



North Wales Safeguarding Children's Board

Extended Child Practice Review:

NWSCB 2022/3

Brief outline of circumstances resulting in the Review

Legal Context

An Extended Child Practice Review was commissioned by the North Wales Safeguarding Board on the recommendation of the Child Practice Review Sub-Group per the Guidance for Child Practice Reviews. The criteria for this review are met under the Social Services and Well-being [Wales] Act 2014¹ (2014 Act); *Working Together to Safeguard People Volume 2 – Child Practice Reviews*² published 2016 (updated, 2021); The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015³. The United Nations Convention on the Rights of the Child⁴ (UNCRC), Rights of Children and Young Persons (Wales) Measure 2011⁵, Equality Act 2010⁶, Well-being of Future Generations (Wales) Act 2015⁷, Children Act 1989⁸, and Social Services and Well-being (Wales) Act 2014¹.

The criteria for this review are met under Chapter 6, Extended Child Practice Reviews:

A Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected, and the child has:

- Died; or
 - Sustained potentially life-threatening injury; or
 - Sustained serious and permanent impairment of Health or development; **and**
- The child was on the child protection register and or a looked-after child (including a person who has turned 18 but was a looked-after child) on any date during the 6 months preceding –
- The date of the event referred to above or
 - The date on which a Local Authority or relevant partner⁹ identifies that a child has sustained serious and permanent impairment of Health and development.

This Child Practice Review identified learning that will benefit future practice. It involved practitioners, managers, and senior officers who explored the detail and context of agencies' work with Child A and her family. The review's outcome will generate professional and organisational learning to promote improvement in future interagency practices with children and families. It includes the circumstances that led to the review, highlighting effective practice and consideration of how to improve future practice (*Working Together to Safeguard People – Volume 2 – Child Practice Reviews* (Welsh Government, 2016)¹⁰).

¹ [Social Services & Well-Being \(Wales\) Act 2014](#)

² [Working Together to Safeguard People – V2 – CPRs](#) (Welsh Government, 2016)

³ [The Safeguarding Boards \(Functions and Procedures\) \(Wales\) Regulations 2015](#)

⁴ [UN Convention on the Rights of the Child - UNICEF UK](#)

⁵ [Rights of Children and Young Persons \(Wales\) Measure 2011 \(legislation.gov.uk\)](#)

⁶ [Equality Act 2010 \(legislation.gov.uk\)](#)

⁷ [Well-being of Future Generations \(Wales\) Act 2015 \(legislation.gov.uk\)](#)

⁸ [Children Act 1989 \(legislation.gov.uk\)](#)

⁹ Local Authority or relevant partner means a person or body referred to in S.28 of the Children Act 2004 or body mentioned in s.175 of the Education Act 2002

¹⁰ [Working Together to Safeguard People – V2 – CPRs](#) (Welsh Government, 2016)

The Terms of Reference for this Extended Child Practice Review are in **Appendix 1.**
Circumstances resulting in the review

The Local Authority had periodic involvement with Child A and her family throughout her life. However, it was following 16-year-old Child A's disclosure of being a victim of sexual assault in October 2020 that her well-being began to deteriorate noticeably. Child A did not disclose the alleged perpetrator's identity in subsequent investigations. At the time of the critical incident, Child A had been a child looked after by the Local Authority since October 2021. Between October 2021 and April 2022, Child A was placed in unregulated, supported independent accommodation in Northwest England and hotels in North Wales. In April 2022, emergency services responded to a critical incident in which Child A sustained injury to her lower limbs.

The period reviewed and why

The Review Panel agreed that the timeline would be from 1 January 2021 to 4 April 2022 and that sufficient information should be included before Child A becomes a looked-after child. Additionally, the Review received contextual background information to assist its understanding of the impact of historical events on Child A's needs.

Introduction to Child A

Child A is the third of four children born to Ms A and Mr A. She has a shy, natural, and youthful presentation. She is someone who loves teddies and milkshakes. When she was 8 years old, her parents separated, and Child A's relationship with her father became estranged. When she was 12 years old, Child A's family became homeless, and they were unable to secure alternative housing. The family responded to their overcrowded accommodation by having an older sibling sleep on the sofa, and Child A went to live with her grandparents. Child A has some insight into her needs, evidenced by her recognition of the loss and despair she frequently experienced during the timeline. Child A loves individual time with practitioners, having them plait her hair and take her out for trips. Child A is creative and loves playing with arts and crafts materials.

Contextual Information

In October 2020, 16-year-old Child A disclosed in school that she had experienced inappropriate touching perpetrated by a non-familial male. This information was shared with the Local Authority and the Police. The Police investigation detailed an incident of sexual assault on Child A by a male who was between one and three years older. The Police visited Child A in school twice, but she declined to provide further information. The assault was not considered part of a multi-agency strategy because the alleged perpetrator was extra familial. The timeline of events detailed the almost daily incidents of concern regarding Child A and her self-harming behaviours.

Timeline of events

Before January 2021, Child A had no previous involvement with CAMHS. However, following the sexual assault in October 2020, she was referred for a hospital-based assessment after reporting four overdose attempts in three weeks. Ms A was concerned about her daughter's welfare and did not feel it was safe for Child A to be discharged from the hospital. Child A was discharged, and there were a further five occasions when she reported an overdose and was admitted to the hospital and discharged again before the end of February 2021. During that time, Child A was unable to engage with CAMHS or the proffered psychiatric assessment. She also absconded from the ward and was returned by the Police. A detailed support plan was compiled, and a multidisciplinary team meeting occurred.

The subsequent 15-month combined timeline provided by all agencies detailed almost daily meetings within and between agencies, reflecting the complex and dynamic interactions required to support Child A. The context of that involvement is detailed below, highlighting the assessments that were undertaken and where support was offered and concerns escalated.

Following a further unauthorised absence from the hospital, Child A was detained in March 2021 under 5(2) of the Mental Health Act 1983 (MHA). A week later, Child A was discharged to the care of her maternal grandparents. A referral was made to the Local Authority for a care and support needs assessment. Child A and her mother cooperated with that assessment. Health practitioners requested a foster placement for Child A. However, the Local Authority concluded Ms A was able to meet Child A's needs, provided there was mental health support in place. Ms A's home remained overcrowded, and it was noted that there was a limited housing supply. Child A expressed that she wanted to be able to live with her mother.

Four days after being discharged from the hospital, Child A was again admitted in the early hours of the morning after being reported missing from home and found with two boxes of pain relief medication. Child A was discharged to her mother's care later that same day. She was again admitted to the hospital following another overdose two days later and detained under s5(2) of the MHA. A detailed assessment by a consultant psychiatrist found Child A had no biological features of depression, significant anxiety, or mental illness. It was determined that Child A was presenting with features of an adjustment reaction, which could be morphing into a trauma response. The indication was given to Tier 3 CAMHS that the appropriateness of continued detention under the MHA would need to be reviewed soon. It was noted that there was no evidence of a neurodevelopmental component to Child A's presentation.

Several recommendations were made:

- Allocation of a Care Coordinator (CCO) with whom Child A has better engagement to explore adaptive coping and trauma-informed interventions. CCO will also consult with the school regarding the disclosure in October 2020.
- Dialectical behaviour therapy skills to be used to support a platform for trauma-informed interventions, psychoeducation regarding trauma response, and evolving behaviours.
- Assist Mrs A in acquiring a larger house so that Child A could live with her.
- Health will support stepping down from North Wales Adolescent Service (NWAS) post-discharge.
- Rapid need for a package of care from Tier 3 and support from strengthening families and the FIT/ edge of care team to support the family in the community.

A brief period of calm occurred over the following three weeks, and in mid-April 2021, Child A became an informal patient and was discharged from the liability to be detained under 5(2) of the MHA. Following another escalation in concerns regarding being missing from home, the risk of self-harm, and the ability of her family to keep her safe, Health services made a child at risk report. Less than two weeks later, Child A was discharged from NWAS. A detailed Health case summary concluded that Child A's difficulties were a result of complex adverse childhood experiences and her family's current circumstances. It was considered that the assault on Child A in October 2020 triggered her reliance on a pattern of coping behaviours, causing her significant social and emotional difficulties. It was suggested that Child A may have experienced unpredictable responses from her mother that might have led Child A to rely on more extreme expressions of distress. Conversely, the Local Authority viewed Ms A as responding appropriately to Child A's needs. It was also observed that Child A might have information processing difficulties that limit her ability to think flexibly or generate various alternative solutions when encountering problems.

The day after the discharge meeting it was reported that Ms A and Child A cancelled the appointment with the consultant psychiatrist. Ms A did not attend the family therapy appointment, and Child A was not brought to the cognitive assessment appointment. Four days later, the ambulance service made a referral to Children's Social Care regarding Child A taking an overdose. Child A refused to attend the hospital, and her mother refused to attend with her. The Police were called. Eventually, Child A attended the hospital, and no treatment was required. Two days later,

Child A overdosed and attended the hospital. Practitioners from the Local Authority visited Child A and Ms A and discussed some of the challenges Child A was experiencing living with her grandparents. Areas of support were identified. In the early hours of the next morning, Child A overdosed and was admitted to the hospital.

This pattern of repeated incidences of absconding and self-harm continued throughout the timeline. In May 2021, notably, in addition to tablets, Child A was now superficially cutting her wrists, and calls to emergency services included a concern about her possession of a blade or razors. Concerns about the impact of Child A's housing situation remained for health professionals who sought to consult with social care. A planning meeting was convened, but the Local Authority did not attend. In June 2021, Health Services made another child at risk report following an incident where Ms A declined to follow the nurse's advice to take Child A to the hospital following a reported overdose. A further overdose took place later that month, and the Police expressed concern about Ms A refusing to go to the hospital with Child A. Ms A cancelled a home visit by the CCO due to a house move.

The start of July saw Ms A reach out to the Police as she was struggling to manage Child A's behaviour at home. In her distress, Child A was throwing furniture and tried to pull a radiator off the wall and assaulted her mother. Ms A refused to have her daughter back home. Over the next week, Child A overdosed again and was taken to the hospital. Child A was not at home on two occasions when Health practitioners visited during that month. Similar concerns continued throughout July, and a child-at-risk report was submitted by the ambulance service (WAST). By the end of July, Ms A explained she could not care for her daughter at home. The Local Authority was unable to provide a placement that weekend. The Police and ambulance service responded to calls from Ms A in response to Child A's behaviours that weekend.

In August 2021, Child A, then aged 17 years, was placed in hotel accommodation while the Local Authority worked to identify appropriate, supported accommodation. Child A refused to remain at that hotel. The Local Authority could not find additional hotel accommodation to enable a support worker to stay with Child A. Child A returned home to her mother's care with support from Health and the Local Authority. Throughout August and September, plans were made for Child A to move to the supported accommodation identified by the Local Authority. Simultaneously, there were multiple reports to the Police that Child A had caused criminal damage to the family home. In late August, Police attended such a call, but concerns arose that Child A had taken a dangerous number of aspirin. Child A was detained under s136 of the MHA (1983). She was discharged home later that day. Further overdoses occurred in the following days, and the Police again employed a s136 of the MHA (1983). Child A was discharged two days later and returned to her mother's care with a safety and support plan. Following a further overdose, the hospital confirmed treatment was required; however, Child A absconded on four occasions, leading to her detention under s5(2) of the MHA (1983) before being placed on s4 of the MHA (1983) for treatment of overdose and further assessment. Child A was admitted to the hospital, placed under s2 of the MHA (1983), and later became an informal patient.

In late September 2021, Child A absconded from the hospital and was detained under s2 of the MHA (1983). A plan was in place to release Child A on s17 of the MHA to allow her to visit the identified supported accommodation. During this latest admission, Child A declined two further cognitive assessments. Multiple multi-agency meetings were convened, and in the second week of October, professionals were advised that the supported accommodation was no longer available. On 21 October, Child A took another overdose. The Local Authority's Children's Social Care and Housing teams worked collaboratively and identified supported Bed and Breakfast accommodation for when Child A was discharged on the 25 of October. The discharge plan included wrap-around support from multiple agencies, including telephone calls and home visits to Child A. The day she was discharged, Child A reported she had taken an overdose, and after attempting to abscond, she was detained under s136 of the MHA (1983). On 29 October, Child A moved into the supported bed and breakfast accommodation; however, she was brought back to the hospital by ambulance later that night after taking an overdose. The Police later returned her

to the supported accommodation. On 31 October, Child A took another overdose, which led to her being detained under s136 of the MHA (1983).

At the start of November 2021, internal health records summarised their significant safeguarding concerns; these included:

- Child A could cause her death by misadventure due to her risky behaviour and overdoses.
- Health considered the hotel an inappropriate placement given Child A's vulnerabilities and emotional dysregulation.
- Ms A had not engaged with the Local Authority regarding signing any s76 of the Social Services and Well-being (Wales) Act, 2014.
- Tier 3 and 4 CAMHS professionals feel the level of support Child A requires is beyond the scope of mental health services.

On the evening of 2 November, Child A took another overdose. Health staff assert the Bed and Breakfast accommodation is not an appropriate placement. The accommodation provider agreed. The Local Authority sought consent to accommodate Child A for one more night. Child A overdosed again that evening and was placed under s136 of the MHA (1983) by the Police. Subsequently, the Local Authority identified an unregulated placement in a town in Northwest England to function as a bridging placement. Child A agreed to move there. On 4th November, Child A moved into the unregulated placement while waiting for a place in a regulated supportive placement. A statutory visit took place on 11 November; the following day, Child A took an overdose and attended a hospital in England. On 18 November, another statutory visit occurred, and the placement was reported as positive. It also facilitated introductions between Child A and the team from the future placement. On 21 November, Child A stayed overnight in the newly identified supported accommodation before absconding to her mother's home. On 29 November, a care planning meeting was convened. On 1 December, a complex case review meeting was held. The Health Service in Wales maintained contact with Child A, who engaged in a discussion about her future.

Throughout December 2021, there were multiple occasions when Child A was reported missing from the unregulated placement. Child A moved into the supported accommodation on 13 December 2021. Days later, Child A had taken an overdose and cut herself with a small blade. Police officers removed 5 razor blades from her. She continued to try to harm herself and was detained under s136 of the MHA (1983). The subsequent week saw several other overdoses being reported, and on one occasion, she had cut herself with glass. Child A overdosed on Christmas day and spent the night in hospital. On Boxing Day, she took another overdose but was supported in her placement. On 27th December, Child A took another overdose, and superficial cuts to her hands were noted. She was intoxicated and had been seen running in and out of the road. She was arrested for being drunk and disorderly, and a small blade was removed from her. Child A was discharged from the hospital on the morning of the 28th December, and overdosed again later that afternoon. On the 31st of December, the Police again arrested Child A for being drunk and disorderly, running into the road, and trying to self-harm by hitting her head against hard surfaces.

Throughout January 2022, Child A was placed in an unregulated placement in Northwest England. The Police responded by making a Protection Order when Child A threatened to jump off a multi-storey car park. Multiple threats to self-harm incidents occurred throughout January, on one occasion leading to Child A being arrested for Breach of the Peace. In February 2022, Child A's behaviour escalated in the level of disruption she displayed within her placement, including damage and reported threats to/assaults on staff. She is reported on more than one occasion to say she wants to kill herself. However, the chronology reflects that there were occasions when Child A presented, to some practitioners, as more positive and settled, within hours, significant concerns about her behaviour reemerged. In mid-February, an unregulated placement in an

Airbnb was sourced. A week later, in Northwest England, Child A is detained under s136 of the MHA (1983) following threats of self-harm, reported overdose, and leaving the hospital. Before discharge, a professional meeting was held with English and Welsh health professionals. On the same day in Wales, a transition meeting was held.

The Police in England made a Police Protection Order under s46 Children Act (1989). Inquiries about additional support for Child A in England were made; however, referrals could not be accepted without a permanent address and Child A being registered with GP in England. Child A had presented to CAMHS in England on multiple occasions before the referral from Wales had been received.

In early March 2022, a multi-agency meeting occurred to discuss Child A's needs amid the escalating risks and new risk behaviours. Attendees noted that s136 had been used while Child A was in England, which was contrary to their crisis plan from October 2021, and they said that s136 was not required as Child A does not have a mental health diagnosis. Further overdoses in March brought Child A to the attention of the hospital, whose records seem unclear when she became a looked-after child. The Northwest England LAC team had not been notified and refused to accept a referral until they had. Child A's presentation continued to be a cause of concern throughout March, and the Police in England responded on multiple occasions. They raised concerns about the suitability of the unregulated placement. On one occasion, Child A was detained under s136 of the MHA (1983) before being discharged to the unregulated placement.

On 20th March 2022, the Police in England received a call from the unregulated placement raising concerns about Child A, who was intoxicated at a railway station. The Police found Child A and returned her to the placement. The Police recorded significant concerns about the ability of the placement to meet Child A's needs. The following day, the placement served notice, and Child A was placed in a hotel in Wales. Simultaneously, in England, a CAMHS internal MDT meeting was convened. In Wales, CAMHS noted they received notification about Child A's move to a Welsh hotel.

The next day, a call from ChildLine via Police in England raised concern about Child A, who said she was in a hotel in Wales and wanted to take an overdose. Police officers attended the hotel and spoke to Child A, who had injured herself with a shard of glass. Child A asked to talk to a female police officer to show her a note about an incident she reported back in 2020 that played on her mind. The note expressed the profound sadness Child A had experienced. The Police took Child A to the hospital. The following day, a family member contacted the Police to report Child A was at the railway station threatening to jump in front of a train. Child A ran away and cut herself with glass, leading to the use of s136 of the MHA (1983). The rest of March continued with repeated concerns involving multiple agencies.

On 24 March, a risk management meeting was convened. On the same day, Child A presented to the hospital emergency department, reporting an overdose from the previous day. Although the CAMHS plan said no CAMHS assessment was needed before discharge, the clinical team noted Child A was living in a homeless B&B hotel and wanted her to be discharged into the company of an appropriate adult. She was discharged later that afternoon. The next two days saw Child A in contact with the Local Authority Emergency Duty Team (EDT), saying she had been drinking and taking tablets. She refused to call the Police. Child A was advised to call the Samaritans, and EDT called the Police. On 26 March, Child A was detained under s136 after there was no one from the family or the Local Authority to take care of her. She was then discharged with a plan for community follow-up. Later that week, members of the public contacted the Police, saying Child A had cut herself. She said she was unhappy at the hotel, where many men were also present. She later contacted the Police and thanked the officers who had tried to help her (and again intimated suicidal intent). Police officers found Child A and returned her to the hospital.

Child A emailed practitioners in Health and the Local Authority to express her suicidal intentions. The Local Authority practitioner responded by email but could not see Child A in person that day due to being unwell. The Local Authority practitioner forwarded the email from Child A to the Senior

Practitioners in Health for their attention. An afternoon Health appointment was arranged. Child A had stayed in the hospital emergency department all night. The Local Authority sent a practitioner to the emergency department. A Health practitioner saw Child A, who reported having a plan and a backup plan in terms of ending her life. Child A said that in the supported and unregulated placements, people did things that could help distract her, but now she needed a hot meal, someone to talk to, and something to do during the day. An appointment was made for the following day, but Child A said she would not be here then. A practitioner from the EDT arrived to take her back to the hotel.

In April 2022, Child A was self-harming in her hotel room with a friend. Child A was thought to be intoxicated, and the two young people climbed onto the roof of the hotel. The Police and an ambulance were called. Child A was taken to the hospital by the Police. The hotel staff informed the Local Authority that Child A must vacate immediately. Local Authority practitioners met with Child A to discuss accommodation options. Child A stated that she would not 'be here'. Child A left the room and was later found by Police and taken to the hospital after taking another overdose. The following day, Child A was placed in another hotel. The Local Authority arranged for a practitioner to stay at the hotel to support Child A. A day later, during the critical incident that led to this review, Child A sustained injuries but was saved from further harm by the extraordinary courage of a Local Authority practitioner.

Practice and Organisational Learning

Identify each learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances.

An integrated needs-led approach would be advisable to the recurrent presentation of distress and risk of significant harm through suicidal intent or associated misadventure.

The contextual information provided in this Review referred to the disruption in Child A's childhood following the separation of her parents. The family experienced overcrowding, which led to Child A living with her maternal grandparents, who lived near her mother. With the support of her maternal grandparents, Child A completed her schooling and commenced college. Regrettably, soon afterwards, Child A experienced a sexual assault in October 2020, an event that was a catalyst for the cyclical distress detailed throughout the timeline. Child A's experience of and response to distress revealed her complex vulnerabilities, which were deemed to be anchored to interruption in her primary childhood attachments. Understanding the adolescent experience of non-suicidal self-injury¹¹ and suicidal intent is complex. The interpersonal-psychological theory of suicide has been found to have some relevance to the adolescent experience¹² when their need to belong is unmet, and they see themselves as a burden to others. Furthermore, recent research¹³ suggests adolescents' insecure attachments to parents can elicit attachment anxiety and avoidance and consequentially lead to suicidal behaviours.

During the timeline, multi-agency efforts to support Child A at home, in the hospital, and in various supported living environments proved unsuccessful. Child A would frequently abscond and, at other times, present self-harming or disruptive behaviours. The Local Authority supported Ms A in applying for a larger property. However, Child A's needs outstretched her family's resources and attempts to engage them in therapy did not come to fruition. Additionally, attempts to understand Child A's cognitive functioning were unsuccessful when Child A refused to complete assessments. Practitioners who knew Child A reflected that she was seeking individual connections with trusted

¹¹ Taylor A. et al. (2015). Non-suicidal self-injury prospectively predicts interpersonal stressful life events and depressive symptoms among adolescent girls, *Psychiatry Research*, 228(3), pp. 416-424.

¹² Stewart, S. M., et al. (2017). The Validity of the Interpersonal Theory of Suicide in Adolescence: A Review. *Journal of Clinical Child and Adolescent Psychology*, 46(3), 437-449.

¹³ Leben Novak, L., et al. (2023). The Influence of Insecure Attachment to Parents on Adolescents' Suicidality. *International Journal of Environmental Research and Public Health*, 20(4), pp2827-.

adults whom she accessed via emergency presentations following incidents of self-harm. This Review learned that practitioners were concerned that Child A was becoming conditioned to the emergency response as a means of managing her distress, and they feared she would suffer significant harm through misadventure. In response, Health services developed a pathway plan to limit the reinforcement of that aspect of learned behaviour. Simultaneously, the recurrence of Child A's presentation of distress limited the Local Authority's options for a suitable placement.

Multiple agencies responded daily to Child A's recurrent crisis presentations. The inability to source a secure base that could emotionally sustain Child A frustrated the ability of Health and Local Authority practitioners to work effectively. Neither agency explored the need for multi-disciplinary risk sharing with senior colleagues and managers. The continual breakdown of placements required the Local Authority to access unplanned emergency accommodation, often unsuitable for Child A's complex needs. Thus, in the absence of an effective response to meet Child A's presenting needs, her distress continued to escalate. Notably, Child A would often present when most daytime services were ending, denoting a time when she felt most psychologically vulnerable. 24-hour designed services such as the Police and the Ambulance service were frequently called upon. The review learned that the Police and Ambulance services sometimes searched for hours to locate Child A safely. That task was more difficult when out-of-area teams responded to calls and did not know Child A or where she was likely to be found.

Learning Event attendees perceived Child A's needs as being beyond the scope of their individual agency's provision, which left them feeling another agency could do more, and vice versa. There was excellent multi-agency practice throughout the timeline. Notably, the frequency of multi-agency meetings required, occurring simultaneously with new presentations of distress, meant not all agencies could be present at every meeting. However, the timeline reflects the significant commitment of multiple services to responding to Child A's needs, and undoubtedly, their actions helped to save her life.

Responding to adolescent distress needs a multi-agency service supported by coordinated policy and practice.¹⁴ This review suggests that collective efficacy¹⁵ will arise from a multi-agency response that is not hindered by agency boundaries but enhanced by a 24-hour integrated service provision. That approach will provide distressed adolescents in crisis with a 24-hour integrated response to further their sense of belongingness¹⁶ and reduce feelings of being a burden. Additionally, integrated risk assessments should be completed for children and young people so they can visualise the multi-agency network around them. Success will require local accommodation, collaborative language, and proactive response structures that reduce engagement barriers. All agencies should be included as they could offer knowledge and support not readily considered by another agency. For example, at some points in the timeline education colleagues could have been invited to offer valuable insights into Child A's information processing abilities and learning style. However, as Child A was no longer in school and was no longer attending college it is not customary to include them in multi-agency discussions.

The Welsh Government's Nurturing, Empowering, Safe and Trusted (NEST) framework¹⁷ published in 2023, refers to a 'whole system approach to mental health and well-being services.' It is a wide ranging report that outlines theoretical and practice principles which can benefit the provision of robust and co-produced services for children and young people. In 2024,

¹⁴ Patton, G., & Borschmann, R. (2017). Responding to the adolescent in distress. *The Lancet (British Edition)*, 390(10094), 536–538. [https://doi.org/10.1016/S0140-6736\(17\)31331-4](https://doi.org/10.1016/S0140-6736(17)31331-4)

¹⁵ Bandura, A. (2000). Exercise of Human Agency through Collective Efficacy. *Current Directions in Psychological Science : A Journal of the American Psychological Society*, 9(3), 75–78. <https://doi.org/10.1111/1467-8721.00064>

¹⁶ Glenn, C. R., et al. (2022). Thwarted Belongingness Mediates Interpersonal Stress and Suicidal Thoughts: An Intensive Longitudinal Study with High-risk Adolescents. *Journal of Clinical Child and Adolescent Psychology*, 51(3), pp. 295–311.

¹⁷ [NEST framework: full report \[HTML\] | GOV.WALES](#)

a joint inspectorate review (JIR), led by Healthcare Inspectorate Wales (HIW) alongside Care Inspectorate Wales (CIW) and Estyn, examined how agencies are working to meet the mental health needs of children and young people across Wales¹⁸. The JIR recognised that despite the dedication of state and voluntary agencies, the mental health needs of some children are not being consistently met. The JIR report made multiple recommendations, which align with many of those suggested by this Child Practice Review. Additionally, this CPR extends the focus of the JIR to include the potential consequential effect of the unmet mental health needs of children upon the practitioners who are supporting them in times of crisis.

Good Practice

All Agencies

- Practitioners responded to Child A's needs within the limitations of their service provision and at times beyond it.
- Practitioners and managers sought to consistently respond effectively to Child A's distress and safeguard her from self-harm.

Local Authority

- Practitioners and managers had a good understanding of Child A's needs and worked creatively with limited resources to provide her with care and support.
- One practitioner showed significant courage during a potentially fatal incident. During the incident, the practitioner was in telephone contact with another colleague who offered support as events unfolded.
- At the Learning Events, practitioners from other agencies gave recognition to the value of the Local Authority's relationship-based practice approach.

Health

- Practitioners had a good understanding of Child A's needs and made safeguarding referrals to other agencies when they were concerned about her safety.
- Practitioners were committed to ensure multi-agency meetings took place and that Child A's needs as she transitioned from child to adult services were planned for.

WAST

- Practitioners made numerous safeguarding referrals during the timeline demonstrating evidence of good practice in correctly identifying and taking steps to safeguard Child A when there were concerns for safety.

Police

Officers were responsive to Child A's physical and mental health needs, including analysing the suitability of her accommodation and raising concerns.

¹⁸ [20241121 HIW Children and Young People Mental Health Joint Review - EN 0.pdf](#)

Learning Events Perspectives and Reflections

All Agencies

- To explore the potential for integrated and locally based care and support provision that can provide intensive care and therapeutic support suitable to meet the global needs of adolescents with self-injurious and suicidal behaviours
- Pathways should be available for all agencies to develop their understanding of each other's service provision.

Local Authority

- The out of hours service is provided by a team of three employees who collaborate to respond to a range of queries and urgent needs.
- Practitioners demonstrated a significant commitment to safeguarding Child A from harm.

Health

- There was scope to improve the cross border handover of information.
- There was at times limited information in health records and minutes.

WAST

- WAST practitioners attending learning event shared they never felt separate from their colleagues and managers in decision-making. Their post critical incident support was timely and effective, and they could receive further support from an external agency.

Police

- Police Officers working in ambulance control centres and vice versa facilitates an integrated response at the point of need.
- The Police can contribute to safeguarding plans by placing warning markers and alert systems on an address and a person.

Education

- Including educational expertise in multi-agency meetings might have offered valuable insights into Child A's information processing and learning style.

Agency Perspective and Reflections

Local Authority

- There was a clear recurrent pattern of agencies reacting to presenting incidents of overdosing, hospital admissions, discharges, and accommodation searches. There were regular multi-disciplinary team meetings to manage risk, discuss safety plans, Placements and attempts to coordinate a multi-agency response.
- There was a missed opportunity for agencies to work collaboratively, including convening a strategy discussion or a joint investigation. Consideration could have been given to a multi-agency response with CAMHS to address the emotional impact of the incident disclosed by Child A in October 2022.

Health

- The Health Board could have explored the need for multi-disciplinary risk sharing at the most senior clinical and managerial level at the earliest opportunity.
- The Health Board could have ensured that all Health Board services currently engaged in the care of the individual were made aware of each respective admission to the Emergency Department as this would have acted as an alert to these services and would have prevented any potential delay in these services working collaboratively with both internal and external services and agencies.

WAST

- Due to absconsion on several occasions, it was necessary and proportionate for WAST to seek assistance from Police to locate Child A to mitigate any risk of further harm. Conversely there were calls to WAST made by police and CAMHS due to concerns about Child A's presentation, vulnerability, and ability to maintain her own safety. This demonstrated good collaborative working between agencies despite frequency and challenging nature of calls.

Police

- Police could have persisted in maintaining contact with Child A to build a relationship of trust.

Employee wellbeing, including lone working and post-critical incident support

The Learning Events provided an opportunity for practitioners and managers to reflect on the differences in their experience of responding to a young person with self-injurious behaviours that could lead to death. Those in attendance explored their misunderstandings regarding decision-making between agencies when there was a desire for another agency to provide for the need that your service could not meet. Attendees remarked that the Learning Event was their first time discussing the sequence of events as a multi-agency group. It also allowed them to understand their practice and decisions in the context of Child A's experiences.

Both Learning Events included attendees who had worked with and knew Child A and her family. Several attendees had responded to Child A in times of crisis and self-injury. There was reflection regarding their desire to sustainably assist Child A, juxtaposed with the reality of their practice, as often ineffectual beyond meeting her immediate primary needs. At times, some Health practitioners felt there was an absence of senior management availability outside of weekday daytime service hours that limited their responsiveness. That experience was not the same for the Police and Ambulance Service colleagues who stated that their access to a control centre meant they never felt alone in their practice.

The Local Authority has a relationship-based practice model with multiple benefits for the public but requires a significant commitment from its employees. For example, a practising social worker provides overnight service cover in addition to their day-to-day duties. Furthermore, the daytime managers oversee social care services' out-of-hours Emergency Duty Team. It was noted that although management cover is shared across the Local Authority, the specialist knowledge lies with the social care managers. Two of the Local Authority attendees were actively engaged in supporting Child A during the night she sustained severe injury. One was present with Child A, and the other provided them with support via the telephone. As events rapidly and dramatically unfolded, one colleague made a life-or-death decision while the other bore witness to an extraordinary act of bravery. Attendees commented on the value of the relationship-based practice of the Local Authority practitioners and recognised its advantages and concerns.

An integrated multi-agency service that supports 24-hour collaborative working¹⁹ would reduce the stress and potential risk experienced by practitioners working with young people in crisis. It would enable the integrated service to meet needs when needed 24 hours a day, thus promoting belongingness and reducing a sense of burden. Integrated risk assessments for children and young people should accompany employee risk assessments. They should be compliant with the employer's duties under the Health and Safety at Work (etc) Act 1974,²⁰ and the Fair Work Wales Policy.²¹ These could be reviewed by an integrated panel with a remit for ethical oversight to draw on the best interprofessional practices when responding to changeable and life-threatening risks. This practice would reduce isolation and promote proactive decision-making helping to safeguard employees' mental and physical health. Interprofessional training for employees working with children at risk of suicide would strengthen the knowledge and skills base, adding to employees' sense of belonging to an integrated service.

Post Critical Incident Support

The North Wales Safeguarding Board has published multi-agency guidance for the support of employees affected by critical incidents.²² The guidance does not replace an agency's internal processes. However, it intends to ensure a commitment to support staff, mainly when an incident has led to a referral for an adult or child practice review. During the review, there was a significant difference in how practitioners experienced their agencies' response to lone working and post-critical incident support. Research²³ suggests emergency service practitioners can experience post-traumatic stress due to the nature of their work and subsequently develop adverse mental health. At the Learning Events, practitioners from the ambulance service said they never felt separate from their colleagues and managers in decision-making. Their post-critical incident support was timely and effective, and they were able to receive further support from an external agency. Similarly, the Police also found their independent de-briefing structures supportive and responsive.

There was evidence of good interagency practice. British Transport Police offered to share their established debrief process, which is offered to their employees following a critical incident. In May 2022, employees were invited to attend group and one-to-one sessions delivered by a critical incident employee assistance provider. Furthermore, an interim Head of Service in the Local Authority sought additional support for an employee. Some participants thought line managers should not deliver debriefing sessions to ensure employee well-being is demonstrably separate from their employer.

¹⁹ Bochatay, N., et al. (2017). A Multilevel Analysis of Professional Conflicts in Health Care Teams: Insight for Future Training. *Academic Medicine*, 92(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions), S84–S92. <https://doi.org/10.1097/ACM.0000000000001912>

²⁰ [Health and Safety at Work etc. Act 1974](#)

²¹ [Fair Work Wales | GOV.WALES](#)

²² [Multi-agency-guidance-for-the-support-of-employees-affected-by-critical-incidents.pdf \(northwalesafeguardingboard.wales\)](#)

²³ Stevelink, S.A.M., et al. (2020). The mental health of emergency services personnel in the UK Biobank: A comparison with the working population. *European Journal of Psychotraumatology*, 11(1), 1–11

Good Practice

Police

- British Transport Police offered to share their established debrief process, which is offered to their employees following a critical incident.

Health and WAST

- Health and WAST services provide an established Trauma Risk Management (TRIM²⁴) response which includes hot debrief immediately after a critical event.

Local Authority

- In May 2022, employees were invited to attend group and one-to-one sessions delivered by a critical incident employee assistance provider.
- An interim Head of Service identified and sourced additional support for an employee.

Learning Events Perspective and Reflections

All Agencies

- There is a need to consider how agencies can further collaborate to enhance a multi-agency response to support practitioners, particularly outside daytime service hours.
- Practitioners would welcome an improved understanding of the decision-making frameworks and processes of other agencies to enhance their ability to collaborate.

Local Authority

- There is scope to consider strengthening out of hours duty provision when practitioners are supporting for adolescents experiencing recurrent distress and suicidal thoughts and behaviours.

Health

- At times, practitioners feel isolated and encumbered with the responsibility of responding to unmet needs of their patients when managers and senior clinicians are not present to make decisions, outside of office hours.

Agency Perspective and Reflections

Health and Local Authority

There is scope for the Health Board and the Local Authority to strengthen operational processes to support practitioners who are responding to children and young people with self-injurious and suicidal behaviours, particularly when crisis is occurring outside daytime service hours. Positively, CAMHS have extended the delivery of their crisis service to 9pm. Additionally, there is always a site manager

²⁴ [0392-12attachment2of2.pdf](#)

Improving Systems and Practice

To promote the learning from this case, the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

(What needs to be done differently, and how will this improve future practice and systems to support practice?)

A review developed, approved and delivered by all agencies involved in this matter of the systems, processes, and pathways that are in place for adolescents experiencing recurrent distress and suicidal thoughts and behaviours; and the practitioners supporting them, particularly outside of daytime service hours. That joint review should consider:

- An integrated and locally based care and support provision, (like the 24/7 crisis hub facility established in Carmarthenshire by Hywel Dda University Health Board) that can provide intensive care and therapeutic support suitable to meet the global needs of adolescents with self-injurious and suicidal behaviours.
- Children experiencing recurrent distress and suicidal thoughts and behaviours to receive a multi-agency integrated care and risk support plan that meets their needs 24 hours a day.
- A review of how risk assessments are completed for employees working with children in receipt of an integrated care and risk support plan.
- A process to review regional integrated care and risk support plans, to develop their effectiveness.
- Interprofessional training for employees working with adolescents with self-injurious and suicidal behaviours, to build relationships and knowledge of multi-agency practices.
- Improving effective communication with services in England for children with an integrated care and risk support plan.

Statement by Reviewer(s)

Reviewer 1
Dr Donna Peach

Reviewer 2
Angela Mansell

Statement of independence from the case *Quality Assurance statement of qualification*

I make the following statement that before my involvement with this learning review:

- I have not been directly concerned with the child or family or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge, experience, and training to undertake the review.
- The review was conducted appropriately and rigorous in its analysis and evaluation of the issues set out in the Terms of Reference.

Reviewer 1
(Signature)



Reviewer 2
(Signature)



Name (Print)	Dr Donna Peach	Name (Print)	Angela Mansell
Date	13.05.2025	Date	15.05.2025
Chair of Review Panel (Signature)			
Name (Print)			
Date	27.11.2025		

Appendix 1: Terms of Reference

Child/Adult Practice Review Process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The process followed by the Board and the services represented on the Review Panel

A Panel Chair and an Independent Reviewer were commissioned, who was, per the guidance, independent of the case management and had the relevant experience, abilities, knowledge, and skills as required by the case and circumstances under review. The Review Panel consisted of representation from the following agencies, all of whom had had an involvement with the individuals at the centre of this review:

- Local Authority
- Health
- Welsh Ambulance Service
- Education
- Police

The practitioners' and managers' knowledge and skills supported a critical examination of Child A's lived experience. Collectively, they co-produced the learning presented within this report. The Reviewers are grateful to the Panel for their commitment and expertise in supporting the learning review process across agencies. Seven panel meetings were held in total.

Family involvement in the review

Ms A and Child A did not wish to participate in the review.

The Learning Events

All agencies were invited to attend two all-day Learning Events; one convened for practitioners on 2nd July and one for managers held the following day. In all, twenty six professionals attended and embraced the critically reflective process.

The time since the consequential incident did not lessen the challenging nature of reflecting on the events at the centre of this review. At each Learning Event, practitioners and managers shared their insights into their experience of Child A. Attendees valued the opportunity to listen, share, and learn from their different involvement with Child A and her family. The presence of practitioners who knew Child A greatly assisted the learning process. The reviewers are particularly grateful for

those who attended the Learning Event despite the potential impact of revisiting past traumatic events. The reviewers are thankful for the invaluable contributions of everyone who participated in the learning process. The willingness of all to engage in critical reflection and seek solutions built on a shared understanding is commended.

Family declined involvement: Yes

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Date information received: (date)		
Acknowledgement letter sent to Board Chair:(date)		
Circulated to relevant inspectorates/Policy Leads:(date)		
Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			