in November 2020. My step mum said I was "fighting" to get well, but I "sometimes sabotaged" the progress I made.

I shared my fear of returning to hospital with my CNTW keyworker. Although my effort to gain weight was acknowledged, my keyworker observed I was "concerningly underweight". My step mum was asked to take me to my GP for my height and weight to be measured. It was unclear if this happened. The lead reviewer explained this may have been a withdrawal shame containment strategy to limit our exposure to uncontained shame. It was not clear what happened to follow this up.

My learning event said this could have been an opportunity to explore what my step mum reported, for example asking more questions to understand why my weight was not improving and what I was eating. This may have helped to understand the information that was being reported and if there were any patterns. The lead reviewer thought it should have been an opportunity to speak with my GP or the dietician service too and it would have also been a point where the consultant paediatrician at hospital 2 could have been contacted.

On 17 September 2022 the headteacher from school 1 contacted the emergency duty team (EDT)[56] by telephone with concerns from another teacher. They followed up the telephone call with an email although the lead reviewer said multi-agency referral form (MARF) could have been used, see developments 3d and 11.

The referrer was concerned I had been seen in the community with my step mum in a pushchair. They said I appeared malnourished and I was not attending school. The referrer said my step mum had stood in front of me when the teacher made enquiries about how I was doing, although I had greeted the teacher and confirmed I had recognised them when they were on the other side of the street.

EDT recorded the referrers concerns in my CSC record and their decision not to take further action. They said I was not in immediate danger/harm to warrant urgent investigation that day. The system to share information between EDT and CSC First Contact triage worked well. An alert was sent to review the information the next working day.

The CSC triage manager reviewed the information on 20 September 2022. The lead reviewer said their oversight was clear, appropriate and proportionate. It reflected an awareness of my physical health because a CSC triage social worker was asked to contact my dad to understand how I was, who was supporting me, when I was last seen by a medical worker, and to establish consent to speak to other agencies to understand my attendance at medical appointments.

The CSC triage social worker tried to contact my dad on the telephone but there was no answer and no facility to leave a message. So they contacted my step mum who said she had expected a referral. She explained that my body language on the day indicated I did not want to speak to the teacher so she did not want to stop and talk. The CSC triage social worker did not challenged this, even though the referrer said I greeted the teacher positively and engaged in conversation when I was spoken to.

They spoke about my physical health. My step mum said I was not well and that I was seen regularly by CNTW. She explained that my dad had given consent for her to manage issues related to me, and that she had taken me to hospital before and she would do again if needed. My step mum said I used to be seen at

[56] EDT is a service that provides an emergency out of hours social work response to children and adults, and an out of hours approved mental health practitioner (AMHP) service when mental health concerns are identified. Tasks are then passed to daytime services if a further action is identified.

hospital 2 but this was too distressing so my height and weight were now recorded by CNTW. She was unsure when my height and weight had last been measured by the service. However, the lead reviewer identified from the letter hospital 2 wrote in February 2021 I was not seen at hospital 2 because my care had transferred to CNTW. There was no written record of hospital appointments being too distressing for me but the CSC triage social worker would not have known that.

They then spoke about my education. My step mum said she was liaising with a SEND officer and the EWS to address me not accessing any form of education. She explained there was also support in place from a charity to complete a personal budget application, and that I attended weekly support sessions with my paternal half-sister. The lead reviewer was aware an application was not made, but the CSC triage social worker would not have known that.

My step mum became upset and said she felt workers had questioned if I was being cared for. She said my parents were trying their best to help me. The lead reviewer explained this could have been an indicator of my step mum's contained shame; her comment offered further understanding of how she thought agencies viewed her as my carer. My learning event wondered if this deflected attention away from my needs. However, if there was a clear plan for me at the time, workers thought it would have been easier for the CSC triage social worker to identify if my parents were doing all the things that had been asked of them in a meaningful way and if it was working to keep me safe and well.

The CSC triage social worker explained if my dad wanted to contact CSC to discuss the referral further then they would speak to him. There was no record of him making contact or of the CSC triage social worker trying to contact him again.

It was not possible to speak to CNTW on the day, so positively when the CSC triage manager reviewed the information they requested a follow up in one week. This was to allow a response from CNTW to understand the support in place for me at the time. A telephone message was left for my keyworker, and an email was sent to the CNTW duty system. An alert[57] was also added to the CSC triage diary, as expected.

CNTW contacted CSC on 26 September 2022. They confirmed I did not have a diagnosed eating disorder and that weekly appointments were offered. They acknowledged I was not being weighed regularly, but said they were confident my parents monitored what I ate and would contact CNTW for advice and guidance if required.

CSC considered this update and the previous information gathered on 20 September 2020. The CSC manager decided no further action was needed, because CNTW confirmed they were supporting me. The lead reviewer said this could have been an opportunity for CSC to consider speaking to school 3 or the EWS to understand more about why I was not accessing any form of education which was another element of the referrer's concern.

The lead reviewer identified this was the third referral within four months with concerns about my physical health. If I was so unwell and I required the use of a pushchair, this showed impact on my health and development. My learning event discussed that an assumption had been made that there was a plan in place for me that was working because a specialist service was involved. This should have been an opportunity to ask specific questions about the detail of my support plan to understand how it was working. This may have identified that I needed a multi-agency plan that recorded the issues about my growth and development, what the tasks would be, who would be involved and when they would be completed.

[57] This is a process when follow up information is required to complete the decision-making process. Example may include challenges in contacting parents or carers, or a worker is on leave. An alert is added to the triage team diary with a timescale; the triage team check the diary daily for alerts and complete the necessary actions. The outcome is recorded on the child's record.

The lead reviewer knows from the CNTW review that I did not always have a formal care plan and my risk assessment was not always updated. At the time my weight was approximately 15kg/2 stone 3 pounds. They said this was considerably less that my weight when I went to hospital in November 2020. So the discussion with CSC could have been an opportunity for CNTW to identify a safeguarding concern based on the information shared in the referral about my weight if a link had been made about my physical, emotional and mental health. See development 5.

From their review, CNTW identified five related areas of learning. First, the need for my weight to be regularly monitored and reviewed. Second, the need to ask questions that could have highlighted escalating levels of risk associated with my low weight. Third, the need to have knowledge about what was a low weight for a child or the necessary steps to escalate concerns. Fourth, the need to consider or assess capacity to make decisions about a child's care and treatment, unwise or not, when there is a concern, like when I did not want my height and weight to be measured. Finally, the need to communicate with physical health services or workers for advice or support. See development 5.

The lead reviewer said this was the fourth time school 3 was not aware of information about me. This detail could have helped school 3 to consider their approach or conversations with my family or an opportunity for school 3 to share information they knew about me and my family.

School 3 and the EWS had been worried they did not have updated information about my progress or my plan of support with CNTW since April 2021. They escalated their concerns to a meeting called the children missing education (CME) tracking panel on 13 October 2022, as expected. The aim was to seek advice from other services and to request an update about my mental health to understand if I was ready to access some form of education. The outcome was for the CNTW representative to explore better communication with my keyworker. This was successful and the EWS received an update about me that identified I was not ready to return to school or access any form of education due to concerns about my physical and mental health.

In November 2022 school 3 requested a placement change for me, which was an action from my last EHCP review. My parents, School 3 and the LEWO said this would give me a fresh start and might have relieved the anxieties I had about attending school 3.

Anxiety was identified as a reason why I did not want to attend school. The lead reviewer said I could have been experiencing shame anxiety.[58] This is when a person feels anxious about the uncontained shame they will experience when they are seen or exposed in some way. It was possible that I did not want to leave the house as I needed to know what was always happening to feel safe and to prevent an uncontained shame event if I did not know what I would be returning to. I had also told my CNTW worker in July 2022 I was ashamed of being seen because of my weight loss and how skinny I was. This could also explain why I was reluctant to go to school or be seen by anyone outside of my family.

The SEND team spoke to lots of alternative education providers about me, as expected. This resulted in two trial offers. My records said my parents declined the first because they were concerned I would not cope, and they did not attend the second. There was no recorded reason why. At my learning event the SEND team acknowledged that although other education placements were being considered, all the things the team was doing had not been well communicated to my parents. The complicated process was identified as a possible factor which workers also struggled to understand. The SEND team thought this could have been an opportunity to use clearer language, to also share written information with my parents and to follow up actions so there was a record of what happened or why they had not progressed.

Between October 2022 and January 2023, I was not always taken to my appointments with CNTW. My keyworker was not always successful when they tried to contact my step mum by telephone, text or email

[58] Dolezal (2022).

and their concerns about my low weight escalated. It was not clear if they were pre-arranged telephone calls or when my CNTW keyworker was available.

In October 2022, CNTW continued to encourage me and my step mum to attend the GP practice to have my height and weight monitored. It was not clear if this had been agreed with the GP. My step mum declined and said this would cause me anxiety which might mean I ended up in hospital again. In November 2022 my step mum reported to CNTW that I was hiding food, I had drastically lost weight and I had "funny turns". She was advised I needed to attend hospital, but it was unclear if this happened. The lead reviewer explained these were probably examples of withdrawal shame containment strategies.

My learning event identified that if workers had felt confident to understand physical health and low weight, this discussion may have been followed up. Although there were other agencies involved the lead reviewer said CNTW had become a single agency making important decisions about me which my learning event recognised probably felt overwhelming and terrifying at the time. Workers agreed this could have been addressed if there was a clear multi-agency plan in place for me, where there was collective responsibly to make decisions about me and to review my plan.

From their internal review CNTW identified related areas of learning. For example, the need for effective internal risk management meetings, the need to record details within action planning and the need for tracking and oversight of actions discussed in supervision. See development 5.

The EWS spoke to CNTW on 3 and 7 December 2022. My CNTW keyworker said I was not ready to engage in any form of education. As a specialist agency this decision continued to be respected. School 3 identified support from colleagues that helped to explore different ways to engage with my family, which were not directed at my education or me attending school, so I knew I was wanted and welcome. An example was the caretaker delivering a Christmas gift on 22 December 2022.

I was taken to two of the three appointments with CNTW in December 2022. My keyworker recorded there was no change in my physical presentation. I remained underweight but it was unclear what my actual weight was.

Following an Ofsted visit in December 2022, school 3 was reminded I should have been visited at home because I was missing from education. This resulted in discussions between the family support partner (FSP),[59] school 3 staff and the EWS about a co-ordinated approach to see me, to reduce any distress this may cause. See developments 21 and 22.

The EWS visited my house in January 2023. They told school 3 my step mum said home visits would upset me because this is what CNTW had said. My step mum was asked to contact my school because telephone calls had not been answered or returned. An update was requested by the EWS from CNTW on 23 January 2023 so they could review if I was ready to access any form of education, but the telephone call was not answered or returned. School 3 tried to contact my step mum on the phone and by email to discuss this too, but this was also unsuccessful.

I was taken to the three appointments offered by CNTW in January 2023. My keyworker told me if there was no change in my weight before easter 2023, a different intervention was needed to increase my weight. CNTW recorded my "low weight and lack of motivation to address my negative thoughts prevented me from eating". It was also documented that I declined to go to my GP for my height and weight to be measured again. It was unclear how this was responded to. The lead reviewer said this could have been a withdrawal shame containment strategy to withdraw from a potentially shame exposing experience if concerns about my weight were identified.

[59] This was a role the school introduced in 2022, as a link between the school and families/carers to ensure they are supported in meeting the needs of the young people, directly or through accessing further services, and to complete visits to CME.

On 27 January 2023 my weight was recorded as 15.5kg/2 stone 4 pounds. The lead reviewer said this was approximately a 6kg/9 pounds reduction in my weight since August 2022 and lower than my weight when I was in hospital in November 2020. If this had been recognised they felt it should have been an opportunity to escalate the concerns which may have included contact with the consultant paediatrician at hospital 2 to urgently address my physical health.

Reflection

People were asked to consider what was the most important thing the NCASP or their agency should know about from this period.

The need to avoid working on assumptions by being curious and asking better questions to understand information that is being shared.

The need to see and speak directly to a child, to understand their lived experience.

The need to stop and think about the plan for a child and if there is not one think should there be.

The need to recognise a different approach might be needed so a child is safe and well.

The need to recognise if a child's weight is decreasing significantly this is a serious concern which needs to be escalated and addressed as a priority.

What has changed since?

Development 21	School 3 has introduced a new process for pupils that are identified as missing from/out on education (CME). Pupils are now visited weekly at home either by school 3 or the EWS. This has resulted in better links between school 3 and the EWS, to monitor and track CME.
Development 22	School 3 has introduced a new process when a parent/carer does not support home visits to see a pupil. They will now liaise with other people working with the family and if there is no response, support will be requested from CSC or the police with consideration given to a joint visit. This has proven to be successful and has demonstrated a clear message that a school has a duty and responsibility to see their pupils to know they are safe and well.

Period five: 1 February to 2 April 2023. I was 13 years old.

Who was involved?

I was registered with the same GP, and I had the same keyworker from the children and young people service (CNTW). I was on roll at the same school, I had the same special educational needs and disabilities (SEND) officer, and the Education Welfare service (EWS) was still involved. Police officers met me and social workers in EDT read information and spoke about me. A different police officer and people in children's social care (CSC) read information and spoke about me. A charity was supporting my parents and met me. Lots of different people in hospital 2 saw me and two approved mental health practitioners (AMHPs) met me and spoke to me.

What happened and why or what was possible and how?

In February 2023, the family support partner (FSP) at school 3 tried to contact my step mum on the telephone and by email. Sometimes there was no response or a returned call. I do not know if these were planned telephone calls or when the FSP was available. When they did speak on 3 and 6 February 2023 my step mum asked for more work to be sent for me and more regularly.

This was a change from the advice shared by CNTW and what my step mum had previously said in meetings and discussions. The FSP investigated this and said weekly packs had been sent in the post since September

2020 but only two packs had been returned. My step mum said there was an issue with the post and work packs had not been received. The EWS continued to seek updates from CNTW to understand if I was ready to access any form of education and requested information on 6 February 2023. They did not receive a response.

On 17 February 2023 a member of the public contacted the police when they saw me eating from an outdoor bin. I told the member of the public I was hungry and asked if they could buy me a loaf of bread. In situations like this, the police do not use the Thrive criteria because of the level of concern about a child. Police officers from the neighbourhood police team (NPT) were sent to the shops and arrived within eight minutes.

The police officer spoke to the member of public then they tried to speak to me, but I did not reply to their questions. Instead, they used their observation skills and recorded that I was "quiet, very slim and small". My step mum came out of the shop and told the police officers I had an eating disorder, and my behaviour was 'normal' for me and was how I coped with stressful situations. My step mum explained I was supported by CNTW, and she shared the contact details of my keyworker.

The police officer contacted CNTW on the telephone and shared their findings. My keyworker confirmed they were working with me, and they had no immediate concerns for me. My learning event identified if the police officer challenged the observed behaviour or my weight as "normal for me" this could have changed their view that this was ok and that there was an effective support plan in place for me. CNTW highlighted this was an opportunity to identify a safeguarding concern about my physical health or that I was not always being taken to appointments based on the information shared by the police officer. See development 5.

On 18 February 2023 a police officer contacted the EDT with an update following their enquiries. The police officer and the EDT identified no further actions were required for that day. The police officer wrote a summary of their enquiries on a CCN, which was shared with CSC, as expected. The EDT summarised the information and updated my CSC record. The lead reviewer said system to share information between the EDT and the CSC First Contact triage service worked well and an alert was sent to review the information the next working day.

The CSC triage manager reviewed the EDT alert on 20 February 2023. Based on the information available they recorded their management oversight for a social worker to consider the information. When the additional information in the CCN was received, the CCN and the EDT alert were discussed at the CCN meeting[60] also on 20 February 2023. There were no safeguarding concerns identified. My CSC record said there was no identified role for CSC and no further triage was required because the police officer had explored the concern and spoken to CNTW.

The lead reviewer identified this was the fifth occasion school 3 was not aware of important information about me. This should have been an opportunity where a process supported information sharing and seeking between agencies. If this happened, school 3 could have built their understanding of what was happening at home for me and my family at the time. This could have helped them to consider their approach or conversations with my family. It could also have been an opportunity for school 3 to share their worries about me being missing from education, not seeing me in person since October 2020 and sometimes not being able to speak to my parents to understand how I was doing.

The FSP delivered an education pack to me on 28 February 2023. Although my family was not in the house, my step mum later reported this had caused me distress. She said I should not be seen by school 3 because that is what the CNTW letter from December 2020 said. However my step mum had reported concerns with post being received and earlier in the month she had asked for more work for me. See development 22.

[60] Those present included representatives from the police, statutory social work team, education, early help and the adolescent service.

The FSP contacted CNTW on the same day by email for advice and explained the statutory duty school 3 had to complete weekly visits to see me. They asked if the weekly CNTW appointments could be used to fulfil this duty, because they were concerned about causing me distress as a "new person". The FSP also asked if a multi-agency meeting was needed and offered to support with its organisation. They did not receive a response.

I was taken to four of the five appointments I was offered with CNTW this month. At one appointment, CNTW asked me about the event at the shops. I said I went to get some food with my step mum. Then when she went into the shop, I got out of the car and I was looking in a bin. I asked the member of the public to get me some bread because I was hungry and they phoned the police. My step mum told CNTW she did provide food for me, which I also confirmed.

I told CNTW I was upset when the school came to my house unexpectedly and I did not want to leave the house because I thought I would be forced to attend school. We discussed I was stealing food, but I could not help it. I explained why and my keyworker understood this was because "past trauma was triggered when I felt very hungry".

When we spoke about my eating at another appointment we talked about my step mum preparing food but me not eating too much in case I got sick. CNTW wrote they planned to speak to EDICT and an occupational therapist (OT) about me. It was unclear if this happened. My keyworker observed I was underweight but it was unclear what my actual weight was. They asked my step mum to take me to my GP to be weighed, but wrote she was reluctant to do this. It was unclear if this happened or if it was followed up. The lead reviewer explained my step mums 'reluctance' could have been a shame containment strategy if she was worried concerns about my weight or other areas of my development were identified.

There was a record of my weight on 8 March 2023 as 15.2kg/2 stone 3 pounds. The lead reviewer identified this was lower than my weight when I was in hospital in November 2020. If this had been recognised the concern should have been escalated as a safeguarding concern.

Somebody visited our house on 9 March 2023 to encourage me to attend a therapy centre.[61] It was unclear what the outcome was.

There was another virtual EHCP review meeting for me on 29 March 2023. I was not there, but my step mum, school 3, a new SEND officer, CNTW, and somebody from a support group were. My views were not recorded because school 3 had not had any contact with me since October 2020 and they did not want to distress me by trying to complete the pupil form.

The record of the EHCP review said my step mum explained I completed the education packs that were sent to me; I did not really like maths, but I wanted more work to complete. CNTW asked for someone in school 3 to consistently mark my work and to give me feedback. They said it was important I had somebody to build a relationship with from school 3 and to give me more structure to my days; this was the first time my learning needs were considered in my EHCP review. However, it was discussed that home visits made me feel as if I was being forced to attend school and should be avoided.

My step mum said I was "up and down" in how I worked with CNTW. CNTW said my weight continued to be a concern, that I was trying to get well but I was struggling. They explained when I did well it could activate trauma and I was terrified that I was going to be forced back into school. Based on this information school 3 and the EWS felt cautious about enforcing plans for me to accessing a form of education without the agreement of CNTW.

[61] This offers animal assisted play therapy, outdoor therapy etc.

My physical and mental health were identified barriers to me attending school. It was recognised that no progress had been made to support me back into any form of education which was a concern for school 3 and the EWS. The outcome of the meeting was for school 3 to make a referral to EOTAS, with a request to support me back into a form of education that was flexible to manage my mental health needs. The EWS said this could have considered online learning and face to face learning with an individual tutor. School 3 said at my learning event this action was not progressed because on the same day, I was taken to hospital by my step mum.

When I arrived at hospital 2 I was unresponsive and my weight was 13.4kg/2 stone 1 pound. The lead reviewer said I had lost another 0.6kg/1.5 pounds in less than three weeks. The paediatricians caring for me were worried I would not survive. My learning event identified me going to hospital was not initially recognised as a safeguarding concern because hospital 2 thought it was related to concerns about my mental health. This was also recorded in the referral to CSC a few days later which said I had "a mental health disorder and my family needed help".

When I was in hospital I refused to eat or drink. Hospital 2 was really worried about me and made a referral for a mental health act assessment (MHAA) on 31 March 2023. To help prepare for the assessment two social workers, an approved mental health practitioner (AMHP 1) and a student (AMHP 2) from the EDT read my CNTW and CSC records before they came to hospital 2.

AMHP 2 identified my dad as my Nearest Relative (NR), under section 26 of the Mental Health Act 1983 (MHA). They contacted him by telephone, to talk about the assessment and to ask if he wanted to be present. He said he was unable to process the information and asked that all contact was made with my step mum, who was at the hospital with me, before ending the call. AMHP 2 said they understood his comment was made because of the emotive situation. The lead reviewer said my dad ending the call abruptly could have been a shame containment strategy if he struggled with the information he heard, if it made him feel like he needed to disappear or if he felt blamed for the situation I was in.

AMHP 1 thought about my dad's involvement in the MHAA and because I was so unwell they decided it was not possible to delay it, to review this decision. The AMHPs spoke to the doctors caring for me on the hospital ward about the reason for me being in hospital and my physical and mental health needs, then with my step mum. They then met me in my room because I was still attached to medical equipment. I was told their names and what their jobs were. My step mum was also in my room and the AMHPs asked if I wanted her to stay to make me feel more comfortable, which I said I did.

AMHP 2 wrote that I was "slightly built and had an extremely visible low bodyweight". They asked me simple questions that I could understand about why I did not want to eat or drink. I explained my eating was linked to fears and thoughts about my mum and that this often stopped me from eating. I told them I wanted to put weight on but that I did not feel I was worthy of food.

The lead reviewer said not feeling worthy was an indication of my contained shame. It explained that I did not eat food because I did not feel worthy of food, so I did not feel worthy of life. How I was thinking, what I liked and did not like, the things that motivated me and how I saw myself were influenced by this. For example, I felt other members of my family were worthy of food, but I was not. They said this would explain how the thoughts that I was 'bad' when I was younger, must be true.

The AMHPs asked if I would accept a nasal feeding (NG)[62] tube, which I declined. I said I did not want to be alive and that I knew by not eating and drinking I could die. I told them I often felt low and that I worried a lot, especially when I thought about my mum. I explained I did not like going in the bath and it was because of things that happened to me when I lived with my mum and her partner. I told them "I do not want to talk about

[62] This is when a child is fed through a small soft tube, which is placed in the nose and it runs down the back of the throat, through the food pipe (oesophagus) and into the stomach.

this" which the AMHPs respected. They had read my records before we met, so the lead reviewer thought they knew that I had been neglected and abused when I was younger.

The AMHPs asked me questions about things I liked. I told them what my favourite foods were, that my step mum was a good cook, that I enjoyed baking and doing arts and crafts. The lead reviewer said this was the second time positive things were written about me. The AMHPs wrote that I spoke positively about my parents and that I was observed chatting with my step mum during my interview. The AMHPs thanked me for talking to them and they told me they needed to speak to two psychiatrists[63] to make their decision.

AMHP 1 recorded the discussion; the psychiatrists said their medical recommendation was that I had a mental disorder.[64] The AMHPs and the psychiatrists agreed that I did not have capacity and decisions related to eating and drinking could not be made with parental responsibility, the use of the Mental Capacity Act 2005 or Gillick Competence.[65] The AMHPs decided I needed to be supported and kept safe under section 2 of the MHA and an application for my detention was made for me to stay in hospital 2 to receive medical treatment. The rationale recorded was my eating on "good days" fluctuated with "bad days". This meant a legal framework was needed to support me with the appropriate medical care to keep me alive.

The AMHPs spoke to my step mum first about their decision and then to me. They explained to me that I needed to stay in hospital with a plan of treatment because I was so unwell. They wrote that I appeared to be "ok" with this, but I asked about the NG tube again. AMHP 2 explained the NG tube would only be considered on "bad days" and if I could not eat. I told them I had eaten that day and planned to eat again the day after too, which AMHP 2 encouraged me to do.

The MHAA was recorded on an MH1 form and left with the clinical manager of the hospital ward, as expected. The AMHPs also told CNTW that I had been detained under the MHA, and they updated my CSC record too. AMHP 2 phoned my dad and explained I had been detained, how long it lasted and what being my NR meant. They asked if he had any questions; he said he did not object and that he hoped I got the help he thought I needed. AMHP 2 agreed to email him the information too because a lot of what they had discussed was legally based and sometimes complicated to understand. My dad said he preferred to receive emails, so he was grateful.

On reflection, AMHP 1 thought about if I should have been spoken to alone. However, they said MHAAs can be intimidating for children and their parents/carers, so they try and manage this as sensitively as possible. AMHP 1 said they are guided by people's wishes to try and make it as comfortable as possible. So because I said I wanted my step mum to be there they did not insist that I was spoken to alone.

Reflection

People were asked to consider what I might have said the most important thing was about everything that happened in this period.

- Professionals spoke to me and listened.
- Hospital was a safe environment.
- My dad was spoken to and he said he hoped I got the support he thought I needed.
- I was being taken to more appointments so I had more contact with professionals and services that could help.
- Workers and agencies spoke to eachother more.

[63] An AMHP, and two doctors, one who is section 12 approved, are involved, although the decision and application process to detain a child/young person is the responsibility of the AMHP.
[64] The MHA 1983 defines mental disorder as "any disorder or disability of the mind".
[65] This is often used to assess whether a child is mature enough to consent to treatment.

3.3 My views, thoughts and feelings

The lead reviewer asked me to answer six questions. I tried my best, but I found it difficult because I did not understand some of the words that were used.

When I was asked about what support I received from services and workers during my review period, I said I had weekly appointments with CNTW. I remembered my keyworker bringing me food, especially raisins, a sandwich or a drink. I did not think the appointments helped because I was still living at home. What stopped things from working better for me included my dad not knowing what was happening at home and not being able to contact important people, like my (paternal) grandma.

I do not think services or workers listened to me for them to really understand how I was feeling or what was happening at home or in my life. To change this, I wanted someone to help me and to be there for me. I think workers and services could have thought oh is something going wrong here?

If this was different, I think I might be happier, taller or I might like myself more now. This might have made them think more about my circumstances, to learn more about who I am, my strengths and my hopes for the future.

On a scale of 0-10 where 10 means I trusted and had every confidence that workers and services could help and support me, and 0 means I had no trust or confidence at all, I picked 7 or 8. I do not know what needed to be different to move up one number, but the most important things I said I needed now are to make and keep friends.

My biggest wish is to be happy.

3.4 Final reflection

People were asked to identify the most important thing they had learned from my review period.

- The need to see a child and think about situations from their perspective in all our interactions.
- The need to work together when a child has more than one developmental need or when a situation significantly impacts on how a child functions and develops.
- The need to share information and be curious about what we see, hear and read.
- The need to have a co-ordinated multi-agency plan when there is one or more professional/agency working with a child and their family.
- The need to have a discharge planning meeting following lengthy, complex or safeguarding hospital stays.
- The need for everybody to use clear and simple communication.

3.5 The views of my family[66]

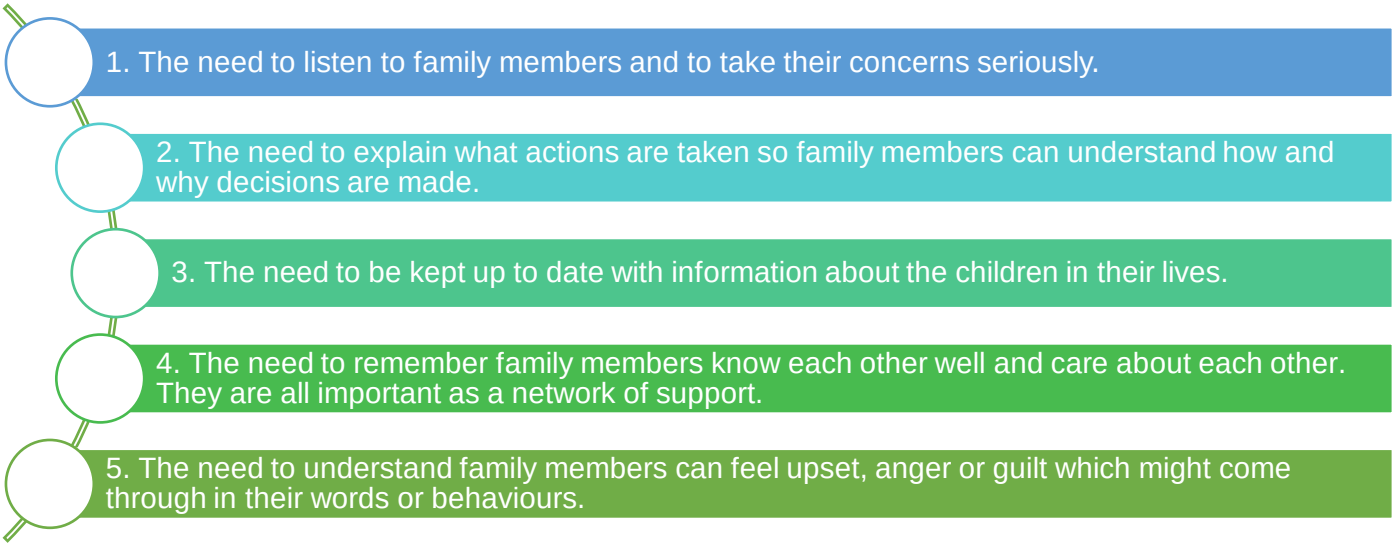
My mum told the lead reviewer she remembered me being "amazing, happy, bubbly and boisterous". She feels angry about what has happened to me because I am not as tall or heavy as I should be.

My maternal family recalled some positive experiences of working with agencies. This included feeling listened to and when workers acknowledged the significant events in my early life but were able to "look

[66] My mum and grandma met the lead reviewer face to face in December 2023. My maternal aunt was spoken to on the phone in December 2023. There was no response from my dad so his views and experiences are unknown.

beyond" this information and work with them and the situation at the time. They said this was particularly important because they did not feel repeatedly blamed or that they were viewed as a 'bad' family.

Things my maternal family thought workers and services should think about when family members contact them in the future included:



My maternal family said their biggest hope for me is that I will be supported well and for them to be part of my life again.

4. FINDINGS

4.1 Practice themes

Seven practice themes were identified by the lead reviewer that can be seen throughout the examples of good practice and areas of key learning in my review.

Accountability
evidence of people taking responsibility for an action, being able to explain its progress and why it was done in the way it was.

Authoritative enquiry
evidence of challenge to fulfil a responsibility to understand, to be heard or for something to be actioned and to make sure information is considered from different sources to correlate and/or challenge an accountgiven and/or action taken.

Childs day to day experience
evidence of what a child said, saw, thought, felt and how they reacted to the world around them.

Collaboration
evidence of people working together to agree or create something collectively.

Communication
evidence of people sharing and asking for information, using clear and simple words that explain who said what.

Identification of need
evidence that a situation, including a childs developmental needs and risks, are understood and actions identified to help, support and/or protect them.

Impact
evidence of what difference was made by the things people did.

4.2 Appreciation and evidence of good practice

The lead reviewer identified practice, system, process and procedure to be appreciated and celebrated. The practice theme(s) they demonstrated have also been identified.

1. The people at my learning event were able to identify learning through good practice and practice that could have been different. This reflects the aspiring NCASP vision to develop a learning culture. **This demonstrated all the practice themes.**
2. There have already been developments made within NCASP and individual agencies which address some of the challenges identified within my review. **This demonstrated all the practice themes.**
3. I was spoken to by some workers, or they tried to speak to me, which was an opportunity for them to hear my views, thoughts and feelings. **This demonstrated child's day to day experiences and communication.**

Throughout different periods of my timeline

4. People often thought about and asked my parents for consent when they wanted to speak to people about me or to consider a referral to another service. **This demonstrated accountability (periods one and two).**
5. People were aware of and used their networks to access support, advice or reassurance when they made decisions about me throughout my review period. For example, speaking to their colleagues, DSLs or safeguarding leads. **This demonstrated accountability and communication.**
6. People involved my parents in discussions and assessments about me throughout my review period. **This demonstrated communication.**
7. The process to share information between the police and CSC through a CCN/CCN meeting worked well and was an opportunity to assess, review risks and identify my developmental needs. **This demonstrated accountability, collaboration, communication and identification of need (period two, four and five).**
8. School 3 maintained contact with my family throughout my review period, despite the challenges of the pandemic and not always getting a response. They kept a clear record of their interactions, which helped to understand what happened, who was involved, the reasons for decisions and actions required. **This demonstrated accountability and communication.**
9. The process to allocate police resource in response to concerns about me worked well. It was swift and used judgement through an established risk assessment and decision-making tool. **This demonstrated accountability, identification of need and impact (periods four and five).**
10. The procedure to share information between the EDT and CSC First Contact service worked well. Recording was clear and thorough, and it was responded to the following day. **This demonstrated accountability and communication (periods four and five).**
11. EHCP review meetings focused on my education and how my developmental needs could be met if I was attending school. Some of the meetings reflected multi-agency attendance, like in March 2021 and March 2023. **This demonstrated accountability and identification of need (periods two and five).**

Period one

12. Despite the challenges of a pandemic schools 2 and 3 worked together to plan and manage my school move, which included me and my family. **This demonstrated accountability, communication, collaboration and identification of need.**
13. The creativity and flexibility of school 3 in all the ways they tried to build a relationship with me, to support me back into school, and to make me feel wanted and welcomed. **This demonstrated accountability, collaboration and identification of need.**
14. School 3 identified me as missing from education early and used the appropriate process to do this. **This demonstrated accountability and identification of need.**

Period two

15. CNTW and the GP provided appropriate advice to my step mum that I needed medical attention when I was unwell. **This demonstrated accountability and identification of need.**

16. There was a clear record of discussions and observations when I was in hospital 1. This showed how my needs were identified and included what happened, who was involved, the reasons for decisions and the actions required or taken. This was then shared with hospital 2 very quickly. **This demonstrated accountability, collaboration, communication and identification of need.**

17. There was evidence my needs continued to be identified by hospital 2 by a range of services and through various assessments. **This demonstrated identification of need.**

18. There were some examples of recorded information that was used to identify when emerging concerns about my physical health started. For example, from the private ambulance service and the hospital dietician. **This demonstrated accountability and communication.**

19. There was evidence the process to escalate concerns to the safeguarding team for advice worked at hospital 2. **This demonstrated communication.**

20. The GP was alert to my CNTW discharge letter and used this to inform their actions with and for my family. They were persistent but respectful to achieve the actions they had identified, which had a positive outcome for me. **This demonstrated accountability, communication, identification of need and impact.**

21. There were some good examples of information sharing between roles and agencies. For example, between hospital 1 and 2, services within hospital 2, hospital 2 and community services like the dietician, and between school 3 and the EWS. **This demonstrated communication.**

22. The process between acute and community health services to share information when I was not taken to appointments was successful. Hospital 2 and the GP were notified I was not taken to dietician appointments as requested. **This demonstrated communication.**

23. The dietician was proactive to contact my dad to confirm contact details for future letters and telephone calls. **This demonstrated communication.**

24. The monitoring element of the children missing from education process was effective. The EWS was alert to a change which resulted in a changed response. **This demonstrated accountability and identification of need.**

Period three

25. The recognition that specialist services needed to be involved and the quality of the referral information from CNTW to CSC. The referral was thorough and contained relevant information that supported CSC decision making. **This demonstrated accountability, collaboration, communication and identification of need.**

26. The escalation to the MASH was appropriate and this worked well to collate information from partner agencies within a specific timescale. **This demonstrated accountability, communication and identification of need.**

27. The CSC advanced practitioner asked my step mum some strength-based questions as part of my assessment. This resulted in one of the first positive insights into something I enjoyed and my aspirations for the future. **This demonstrated child's day to day experiences and communication.**

Period four

28. CSC First Contact managers were mindful to avoid a reliance on self-reported information in their decision-making and made use of an alert system to complete their decision making. **This demonstrated accountability, authoritative enquiry and identification of need.**

29. The escalation process to the CME tracking panel for multi-agency support and guidance, was appropriately used and had a positive outcome. **This demonstrated accountability, collaboration, identification of need and impact.**

30. School 1 identified specialist services needed to be involved to consider concerns about my physical health and educational needs. Their referral included behavioural details as evidence. **This demonstrated accountability, communication and identification of need.**

31. School 3 reflected on the advice received from Ofsted and made changes to their approach to see me at home as a child missing from/out on education. **This demonstrated accountability, collaboration, communication, and identification of need.**

Period five

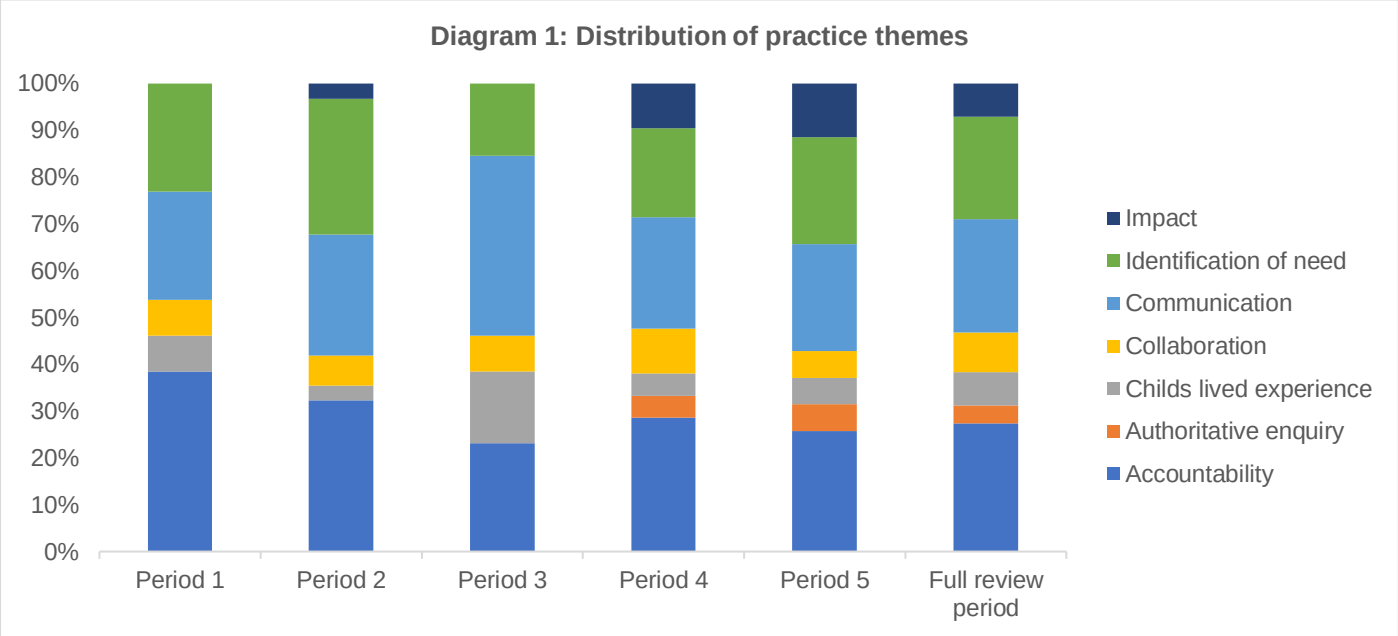
32. The police officer's exploration of concerns was logical, considerate and sensitive. They considered what was happening rather than assuming or accepting a single source of information. This was made possible through observations, asking questions and listening, to check out and reflect on all the information they had received. **This demonstrated authoritative enquiry, communication and accountability.**

33. The clinical actions of hospital 2 saved my life. **This demonstrated accountability, identification of need and impact.**

34. AMHP 2 recorded the discussion with me in hospital, which showed how they spoke to me and how they made a connection between my experiences of neglect, abuse, my situation at the time and disordered eating, and how they respected that it was difficult to talk about. **This demonstrated accountability, authoritative enquiry, communication, identification of need and impact.**

35. AMHP 2 thought about sharing information with my dad in a different way. This resulted in him receiving information in his preferred method of communication, which helped him to understand the Nearest Relative role and legal framework of the MHA. **This demonstrated accountability, child's day to day experiences, collaboration, communication, identification of need and impact.**

Diagram 1 shows the spreading of practice themes identified in the examples of good practice throughout my review period.



4.3 Key learning

1. People were aware of the neglect and abuse I experienced as a young child, the effect it had on how I thought and felt about myself and how I communicated through words and behaviours. However, this should have been strengthened if my experiences throughout my whole childhood were considered and understood.

2. The record of my life described me as "complex", "challenging" or a "problem". Exploring my strengths and/or successes would have supported workers to understand me as a person and to avoid blame.

3. Information recorded about me was often open to an interpretation of other people's understanding. Information should have been recorded using plain and behavioural language to avoid any confusion.

4. I was not seen frequently, consistently or alone So there were less opportunities to build relationships.

5. Nobody really understood my day-to-day life and the complicated issues I was trying to manage and understand. I was experiencing lots of emotions, thoughts and behaviours which made me feel scared, confused and worried.

6. I did not feel listened to or that my experiences were really understood. Often my views were presented by other people which were accepted without workers exploring the meaning or how they affected me.

7. Agencies considered specific aspects of my growth and development rather than all my developmental needs and risks. I needed support with my physical, emotional, educational, social and mental health needs but I was never considered as a child in need.[67]
8. People were not confident to identify my significant physical health concerns and they did not know where to get support.
9. There was an over reliance on one agency to share information about me and to make decisions about me. These decisions were rarely challenged.
10. Important information about me was known by agencies but this was not always shared because it was not part of a process or people's role and responsibilities were not always fully understood.
11. There were opportunities to develop a multi-agency plan for me that clearly explained what everybody would do to support me. This would have provided clear expectations of my family and workers and brought everybody together to identify what was working well, any concerns or what needed to change in a co-ordinated way.
12. Although agencies were involved and workers were trying to support me there was no change to my circumstances.

WHAT SHOULD HAPPEN

5.1 Aspirations

Using the strengths and successes identified throughout my review, the lead reviewer recognised the common qualities that made/could make the best practice examples possible in future work with other children and families (table 1).

Table 1

What already works/has worked	What could/should be possible
• Working together and sharing information and ideas. • Being confident to ask questions or to challenge assumptions. • Tenacious to maintain contact/gather updates on any progress made. • Using challenge processes to make something change. • Using/having processes that work well to assess a child's needs and risks. • Seeing children at home and having communication skills to understand and identify strengths and worries. • Recording information about what happened, who was involved and the difference it made. • Being prepared for interventions; reading historical information, thinking about who needed to be spoken to and the questions to ask. • Learning about what could be different through reflection.	• Understanding the roles and responsibilities within a family. • Using clear and simple language that everyone can understand. • Everybody having the same information and feeling informed. • Having a clear multi-agency plan that family members and relevant people contribute to. • Using a plan to co-ordinate information sharing and to understand what has changed through its review. • Recognising and understanding child growth and physical development in assessments. • Asking best questions to establish facts. • Using support within networks for advice, guidance and reassurance. • Being confident to challenge information to understand what it means for a child. • Being confident to recognise when a different approach is needed.

5.2 Possibility themes

Diagram 2 shows the six possibility themes the lead reviewer identified which represent what working with children and families should look and feel like. The themes are interlinked. For example, how workers and

[67] Section 17 of the Children Act 1989.

agencies seek and understand a child's day to day experiences will influence how it is recorded. Or the quality of a worker's supervision will influence how good practice is encouraged, supported and celebrated.

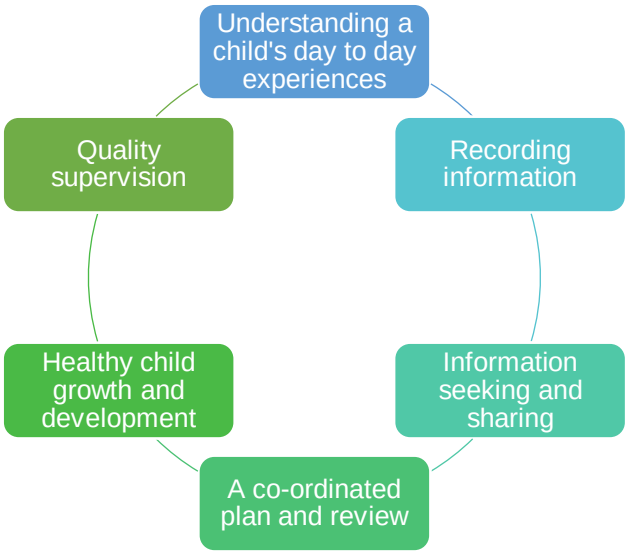


Diagram 2: Possibility themes

5.3 Possibility statements

The possibility statements describe what practice will look like for each possibility theme if the aspirations are consistently happening. The actions then explain how each statement will be achieved.

1. Understanding a child's day to day experiences[68]

People who work with children will know how to build trusting relationships with us and how to understand who we have in our life, who helps and loves us. They will speak to us alone and somewhere we feel comfortable and safe. They will understand that sometimes what we say might be different to what we do and that should help them understand our worries and our feelings. If they are not able to see us they will speak to our family and the other people who work with us to see how they can make sure we are ok, and to plan the next steps. When someone tells them about us they will make sure they check this information out, making sure that it is not just one person's view. They will not assume that is what we think or feel. People will think about what the best questions are and how to ask us, our families or other people that know us. We will then know that our views, thoughts and feelings are important and understood, because these will be being used when decisions are made about our life.

How can this be achieved?	• Agencies should encourage workers to gather a detailed history with parents and carers to identify roles and responsibilities, as well as indicators of shame and their containment strategies. This is especially important as some strategies may impact on a child. • The NCASP and single agency learning and development offers should include the importance of understanding a child's day to day experiences highlighted in this statement.

2. Recording information

People who work with children will make sure that when they write things down they will use words that are respectful and clear. It is important that not everything in our lives is a problem, we have strengths and hopes for the future too. People will be clear about what difference their work is making to us and their responsibilities towards us. They will say whether what they are writing is fact or opinion, who told them and use the words of the person that said it. They will keep in mind that this is our lives they are writing about and

[68] As highlighted in the United Nations Convention on the Rights of the Child (1989), the Human Rights Act 1998, the Children Act 1989, Working Together (2018) and by Munro, (2011:26), Cossar et al. (2016) and Munro (2011).

how it would feel to read what they are writing if it was them. By keeping accurate and clear records themes or continuing issues will be identified which will mean our story does not have to be told over and over again.

How can this be achieved?	• The NCASP should encourage agencies to record information in a child's record as if they are writing to children and their family and support the detail of this statement to be included in single agency procedures. • The NCASP should encourage agencies to be more creative; information is not only recorded using words.

3. Information seeking and sharing

People who work with children will think about what has happened to us in the past but they will also know how important it is to consider what our lives are like now and what that means to us. They will ask questions not only of our families but of other workers too. They will not make complicated decisions without listening to what others say. They will feel confident to share information about us and our families which is relevant. This will mean that everybody has the right information so they can be part of discussions about how best to help us.

People who work with children will feel able to have difficult conversations about their concerns and say who else they may need to speak to or what they are going to do about it. It is important they are honest with us and our family, especially if people think we, or someone else, may not be safe. If someone thinks we might not be safe and they decide not to speak to other people about this, they will write down why and what they did do to make sure that other people can understand what risks and safety they could see. This will mean that the people who need to be involved with our families are the right people and that we have the right help. It also means that the decisions being made will be supported by clear information from all the people who work with us.

How can this be achieved?	• The First Contact systems, processes and procedures should be reviewed to consider how information will be shared with and requested from partner agencies at the point of contact, referral, assessment and closure. There should be a specific focus on: - the links to and with education provisions, and - how information within a CCN will be shared with the relevant agencies. • The NCASP should update its information sharing procedures to match the information seeking and sharing statement.

4. A co-ordinated plan and review

When there is more than one person working with our families and there are lots of things happening that make people worried, the important people in a family like the child and their parents or carers and the relevant workers will come together to talk about what is happening. People will understand that for us and our families to work with a plan it should be our plan not theirs and that we should be fully involved in making the plan and agreeing the actions, unless it would make us unsafe to do so. There will be a lead professional that helps everyone to explore and understand what everyone is worried about but also the things that are going well. Everyone will help to create a multi-agency plan that includes all the tasks that need to be done and why, who will do them and how, by what date and what it will look like to know the plan is working. This will mean everybody will understand what is expected from them and what they can expect from others. There will be an agreement about how often the multi-agency plan needs to be reviewed. At the review meetings everyone will talk about the progress that is being made using behavioural examples. If the plan needs to change, everybody will share their best ideas about what needs to be different to make it work to keep us safe and well, and how. If nothing changes, then everyone will know what the next steps will be to make sure we are happy and safe.

How can this be achieved?

- Agencies should review their procedures to ensure discharge planning meetings take place for children with multiple developmental needs who have been in hospital for lengthy periods of time or where there have been concerns about their safety that will require co-ordinated support from a range of agencies and services.
- The NCASP should develop a framework that supports people to feel confident in the role as a lead professional for any type of plan. This will set clear expectations of the lead professional role and others who are part of the team supporting the family. The framework will emphasise the lead professional will be the best person for the family rather than what is best for the agencies involved.
- Agencies should include the detail of the co-ordinated plan and review statement into their procedures.
- The NCASP should support all multi-agency meetings with families to be face to face.

5. Healthy child growth and development

People working with children will have the knowledge they need about healthy child growth and development, and they will understand how our day to day lives might influence our behaviours. They will feel confident to recognise our physical health needs, know when things are going well or when to worry and what to do about it. They will understand that this may change so it will need to be considered often. If they feel that they do not have enough knowledge they will know who to speak to and how to involve others who may be specialists.

How can this be achieved?

- The NCASP should provide multi-agency learning and development opportunities to support people to feel more confident to identify what healthy growth and development is and what this means for a child.
- The NCASP should provide guidance about child developmental milestones and growth charts that can be used alongside the threshold of needs document.
- Agencies should ensure a family has accessible information about what support they will be provided and what the purpose of interventions will be.

6. Quality supervision[69]

People who work with children will be able to talk about us and our families with someone who is knowledgeable and experienced and who will help them reflect and think about our day to day lives, how our plan is working, and what needs to happen if it is not. When there are lots of people involved with us and our families it can be complicated so having a network of support from other workers helps people remain clear about what they are doing. People should have the opportunity to reflect on these things as a group to help them keep us safe. These conversations might be difficult for people as they will be encouraged to think differently about our situations and their responsibilities, but it will make sure that we remain at the centre of their thinking and planning.

How can this be achieved?

- Agencies should review their supervision procedures to include key areas of discussion, like the child's day to day experiences, the child's plan and feedback from families and other workers.
- The NCASP should support DSLs to have access to regular and accessible safeguarding supervision from an experienced worker that has safeguarding and management experience. This will be in addition to the service level agreement (SLA) with the SST, it will reflect education as a key safeguarding partner and it will ensure all education provisions have access to supervision not just those that pay for it.
- The NCASP should support DSLs to have access to learning and development opportunities specific to the supervision of others.

[69] Reflected in Forrester et al. (2012).

- The NCASP should support ongoing multi-agency opportunities to reflect as a group on a specific circumstance for a child or a specific element of multi-agency working. This will strengthen networks and be a regular opportunity to reflect and learn as a partnership.

6. CONCLUSION

There is a lot of practice to be celebrated within my review as well as areas to be developed. The challenges are consistent with findings in other reviews, however information seeking and sharing continues to be one of the most important issues identified. So why does this keep happening even though reviews like mine are completed?

As well as the factors that have been identified, the lead reviewer said shame and the lack of understanding about shame could have been what made effective multi-agency working more difficult in my situation.

The lead reviewer said in recent years there has been a lot of focus on people that work with children and their families using a trauma informed approach. This includes an understanding of trauma, how it can present and how it can affect a child's growth and development. They said it is important that this continues to be offered as learning and development opportunities and Northumberland has already started its commitment to working in this way.

However to be truly trauma informed the lead reviewer said people need to also understand shame and be aware of its significance as it will always be present in the response to difficult experiences. This understanding will encourage work with children and their families, and with each other, to be more sensitive and supportive whilst avoiding any additional harm. This can be achieved through a greater awareness of what happens in relationships which can be used to manage interactions with more understanding. To support this, the NCASP needs to become shame sensitive by acknowledging shame, avoiding shame and addressing shame.[70]

If trauma and shame are not properly understood this may become a barrier to successfully working with and supporting other children and their families.

6.1 Recommendations

1. The identified agency, service or the NCASP will progress with embedding developments 1-22 into day-to-day practice to be able to explain what has happened and why, but most importantly what difference it has made to children and families and how.
2. The NCASP should consider how it can introduce shame sensitivity and shame sensitive practice into learning and development opportunities, to complement the developments towards a trauma informed approach within work with children and their families.
3. Agencies should encourage workers to gather a detailed history with parents and carers to identify roles and responsibilities, as well as indicators of shame and their containment strategies. This is especially important as some strategies may impact on a child.
4. The NCASP and single agency learning and development offers should include the importance of understanding a child's day to day experiences highlighted in possibility statement 1.
5. The NCASP should encourage agencies to record information in a child's record as if they are writing to children and their family.
6. The NCASP should encourage agencies to be more creative; information is not only recorded using words.
7. First Contact systems, processes and procedures should be reviewed to consider how information will be shared with and requested from partner agencies at the point of contact, referral, assessment and closure. This review should include all relevant agencies and there should be a specific focus on:
    - the links to and with education provisions, and

[70] Dolezal and Gibson (2022).

- how information within a CCN will be shared with the relevant agencies.

8. The NCASP should update its information sharing procedures so it matches possibility statement 3.
9. Agencies should review their procedures to ensure discharge planning meetings take place for children with multiple developmental needs who have been in hospital for lengthy periods of time or where there have been concerns about their safety that will require co-ordinated support from a range of agencies and services.
10. The NCASP should develop a framework that supports people to feel confident in the role as a lead professional for any type of plan. This will set clear expectations of the role and others who are part of the team supporting the family. It will emphasise the lead professional will be the best person for the family rather than what is best for the agencies involved.
11. Agencies should include the detail of possibility statement 4 in to their procedures.
12. The NCASP should support all multi-agency meetings with families to be face to face.
13. The NCASP should provide multi-agency learning and development opportunities to support people to feel more confident to identify what healthy growth and development means for a child and what their behaviour could mean.
14. The NCASP should provide guidance about child developmental milestones and growth charts that can be used alongside the threshold of needs document.
15. Agencies should ensure a family has accessible information about what support they will be provided and what the purpose of interventions will be.
16. Agencies should review their supervision procedures to include key areas of discussion, like the child's day to day experiences, the child's plan and feedback from families and other workers.
17. The NCASP should support DSLs to have access to regular and accessible safeguarding supervision from an experienced worker that has safeguarding and management experience. This will reflect education as a key safeguarding partner and it will ensure all education provisions have access to supervision not just those that pay for it.
18. The NCASP should support DSLs to have access to learning and development opportunities specific to the supervision of others.
19. The NCASP should support ongoing multi-agency opportunities to reflect as a group on a specific circumstance for a child or a specific element of multi-agency working. This will strengthen networks and provide a regular opportunity to reflect and learn as a partnership.

6.2 The lead reviewer's reflection on my review approach

The lead reviewer said using an Appreciative Inquiry has been a successful way to bring people together to explore how agencies worked with me. This allowed workers, managers and leaders to reflect and to think about how they want to work with children and families in the future, and all the creative ways to achieve this.

Knowledge and skill, ways of thinking, learning together, systems thinking, and a shared vision are significant actions to support individuals and agencies to think about learning and how it is shared to make improvements.[71] This is called a learning culture. The lead reviewer knows this is the aspiration of the NCASP. They said when the five actions are consistently considered by managers and leaders the actions can make the hope becoming a reality. This can also be supported by Appreciative Inquiry which aims to communicate the 'best' practice that takes place.

If the NCASP uses Appreciative Inquiry regularly to develop practice, respecting what already works and what works for workers, services and agencies, the lead reviewer said it could strengthen the five action areas. These could then be the foundation for maintaining the best practice identified in my review whilst also developing the identified practice themes and progressing the recommendations, to achieve the six possibility statements.

The lead reviewer would like to thank the members of my family that have shared their views, thoughts and feelings; this was not easy but their views have been valued and have provided important information for

[71] Senge (2006).

agencies to consider how family members are included but also how their actions can make others feel. They would also like to thank the people that wrote reports and contributed so openly to the discussions about current and future practice during my events.

6.3 Your final reflections

Thinking about all the information you have read about me,

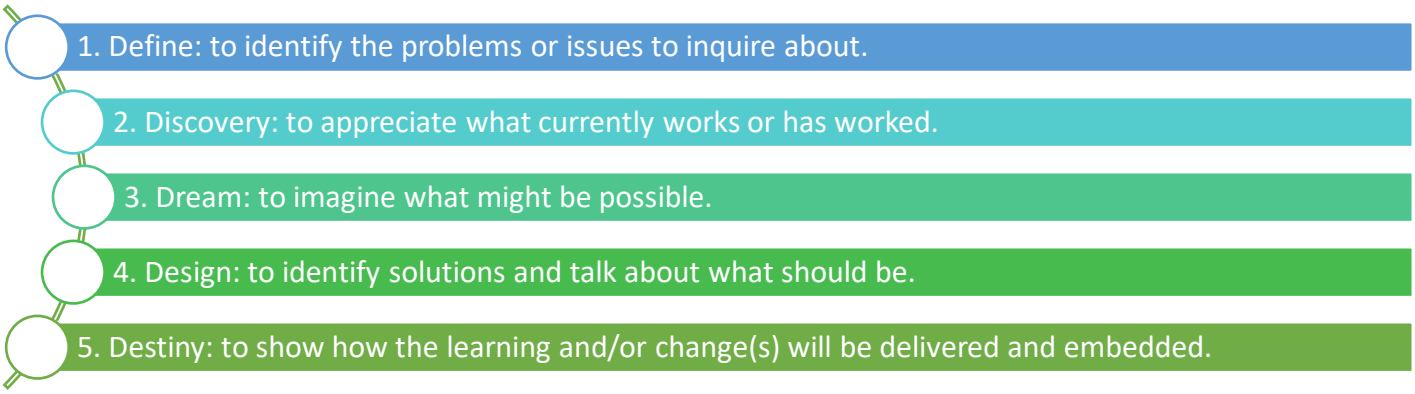
- what are your biggest hopes for my future?
- what will you now do differently when you work with children and their families?

7. APPENDICES

Appendix A- Me and my family

Appendix B- Key steps in my review

My review included the five phases of an Appreciative Inquiry.[72]



An independent lead reviewer and a review group of safeguarding leads[73] were identified in July 2023. The lead reviewer arranged an initial briefing session to share their plan, which was also in July 2023.

By September 2023, agencies[74] that had direct or indirect contact with me and my family during my review period were asked to provide an analysis of their involvement including relevant information to each KLoE and any identified single agency learning. Agencies or services who had limited involvement with me were asked to provide a summary report. The lead reviewer asked clarification questions and identified developments within agencies or the NCASP during September and October 2023. These activities were part of the discovery phase.

The lead reviewer presented their initial findings to the review group in October 2023, including key events and practice themes.

People[75] were invited to my face-to-face learning event in October 2023. A timeline based on the agency reports and a storyboard of the event were shared in advance. The event focused on understanding what happened and how, including the identification of relevant systems, processes and procedures.[76] Questions explored the 'best' times and 'strongest' examples. Challenges were also considered to explore possible actions or situations for future work with children and families. The lead reviewer asked clarification questions during November 2023. These activities were part of the discovery and dream phases.

My closing of the loop event[77] was held in December 2023. The event reflected on the findings, developed possibility/vision statements and considered what is needed to support a change in how workers, agencies and the partnership work with children and families. These activities were part of the dream and design phases.

A final draft report was presented to the review group in January 2024. The final report and storyboard were presented to the NCASP executive group the same month.

The lead reviewer contacted my mum and dad separately in January 2024 with an invitation to go through the report, to explain why it was written in the way it was and to answer any questions. They also made arrangements for me to be supported to understand my review by the people that know me.

[72] Hammond (2013).
[73] A list of representation can be found in Appendix C (table 2).
[74] The details of the agencies and services that contributed with written information can be found in Appendix C (table 3).
[75] The list of workers by role who were in attendance can be found in Appendix C (table 4).
[76] A system is a set of things working together, a process describes the what, and a procedure describes the how.
[77] A list of people by role who attended can be found in Appendix C (table 4).

The NCASP will consider the information in my review as part of the destiny phase to identify the actions that will explain how the recommendations will be developed so the difference they make can be understood.

The review cycle should then start again at the discovery phase, to learn about what difference my review has within the NCASP, how the NCASP uses appreciative inquiry in the future and how agencies and workers engage with and complete work with children and young people, their parents, carers and network members.

Appendix C- Contributions to my review

Table 2

Review group
❑ Lead reviewer. ❑ Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW) Named Nurse Safeguarding and Public Protection Team. ❑ Harrogate District Foundation Trust (HDFT) Named Nurse Child Protection for 0-19 Service Safeguarding Team. ❑ North East and North Cumbria Integrated Care Board (ICB) Designated Nurse and Named professional for vulnerable people. ❑ Northumberland Children's Social Care (CSC); Heads of Service for Safeguarding and Quality Assurance, and the Schools' Safeguarding Team Manager. ❑ Northumberland Children and Adult Safeguarding Partnership (NCASP) Business Manager for children. ❑ Northumbria Healthcare Foundation Trust (NHFT) Acting Head of Safeguarding. ❑ Northumbria Police (NP) Detective Chief Inspector, Strategic Safeguarding.

Table 3

Single agency reports were received from	**Clarification information was received from**
❑ CNTW ❑ HDFT ❑ Newcastle Upon Tyne Hospitals (NUTH) ❑ ICB ❑ CSC- statutory social work, school 2 and 3, Education Welfare service and SEND ❑ NP ❑ NHFT Note- information from the adult social care rapid review report was also considered.	❑ Emergency Duty Team (EDT) ❑ EHCP/SEND Co-ordinators who are alerted to EHCP reviews. ❑ Learning and development team who manage and deliver the multi-agency training programme for the NCASP. ❑ Neighbourhood police team

Table 4

Roles that attended my learning event	**Roles that attended my closing the loop event**
❑ CNTW Named Nurse for children's safeguarding. ❑ CSC Head of Service for quality assurance, the senior manager*, triage* and assessment managers from First Contact. ❑ HDFT complex case clinical lead for safeguarding children. ❑ ICB Designated Nurse for safeguarding children and Named Professional for vulnerable people. ❑ Lead Education Welfare Officer.* ❑ NCASP Business Managers (children's and adults). ❑ NHCFT Named Nurse for safeguarding children and dietician.*	❑ CNTW Named Nurse for children's safeguarding. ❑ CSC Heads of Service for quality assurance and safeguarding, the senior manager* and triage manager* from First Contact. ❑ HDFT Named Nurse for child protection and complex case clinical lead for safeguarding children. ❑ ICB Designated Nurse for safeguarding children and Named Professional for vulnerable people. ❑ Lead Education Welfare Officer.* ❑ NCASP Business Managers (children's and adults).

❑ NP Detective Chief Inspector. ❑ NUTH Named Nurse for safeguarding children. ❑ School 2 Deputy Headteacher/DSL.* ❑ School 3 Headteacher*/DSL and Deputy Headteacher/DSL.* ❑ School's safeguarding team consultant.* ❑ SEND Lead Officer.	❑ NHCFT dietician* and Senior Advisor Safeguarding Children. ❑ NP Detective Chief Inspector. ❑ NUTH Named Nurse for safeguarding children. ❑ School 2 Deputy Headteacher/DSL.* ❑ School 3 Headteacher/DSL.* ❑ School's safeguarding team manager and consultant.* ❑ SEND Lead Officer.
Invited but did not attend: NUTH consultant paediatrician[78] and the GP due to work pressures at the time of the event.	Invited but did not attend: NHFT Named Nurse for safeguarding and CSC First Contact assessment manager.

*People who had direct contact with me or an active role during my review period.

[78] Although they were unable to attend my learning and closing the loop events they have provided a response to the questions from the lead reviewer.

Appendix D- Shame containment theory[79]

Attachment injuries

If a child feels connected to their caregiver they will feel worthwhile and valuable. They will survive because their caregivers will want to keep them safe. Attachment injuries are events in a child's early life where the connection to their caregiver is broken.

Attachment injuries can be caused by experiences like a parent or carer being consistently busy or overwhelmed and not giving a child the time needed, being good at providing clean clothes and food but not being able to display physical or emotional affection, or disciplining through shouting or telling a child to go to their bedroom which casts them out of the family group even for a short period of time. Attachment injuries can also be caused by experiences of physical, sexual and emotional abuse and neglect.

These experiences make the child feel that they are not connected so they can feel abandoned, unsafe and that they will not survive.

As part of the attachment system, shame is produced as a response to an attachment injury. It tries to keep the child as safe as possible by telling them they are 'bad' and that they need to change their behaviour(s) in some way so they will want to reconnect with them. If this happens the child can feel that despite people making mistakes they are still seen, heard and are always loved and cared for.

Contained shame

If the connection is not repaired, the shame cannot be understood by the child or expressed so it remains stuck or 'contained'. Contained shame is experienced internally, either consciously or unconsciously. Although shame is a response to an attachment injury that happen as a small child its script can remain throughout the person's life. This means if parents, carers or workers have attachment injuries they will have contained shame.

Contained shame is what makes people feel unlovable, 'wrong', 'bad' or that they must present themselves in a positive light, otherwise they will experience a terrible or unpleasant consequence. Until shame is understood by the individual and it is addressed appropriately it needs to remain contained, so it is not felt by the individual or seen by others.

Uncontained shame

Uncontained shame is experienced occasionally but when it is it can feel devasting because the shame that has been contained erupts suddenly. This means the person feels all the shame that has been contained in one moment. Secondly the persons nervous system remembers the terror of disconnection, abandonment and the threat of imminent death that was felt before, even if they have no memory of it. This means it can feel overwhelming, excruciatingly painful and terrifying.

Uncontained shame will always have been triggered by an event that happened at that time and it generally presents as a shock. For example, when something happens that has not been predicted, like if a child is being shouted at, or there is a threat of violence or being hurt.

Containment strategies

Uncontained shame events are so terrifying people need to make sure they do not experience them. To keep shame contained people develop shame containment strategies. These can be used consciously or unconsciously. There are four types of strategies (see diagram 4) with some examples provided that are relevant to my review.

[79] Etherson (2023).

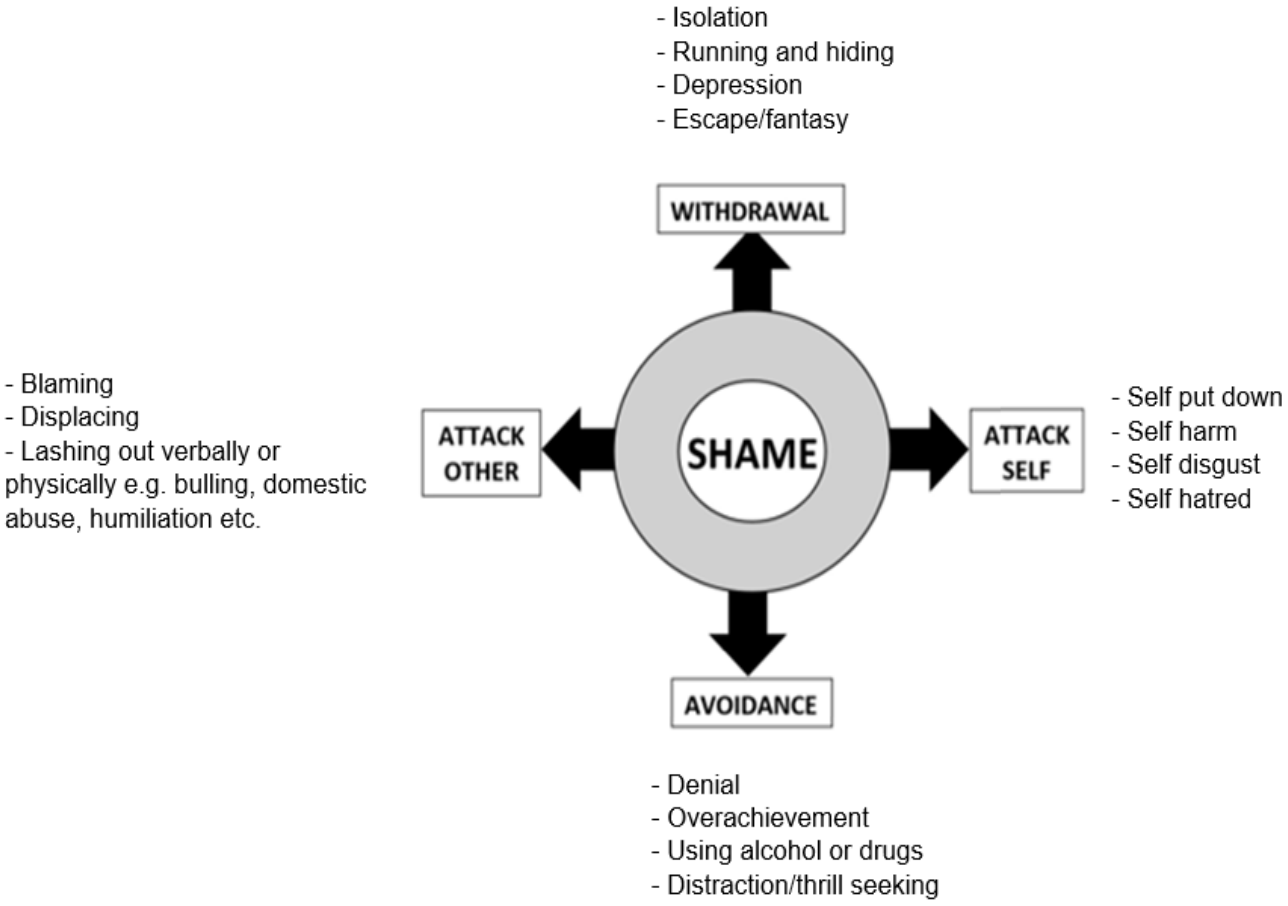


Diagram 4: The compass of shame[80]

Re-containment strategies

When shame has been uncontained, either as a big, devastating feeling or as a smaller leak, strategies are required to re-contain it because to remain in a state of uncontained shame would be intolerable. Depending on the circumstances and how big the uncontained shame feels will determine the type of re-containment strategies people use.

[80] The compass of shame (Nathanson, 1992) explains how people can react when they feel shame.

Appendix E- References

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