

7 Minute Briefing

'CASSIE'

Introduction

An extraordinary meeting of the Safeguarding Partnership Review Group (SPRG) was convened to address critical findings in the case of Cassie, a child under the age of 18 who spent over 15 days in the Emergency Department of Croydon University Hospital in late 2022. This meeting was particularly significant as it marked the inaugural application of the newly introduced **Case of Concern Process**.

The case of concern process, a recently approved collaborative initiative by the Croydon Safeguarding Children Partnership, was implemented for the first time. This process is designed to review cases that do not meet statutory thresholds but still offer valuable learning opportunities for the broader partnership.

During the meeting, it was revealed that after Cassie was discharged from the hospital and placed in her grandparents' care—supported by a robust system of assistance—she experienced another serious incident. This led to an emergency hospitalisation after she ingested a battery, likely as an act of self-harm.

Following this critical event, Cassie was placed in a secure care facility. Reports indicate that Cassie now feels “safe and cared for,” underscoring the importance of timely intervention and the establishment of secure and supportive environments.

This case has highlighted the need for continuous evaluation and adjustment of the case of concern process to ensure that vulnerable children receive appropriate and coordinated care across agencies.

Key Lines of Inquiry

1. Child's inappropriate extended stay in A&E (role of Children's Social Care and CAMHS)
2. Placement sufficiency (Children's Social Care)
3. Process for escalation of concerns (Multi-Agency)

Findings

Lack of Protocol: Cassie's prolonged stay in the Emergency Department was due to gaps in an inter-agency discharge protocol, which existed but wasn't implemented or monitored properly.

Leadership: It was agreed that leadership for Cassie's care should come from Children's Social Services, a move to be formalised in future protocols.

Premature Escalation: Escalating the case too early in the hierarchy without full understanding led to inefficiencies.

Placement Shortage: Limited availability of specialised placements was a significant issue, highlighting a national problem needing urgent attention.

National Impact: Unregulated placements are closing due to new OFSTED regulations, further shrinking placement options, which must be addressed at a national level.

Conclusion: The challenges of suitable placements are a national issue but does not appear to have a national response. The absence of a suitable protocol exacerbates the feeling that "nothing is being done" and masks the parallel processes occurring (often in different agencies) to support a safe discharge.

Escalation can be helpful but must be proportionate and rely on process not relationships.

Improving practice

When dealing with a child or young person in crisis, especially in cases like the one discussed in the briefing, professionals should ask themselves a range of questions to ensure they approach the situation in a sensitive and effective manner.

Here are some key questions that professionals might consider:

Has a clear and agreed protocol been established for managing the child's discharge and placement?

- Are all agencies involved aware of the protocol, and is it being followed to ensure a coordinated effort in moving the child to a suitable placement?

Are we exploring all possible placement options that are regulated and meet the child's specific needs?

- How are we addressing the potential shortage of specialist placements?
- Are we collaborating with national bodies or advocating for additional resources?

Are we escalating concerns at the appropriate level and at the right time?

- Is the escalation process proportionate to the situation, and are we ensuring that decisions rely on protocol rather than personal relationships?

Are we effectively communicating with all relevant agencies to ensure a coordinated response?

- Do all parties have access to up-to-date information, and are we holding regular inter-agency meetings to ensure everyone is aligned in supporting the child's best interests?

Have we involved mental health services, such as CAMHS, early enough to provide the necessary support?

- Are there systems in place to fast-track high-risk cases like this one, ensuring that mental health interventions are timely and prevent long hospital stays?

Are we actively considering the child's emotional and psychological safety in their placement and care arrangements?

- Have we put in place secure and caring placements that address the child's sense of safety, and are we monitoring their well-being regularly?