Case Example:
A woman in the early stages of pregnancy attended County Durham and Darlington NHS Foundation Trust's University Hospital Durham ED for treatment following self-harm. She then attended again two months later at 22 weeks gestation. Risks were identified in relation to substance misuse and that there was a social worker involved. The woman was seen by the mental health crisis team before discharge.

Emergency department notes indicated there was a plan for the clinician who treated her to discuss the case with the social worker the next day but there was no recorded evidence that this was followed up with children's social care, discussed with the safeguarding lead or that further discussion has been had with midwives regarding risks to the unborn child.

1.12 CDDFT ED and paediatric assessment documentation did not include a mental health risk assessment tool. The ED used the SAD tool for adults. It was recognised that this was not appropriate for use with children and had been withdrawn (but not replaced/adapted) in the review of the self-harm pathway. Risk assessment documentation lacked prompts and trigger questions; was reliant on the professional understanding and curiosity of the examining clinician in identifying child safeguarding concerns. Cases we reviewed demonstrated that professional curiosity was lacking on a number of occasions resulting in less than comprehensive risk assessment and identification. Recording of clinicians' actions and voice of the child was weak in ED and the urgent care centre (UCC) which we visited and there was limited evidence to demonstrate that young people were routinely seen alone to enable them to express their views and disclose any sensitive information within consultations or examinations *(**Recommendation 1.3**)*.

1.13 Focus on the identification of the hidden child in the adult ED at University Hospital and at the UCC was lacking. Adults who presented at ED were not routinely asked if they have parenting responsibilities or have a social worker. This gap in basic information seeking was clearly illustrated by one of the cases we tracked across services: given the question of parental responsibility or social work involvement was not asked, ED staff were unaware of a long-standing history of concerns about the family undermining the robustness of their safeguarding risk assessment. The approach to identifying children at potential risk of hidden harm from adults who present as a result of risky behaviours, mental ill health or domestic violence was also underdeveloped. This means that some children who may be exposed to significant risk might not be identified by acute health staff and their health and wellbeing may not be protected as a result *(**Recommendation 1.4**)*.

1.21 The home environment assessment (HEA) tool was an important new development initiated from learning from the 2014 Darlington CQC CLAS and a serious case review. Its implementation across multi-disciplinary and multi-agency services is innovative however; being routinely used by midwives and health visitors, and being introduced in wider services such as housing. This is an evolving tool and we note it had been strengthened with the inclusion of learning from a local SCR as to whether there are locks or bolts on bedroom doors. There was scope to develop the HEA further. There was no prompt for final risk analysis by the practitioner or guidance about what action might or should result from the risk assessment and subsequent analysis. Inclusion of these would strengthen this tool and potentially enhance its impact on multi-agency risk assessment significantly *(**Recommendations 1.7** and **3.1**)*.

1.22 Young people had good access to a range of contraception and sexual health services across the county and these were appropriately targeted at areas of higher need and communities with limited access to public transport. The health improvement practitioners' (HIPs) role provided effective and targeted support leading to good outcomes for young people through their improved health and wellbeing. Taking more of a risk assessment based approach to whether the three contacts offered by the HIPs are home visits or telephone contact would strengthen this offer. The Optimum and Primetime programmes for small cohorts of teenage or young mothers operated by the local authority had proved effective in promoting young people's continuous engagement with education.

1.23 The sexual health service was well engaged with the missing and exploited group (MEG) arrangements and with the child sexual exploitation team, ERASE. We found some examples of good recording of clinicians' observations of young people's body language and demeanour where this gave the practitioner cause for concern; although this was not prompted as part of the assessment tool within the electronic system so that it becomes routine embedded practice *(**Recommendation 4.1**). This has been drawn to the attention of Durham County Council Public Health as the commissioner of the sexual health service.*

1.24 The school nursing service maintained an effective relationship with the ERASE team and had an active presence at case discussion meetings where they contributed to assessment and re-assessment of young people at risk of CSE. This enabled them to undertake actions arising from the case discussions so that young people, and in some cases their families, had opportunities to benefit from preventative and supportive health interventions. This included receiving sexual health and contraceptive advice and being supported with work to improve their self-esteem and emotional wellbeing.