



**QUICK REFERENCE LEARNING POINTS FROM HARROW SAFEUGARDING PARTNERSHIP**

**LEARNED LESSONS REVIEW: YOUNG PERSON ‘J’**

**Learning about Trauma-Informed Practice, Legal Powers, and Planning for National Crises Impact on Service Delivery**

**Background**

Young Person ‘J’ suffered sexual abuse as a young child and began self-harming in her early teenage years. Whilst at secondary school she experienced peer on peer bullying and her self-harming behaviour began to escalate, despite considerable support and intervention by her school and CNWL. She also made threats to harm others, including a small child in her extended family.

‘J’ received inpatient care following some of her self-harming behaviour and it was felt that her mother was unable to keep her safe at home. There was some suggestion that her mother might have had a mild learning difficulty.

On one occasion, J was discharged to another relative who had a young child.

Following another hospital admission, ‘J’ was found a foster placement, but her self-harming behaviour continued, and readmission was required. During this episode ‘J’ was tasered and arrested to prevent further harm to herself and others. These circumstances were very unusual for a child in Harrow, so a review was carried out to see how well agencies worked together leading up to this incident.

**Understanding Legal Powers**

Agencies struggled with identifying which legal route to follow when unsure about J’s ability to consent to a s20 Order (relating to her being placed away from home) – i.e. not clear about whether it was the Children Act or Mental Health Act that best applied. There were lots of discussions about whether her mother or J should sign their consent – and whether this was enough

**Training need:** Practitioners and their managers should have access to legal training which recognises the complexities in balancing the rights and protection of young people and explains how the Mental Capacity Act , Deprivation of Liberty Safeguards and the forthcoming Liberty Protection Safeguards should be applied.

**Professional Curiosity about Childhood Trauma**

**Gaps in Information Sharing:**

* Not all involved agencies were fully aware of the bullying J experienced from her peer group
* J’s School were not made aware of any of her early childhood experience of sexual abuse
* Emergency services, such as LAS and Police, are often excluded in information sharing regarding a child’s history of trauma, which means that they can’t always make a decision in full context -and their default position is to admit to hospital which - might not be in the young person’s best interests

**Good Practice:** Practitioners were sensitive to the history of abuse within the family and took this into account when not returning J to her immediate home environment – feeling that she needed to recuperate in a different environment.

**Impact of Covid-19 on Suitability of Placements**

There were initial tensions between agencies regarding the need to balance keeping J safe from herself in hospital, whilst seeking an appropriate placement – and the need to remove her and others from the risk of Covid-19 in the hospital setting.

An initial placement for J was made with a relative, whose young child J had previously threatened. This decision was based heavily on the confidence the relative had in managing the situation. The arrangement broke down soon afterwards.

**Good Practice:** The foster placement that was found was an excellent match for J’s needs – A very experienced carer, who was provided with additional support and a good level of supervision. This placement was found despite the unprecedented impact on the availability of placements – foster carer and residential during the Lockdown.

**Strategic learning:** Cross-agency contingency planning is required for placements when national crises impact on the normally available short and longer-term options.



**Parents with Additional Needs**

LAS was informed by a relative that J’s mother had a learning difficulty and this information was relayed in their initial safeguarding referral.

Independently, some agencies suspected that J’s mother had mild learning difficulties and took some steps to assist her in understanding plans, but this was not discussed between agencies. Adult Social Care were consulted on one occasion, but when J’s mother refused to engage in an assessment no further advice was sought by those working with her.

**Repeated case review learning:** The need to seek advice from Adult Services, even when the need is not acknowledged or accepted by parents is crucial to the **Think Whole Family** approach. See previous Serious Case Review: <https://www.harrowscb.co.uk/wp-content/uploads/2019/09/Child-LH-LewishamHarrow-Overview-Report-for-Publication-4.7.19.pdf>