Practice Review Group. Desktop Review. Child O

Background

A Multi-Agency Practitioners' Review of this case was requested to establish the circumstances leading up to what has clearly been a severe crisis for this young person, to see if there are any lessons to be learned that might help professionals to better work together towards prevention of similar crises.

Case Study

Child O was initially subject to Child Protection Planning but this was de-escalated to Child in Need in April 2016.

In May, Child O was admitted to the Paediatric Ward at Rotherham General Hospital following a significant intentional overdose.

Child O was known to Child & Adolescent Mental Health Services (CAMHS) and was engaging in work with a CAMHS Care Coordinator. She had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in 2016, a few days before her sixteenth birthday, and had been commenced on Methylphenidate medication. She said that she was happy in school, calmer and more settled, since starting the medication.

In May 2016, South Yorkshire Police issued a public appeal for information after Child O was reported missing from.

She was found the next day.

Findings

- Evidence of good cooperative working between Health Professionals.
- When Child O was admitted to the Children's Ward following overdose, there was evidence of good communication between partner agencies, including Police, Youth Services, TRFT Hospital staff and School Nurse, CAMHS, and Social Worker.
- However, when she went missing, this had not been communicated to Health services involved in her care: the CAMHS Practitioner heard about it in a news report. The child was due to be seen in CAMHS that day.
- When Child O's mother expressed concerns to a CAMHS Practitioner regarding maltreatment of Child O's cousin's daughter, advice was given for her to contact the Social Worker. This would have been better if shared by the CAMHS Practitioner to ensure that it happened.

Conclusions

Child O was experiencing stress due to having recently regained contact with her birth father via social networking.

She had recently lost an elderly uncle that she was very fond of.

Following a recent split from her thirteen year old boyfriend she had sent him naked pictures of herself, which she was now regretful and worried about.

Child O's explanation for having taken the overdose was following the split with the boyfriend, and 'something that she alleged he had done to her', which had been shared in her friendship group. Child O did not disclose what had happened as she feared that the boy would be locked up.

"I just took the tablets. I didn't think of the consequences. The Doctors told me I could have died. I will never do this again"

Recommendations or Action Plan

Due to the use of multiple record keeping systems across the Health partnership, individual Practitioners cannot have sight of the full record. This exacerbates risk where it exists across a range of concerns. Unfortunately, no universal national patient record system exists, in spite of ongoing NHS attempts to establish one.

Jointly established Policies and Procedures should be developed to ensure that all agencies involved with a child are informed of missing episodes in a timely and effective manner when they occur