



## **BOLTON SAFEGUARDING CHILDREN BOARD - LESSONS LEARNED**

### **Experiences of a Looked After Child**

R was sixteen years old at the time of her death and looked after by the Local Authority.

For much of her childhood she had been in stable placements which met her needs. Practitioners recognised the importance of her birth family and worked together to manage the challenges this brought. During the last two years of her life her self-harming behaviours increased although the full extent of these, in particular 'cutting', only became apparent after her death.

This review highlighted a number of key learning points which are summarised in this briefing.

### **INFORMATION SHARING**

This review has highlighted that key information about R's history of abuse was not fully shared with her school. In response to this BSCB, in partnership with the Corporate Parenting Board have developed information that all schools should have when they are working with Looked After Children.

**You can access the list of core information**  
<http://boltonsafeguardingchildren.org.uk/documents/2016/03/having-a-looked-after-child-in-your-school.pdf>

### **INFORMATION SHARING**

Not all practitioners attended R's multi-agency reviews – for a range of reasons including in response to her wishes.

Attendance and contribution to Looked After Children Reviews should be a priority.

**If you can't attend or have been asked to share information only you should make sure you get feedback on the outcomes and decisions from the meetings; recording these in your records**

### **ACCESSING THE RIGHT EMOTIONAL HEALTH HELP**

Therapeutic options were discussed and offered to R, primarily via CAMHS services. This focussed on addressing self-harming and promoting good emotional health. As R did not want to take up these offers further consideration could have been given to promoting her access to alternative services and interventions such as Young Minds or National Association for People Abused in Childhood.

**These options should be considered during assessment, reviews or other planning meetings.**

### **INFORMATION SHARING**

It was not always clear to the school, particularly when they had worries about R, when and with whom they should share information – some information was shared only with the foster carer, at other times it was with both the social worker and foster carer. This led to gaps in identifying what was happening for R and developing a full picture of her self-harming.

**If you are part of a multi-agency group working with a child make sure you know who you need to share information with**

### **LONGER-TERM IMPACT OF ABUSE**

R's experiences showed that while there are strengths in the investigation and immediate assessment of abuse allegations; our system is not as strong in considering or planning for the medium to longer-term impact of child abuse or neglect.

This was particularly evident as R moved into adolescence. **During adolescence young people are likely to question and reflect on their experiences of abuse and workers need to be considering this when planning their work and interventions with young people.**

### **REFLECTING ON LESSONS LEARNED**

- Are you confident that you know the history of Looked After Children you work with? Do you consider how their experiences will impact on their behaviour and presentation? Are you proactive in seeking information?
- Are you clear when and how to share information when you have worries about a child – are you making sure that your information is shared with the lead professional at the right time?
- Do you re-consider, assess and plan for the future impact of childhood abuse and neglect for children you work with?
- If current services to support children's emotional health are not working, do you review this and consider alternatives?