# Safeguarding Children Partnership

# Local Child Safeguarding Practice Review C81

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C81 is a mature, polite and caring individual whose journey to adulthood has been shaped by her early life experiences and the complexities of her family life. During that journey she has been exposed to criminal exploitation, bullying, harassment and episodes of violence which in turn influenced her behaviour and presentation to agencies. C81 has now made the transition to adulthood and those professionals that have worked with her believe that she has the strength of character, determination and drive to make a success of her life.

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## Introduction

1 This review relates to a young person who was in the care of the Local Authority and who has been given the pseudonym of C81. C81 was aged seventeen at the time of the incident which instigated this review. The report was commissioned by the local Safeguarding Children's Partnership to examine the partnership approach to C81's care and the impact that her placement out of area had on her life.

2 A comprehensive terms of reference were agreed and these identified the following themes for exploration;

- C81's Background and Experiences:
- Response to Missing Episodes
- Supervision & Oversight
- Safeguarding Practice
- Response to Criminal Exploitation
- Local / National Learning – to include progress made by the Partnership since this case.

## Summary

1. C81 is a white British heterosexual national. She was described as professionals as a polite and caring individual who had grown into a mature young person. She was able to make informed decisions about her care and when asked was able to clearly articulate what she wanted from life. C81 was a creative young person who on occasions had difficulty in regulating her emotions and she could sometimes struggle with the boundaries that were set for her due to her previous life experiences.

2. Throughout her life C81 had experienced numerous adverse childhood experiences. She had been exposed to neglect and sexual abuse within the family setting and due to increasing safeguarding concerns C81 and her siblings had been placed on a Child In Need Plan (CIN). Despite agencies working together to support the family C81 was made the subject of a full Care Order on the 30th October 2017 and subsequently placed in a setting out of area.

3. Concerns regarding C81's vulnerability to Child Sexual Exploitation (CSE) had been evident and a central part of the planning prior to her move out of area. These concerns had however escalated over time and there had been clear indicators and evidence that she was being exposed to criminal and sexual exploitation for a number of years. C81 had stated that she was being forced into repaying drug debts through 'drug running' and she was brokering the buying of drugs by friends to repay her debts. There was also evidence of physical abuse and threats made against her life. Concerns had also been raised in relation to the impact that C81's lived experience at this time was having on her siblings. This had led to arguments in the family home and the request from both of her parents for her to be accommodated elsewhere. C81 had also been expelled from her school. As a result of the concerns raised and the decision from her family C81 was placed out of area on the 21st February 2018.

4. C81's initial placement was found to be unsuitable and she was then moved to a second care setting in February 2018. During her time at this location C81 was reported as missing on thirty eight occasions and there were continuing concerns regarding her risk to exploitation. These episodes culminated in C81 jumping out of a window after police

entered a premises in order to find her. As a result of this act C81 sustained a fractured ankle which required surgery.

## Methodology

5. This review was carried out according to statutory guidance and sought to understand C81's experiences within a framework that was participative in terms of including those professionals that were involved in her care.

6. The review process was overseen by a multi-agency review panel which consisted of representatives from the following agencies:

   - Children's Social Care (covering children in care, Local Authority Designated Officer (LADO) & Independent Reviewing Officer (IRO) Services)
   - Education
   - Health (Clinical Commissioning Group (CCG) Children's Community Services, & Primary Care)
   - Police
   - Independent Reviewer
   - TSCP support staff

7. Following the decision to undertake the review all relevant agencies were requested to check their records about any interaction that they had with C81. Where it was established that there had been contact, agencies were asked to provide a chronology. The following agencies supplied chronologies:

   - Police – Local/placement area.
   - Health- Children and Family Health NHS Foundation Trust, General Practitioner (GP), Health Team (placement area), Child and Adolescent Mental Health Services (CAMHS)
   - Children's Social Care- Responsible and Host areas.
   - Children's Society
   - Education.
   - Youth Offending Team (YOT)

8. A combination of desk-based review work and 'face to face' engagement activities were undertaken as part of the review. Engagement with professionals consisted of individual meetings and the facilitation of a focus group with those that were involved in C81's care.

9. C81 was contacted both directly by the review author and through her support worker to establish if she wanted to participate in the review. This contact was made through a letter, briefing by her support worker and through telephone messages and texts. C81 was advised that she could contribute to the review through any media that she wanted to use. Despite the offer to engage in the process C81 did not make contact with those involved.

10. Following consideration by the Panel it was decided that C81's family would not be approached unless she agreed.

11. The period of review is the 1st April 2016 to ensure that the review covers C81's first experiences of exploitation, until the 18th October 2019 which is the date that she injured herself.

## Background Information

12. C81 was a Cared for Child (S.31 Care Order) from the date of her birth until 2006 as her mother was deemed unfit to look after her. At that time C81's mother, who had separated from her father, had been involved in a number of relationships and there were concerns regarding homelessness and domestic abuse. In 2006 C81's case was closed as she had been placed in her father's care. C81's father was a known perpetrator of domestic abuse and the children had witnessed violence in the home.

13. In the years that followed her mother was reassessed as being capable of providing the support and care that C81 needed. Those that worked with the family stated that her relationship with both parents would on occasions deteriorate causing her to move from one address to the other. C81 had also lived with her maternal grandmother and her father.

14. For the period covered by this review C81 was predominantly living with her mother and two siblings. Her home was described by professionals as being chaotic and unhygienic.

15. There was a great deal of acrimony between C81's parents and grandparents. Professionals have described how this was 'played out' in front of C81 as they would prioritise their partners over C81 which had led to attachment issues. There was little understanding by the parents of what C81 was going through or the role that they need to play in caring for her.

16. C81's mother was described as being open and engaging and would, with agency support, try to actively provide a safe environment for C81 and her other children. Despite intensive family intervention C81's mum continually struggled to cope with the risks that were presented by C81's behaviour. C81's father was seen as less cooperative and often unwilling to engage with services. C81 had a difficult relationship with her father and he was known to be quick to judge her.

17. Professionals describe how her parents would treat her as an adult, expecting her to make her own independent decisions often without their support. Her father failed to take any parental responsibility for helping her to overcome the troubles that she faced.

18. In February 2015 the family received Level 3 support after C81 had attempted to take her own life. Later that same year C81 made a disclosure that her father had physically assaulted her and this was shortly after the break-up of his relationship with her mother. C81's behaviour would appear to have escalated after the breakup.

19. Agency records documented that C81 had a history of self-harm and substance misuse (cannabis, ecstasy, and alcohol), aggression and impulsive behaviour. C81 was considered to be at risk of CSE and professionals were concerned about her sexualised behaviour. She had also started to commit criminal acts such as theft and assault.

20. C81 and her family were initially supported through Child in Need Plans (CIN) and by the Intensive Family Support Service (IFSS). In April 2016 there was a clearly identified risk to C81 of CSE and she was involved with CAMHS who were providing mental health support. C81 had experienced poor mental health throughout her life although she was never diagnosed with any specific condition.

21. On the 24th June 2016 there was a disclosure by C81's mother that her daughter had sexually assaulted one of her siblings. A joint agency investigation was initiated but a decision was made to take no further action. A strategy meeting was held and C81's

mother was deemed as acting protectively at that time. C81 also had support through an Integrated Youth Support Service (IYSS) worker. Professionals agreed that further support was required for the family with a single assessment recommended. This assessment was initiated on the 26th June 2016 and completed on the 14th September 2016.

22. On the 13th July 2016 C81 disclosed an incident of inappropriate sexual behaviour by her stepfather. C81 was seen but did not make an allegation at that time. A strategy meeting was held and a decision made to take no further action. The family continued to receive Intensive Family Support and C81 was seen by CAMHS.

23. In September 2016 C81 went missing and when she was located a return to home interview was conducted. During that interview C81 stated that she had been the victim of abuse but felt that she hadn't been believed by professionals.

24. In October 2016 C81's case was discussed at a Multiagency Child Sexual Exploitation (MACSE) meeting and two actions raised. In that same month C81 had also stated to a friend that her father had raped her. Agencies were notified but no other details were recorded in agency records or further disclosures made. In that same month C81's mother stated to Children's Services that she didn't want C81 at home and asked for C81 to be accommodated as she was unable to control her. C81 was not moved at that time.

25. In November 2016 (27/11/16) there was an entry in Children's Services records which stated that the IFSS had ended their intervention due to C81's mother cancelling seven sessions. C81 had also been seen by CAMHS but had declined further contact.

26. In December 2016 it was apparent that C81's risks to exploitation were increasing and that threats had been made against her and her family in relation to the drug debts that she owed.

27. By the end of 2016, C81 had overdosed on five occasions and experienced what she had seen as repeated rejections from her mother. C81's father had also stated she was unable to live with him due to work commitments. C81's paternal grandmother, who had been a constant form of support throughout the split between her parents, had also stated that she was unable to care for her.

28. On the 12th January 2017 an Initial Child Protection Conference (ICPC) was held and C81 and her siblings were made the subject of child protection plans (11 years after the first CIN plan) with the identified risks of physical and emotional harm. There were concerns that the situation at her home was not changing and that C81 was continuing to present risks to her siblings. There were also continuing concerns regarding C81 being at further risk of CSE.

29. In March 2017 C81 and her siblings remained the subject of Child Protection plans due to concerns that there had been no improvement in the family setting. At that time C81 was still deemed to be a risk to her siblings. The Child Protection Review conference held on the 28th March 2017 resulted in a single assessment being completed. At this point it was also identified that C81 had unassessed mental health needs and that she should be required to undertake substance misuse work.

30. During the early part of 2017 C81's behaviour deteriorated further with increased instances of going missing, substance misuse and behavioural difficulties.

31. C81's criminal offending also increased with her committing theft and burglary and she was charged with fraud offences. This escalation in behavioural problems led her mother's partner to withdraw his support and it was at this point that she stated that she was unable to protect her other children from C81's outbursts and insisted that her daughter should be taken into care.

32. In March 2017 a Proof of Evidence Meeting (POEM) was held and C81 was deemed to be at risk of significant harm as well as a risk to her siblings. Legal proceedings to formalise her care were initiated.

33. In May 2017 (seven months after her mother's original request for C81 to be removed from the family home) C81 was accommodated and then placed out of area. That placement broke down and in February 2018 and C81 was moved to a setting in another area of the County. Following that move C81 was reported missing on thirty eight occasions and continued to be exploited and threats were made against her life.

34. In July 2018 a disclosure of sexual abuse was made by a friend of one of C81's sisters. This incident had allegedly occurred in 2016 at that child's home address. The police stated that these allegations matched disclosures by C81's younger sister of alleged sexual abuse by C81 in 2016. Following a joint investigation the decision was made to take no further action in this matter. The allegations were described by the police as being clear and consistent but were not corroborated and they were denied by C81. No supporting evidence was obtained or family members seen. At that time no strategy meeting was held or the wider risks assessed.

35. Throughout 2018 C81 continued to self-harm and frequently went missing. C81's levels of risk remained high and were being monitored through regular reviews and strategy meetings in the host area.

36. On the 14th October 2019 C81 went missing from the setting. C81 was located by the police but as they entered the premises she jumped from a window and landed awkwardly on her foot. As a result of this fall she sustained a fractured ankle.

37. Following a period of consultation with C81 and further planning by agencies she has returned to her home area. C81 has since transitioned to Adult Services.

## Findings and Learning

**Adverse Childhood Experiences (ACE's)**

38. C81 was exposed to a number of adverse childhood experiences in her life:

- Her mother had a history of being accommodated in care herself
- Her mother had a history of substance misuse
- Exposure to domestic abuse involving both of her parents
- Physical abuse and sexual abuse
- Neglect
- Instability due to parental separation
- Parental abandonment
- Inconsistent care and support networks

39. It is unclear what the true impact these experiences had in relation to C81's behaviour and her ongoing life experiences. In this case C81's life experiences had led her to behave in what some saw as destructive behaviour, which included self-harm, drug misuse, violence and offending.

40. Agencies have reflected that the multi-agency response to the neglect issues identified within the family setting in the early stages of C81's life were inadequate. Assessments did not identify the signs of risk to the children, ascertain their needs and co-ordinate support for them. Policy and practice was in place at the time but not followed due to high workloads, inconsistent recording practices and poor case management and supervision. This meant that C81 and her siblings continued to be exposed to ongoing neglect issues in the family setting.

41. The ACE's in C81's life were known to some agencies although there was no holistic overview of her case or full consideration of their effect in relation to the complexities of her behaviour. At times practitioners were working in silos and multi-agency oversight and intervention was uncoordinated.

42. Practitioners did not always recognise the impact of her past experience on her wellbeing or know how to appropriately respond to them. Attachment issues were seen by those professionals that worked with C81 as being a key factor in driving her behaviour and yet this had not been consistently recognised in the plans that were put into place or adequately explored with her and her parents.

43. **Learning:** To fully understand the needs of young people like C81 the partnership agencies need to promote a trauma-informed approach[1]. Practitioners therefore need to be trained to understand the impact of adverse childhood experiences and how a young person's experiences in early childhood can impact their mental health and presentation in the present day. **(Recommendation: 1).**

## Risks

44. The risks that had been identified in relation to C81 were clearly documented and these included:

- Child sexual/criminal exploitation due to her drug abuse, missing episodes and association with older males.
- Concerns highlighted regarding mental health.
- Rejection by both of her parents.
- Risk posed to her siblings due to her violent behaviour.

45. There was evidence within agency records that demonstrated not all professionals were proficient at identifying and assessing the risks evident in this case including those in relation to self-harm. This risk had increased over time with presentations relating to the ingestion of harmful fluids and razor blades. There had also been attempts by C81 to hang herself. Risk assessments for self-harm and suicidal thoughts should have included all the factors in her life that might have caused the deterioration in her mental health. These

[1] Trauma-informed approaches' are ways of supporting people that recognise specific needs they may have as a result of past or ongoing trauma.

risks and all of the background information should have been linked to a clear multi-agency support plan. Whilst C81 was engaging with CAMHS at the time there was little co-ordinated oversight of all the risks and the action required to mitigate them due to poor case management and supervision practices.

46. The use of language by professionals in terms of minimising risks and their effect on the action that was subsequently taken by agencies was highlighted by operational staff and managers. Documented comments recorded in some minutes and within the chronology failed to take account of all of the presenting risks and historical information available to agencies and this was a consistent theme in the review.

47. Overall there was no evidence of a coherent and coordinated risk management plan which had been overseen and driven by the responsible Authority and which would have been readily available to all staff involved in this case. Working practices should exist to quality assure risk management plans. **Learning:** Reassurance was provided by managers that practice has now changed and that all risk assessments for children placed out of area are held on a tracker and reviewed on a fortnightly basis.

48. In terms of good practice there was evidence of active and timely risk assessments being completed by the host Authority where C81 was finally placed, particularly following missing person episodes. There was also evidence of effective safety planning in place (i.e. with regards to the relationship that C81 had developed whilst she was with the host Authority).

**Voice of the Young person**

49. C81 wanted to have control of her life and she should be consulted with at each stage of her journey through the care system[2]. There is evidence in the minutes of meetings that C81 did have the opportunity to have her wishes recorded which was positive. This type of inclusion was however inconsistent and on some occasions the decisions made during these conversations and the agreements reached were not fully recorded or actioned.

50. There were also occasions where professionals made decisions without appropriately consulting C81. In some instances her wishes and needs were overlooked because she was displaying behaviour which was perceived to be challenging or because she had struggled to engage at that time. There was no record of what action was taken in terms of promoting further engagement, trying to understand why she had not engaged or capturing her voice at a later date. Interaction with C81 was further impacted upon by the fact that she had eight social workers during the period covering this review. The responsible Authority has since recognised the impact of such changes and has sought to improve consistency in the management and oversight of cases.

51. On occasions where professionals had listened to C81 and her voice recorded, it would appear that there was little consideration to the content of that disclosure. Relationships were really important to C81 and at case conferences she was clear about her desire to share her time between her parents. Her parents chose to ignore her request and they were not challenged over this.

52. In C81's case there were a number of entries in records that were insensitive and victim blaming including references that stated that she 'enjoys risk taking behaviour' and yet

[2] Sec 22(4) Children's Act 1989

this conflicted with the issues raised though her early life experiences and the fact that she was being exploited and reacting to the circumstances which were beyond her control.

53. The language used by professionals was also identified as a barrier to C81's engagement and the ability to provide her with the support that she needed. The triggers for a significant number of the incidents involving self-harm was the receipt by C81 of negative family information (family weren't available to see her or they had further rejected her). On these occasions some of the professionals that had been working with her had failed to consider the impact of the language used or learn from previous experiences.

54. There were occasions where C81 would reach out and discuss the issues that were affecting her life. She had been referred to counselling with the Children's Society where she had talked about being bullied at school and verbal and physical abuse taking place. From the chronology, there wasn't any reference to this disclosure being followed up or whether it had been considered for police involvement. Throughout the chronology C81 told professionals a great deal of detail which was never acted upon due to the poor oversight and management of the case prompted by high case workloads, inconsistent systems of practice and staff instability.

55. On reviewing her case one manager from Children Services stated that "no wonder she would not engage with services when no one acted on the information that she had previously told them. You could see this in the fact that no one proactively dealt with the information she had provided in return to home interviews." Critical reflection on what children and young people tell professionals is essential in building relationships and identifying protective factors in a case.

56. Those professionals that were engaged with as part of this review stated that since this incident staff have received training about the importance of listening to children and young people and that their views should be at the centre of any action that is taken. Managers have stated that through supervision meetings and records they have seen tangible improvements in this area of practice.

**Support for C81**

57. C81 and her family were initially supported through Child in Need Plans (CIN) and through the Intensive Family Support Service (IFSS). Parenting support was also provided. In 2016 (27/11/16) there was an entry in Children's Services records which stated that the IFSS had ended their intervention due to C81's mother cancelling seven sessions. There was an acceptance by the Panel that this was poor practice and there should have been proactive follow up due to inconsistent practices. Managers involved in the review stated that changes in practice now ensures that additional efforts would be made to re-engage families in such circumstances and that effective supervision is now in place to ensure that cases aren't finalised in such circumstances. Personal advisers have now been introduced and these meet CIN Social Workers on a regular basis to improve supervision and oversight in cases.

58. C81's individual welfare needs were met through a variety of proactive social work interventions. These included CAMHS, Cognitive Behavioural Therapy (CBT), life story work (although referred to it is unclear as to whether this was completed) and advocacy support. Records show that the Crisis Team within CAMHS had provided a good service in terms of meeting her immediate needs and through follow up assessment.

59. Despite the interventions that were being put into place by agencies, minutes and professional feedback have highlighted that there was a lack of proactive and focused work taking place to fully understand the reasons behind C81's behaviour. Her behaviour was seen as "challenging" or "risk-taking" and for some "a deliberate choice". This led professionals to see her behaviour as the problem, rather than identifying what might be causing it, what risks she might be exposed to, and what support was needed. Professionals felt that C81 would have benefitted from more specialist support in terms of therapeutic intervention.

60. There were occasions where C81's case was not effectively co-ordinated or overseen by agencies. Where services work in silos, this can often mean that there is no overall picture of the young person's situation and no overarching plan about how to best support them. There was also a lack of recognition that the intervention that had been put into place was failing to achieve the desired outcomes for both C81 and her family and there was a need for an alternative plan to be put into place. Practitioners felt that there was a failure to truly consider alternative options in the approach to her case due to poor working practices that proliferated at that time.

61. No one professional ever understood C81's needs or reinforced any of the positive behaviours that she exhibited. An example of this was when those working with her never explored her love of gymnastics which had been a constructive activity in her life that had positive benefits mentally and physically. It was felt that a strengths-based approach[3]to supporting her would have been beneficial and should have been explored with her in the early stages of her care. Had this taken place, those that knew her felt that this could have provided her with a focus in her life.

62. When reviewing and monitoring C81's case professionals felt that the Independent reviewing Officer (IRO) oversight could have been stronger in terms of addressing the particular issues that C81 had faced whilst living away from her home area. Managers felt that overall the level of IRO challenge lacked rigour particularly in terms of drift and delay and failed to adhere to guidance[4]. In some instances safety plans had not been completed and lapses in providing a co-ordinated approach to her care had not been challenged, including the progression of the health assessment and the response to her early encounters with CSE. On review it is clear that the processes in place at the time prevented the IRO from having full sight and knowledge of the cases that they held. Case workloads were especially high and decisions were resource led. There was an over reliance on IRO's being notified through the PARIS[5] system and despite requests for them to be informed of updates and changes in circumstances this did not occur. Continuity and effective information sharing were also affected by the numerous changes in social workers that occurred in this case. Professionals from all agencies must recognise the part that they have to play in the management of cases and the need for them to challenge poor practice. They also need to have an understanding of the role of the IRO and that they have a duty to contact them if they have concerns about case management.

63. There were numerous changes in supervisors and managers overseeing the IRO's in the responsible Authority and this was seen as having a negative impact on improving service delivery at the time that this case was being managed. Cases, including this one, were reallocated through internal changes and this impacted on the continuity of knowledge. Since this case there have been changes to the management team and internal

[3] Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.
[4] Department for Children, Schools and Families (2010)
[5] Primary Access Information System - Case Management system used by Children's Social Services.

restructuring in terms of workload allocation and this has improved IRO's oversight of cases and the communication between those involved with the service.

64. One of the IRO's met with C81 on three occasions before or after statutory reviews whilst she was placed in a host area. On these occasions there was good interaction with C81, her social worker, key worker, education representative and her mother. The IRO built up a good working relationship with C81 and she had appeared to have reacted positively to that. The IRO on reflection did state that additional contact with children between reviews would be beneficial.

65. Local Authorities have a duty to ensure that independent reviewing officers closely monitor, review, and pursue good progress in the plans for children living out of area. The responsible Authority have strengthened this oversight in that they have introduced a 'midpoint' check between reviews where the IRO check in with the allocated social worker and review records to prevent drift. IRO's also now have a greater opportunity to influence senior management oversight of cases at a High Cost Panel and raise issues such as delays. There is also the ability for IRO's to call consultation meetings with the relevant professionals involved in a case and a confidence in challenging current processes if they didn't meet the needs of the young person. These were seen by IRO's as being positive in terms of case management but there is still a need for social workers to fully brief IRO's on a regular basis.

66. Long term placement cases are also now reviewed to ensure that there is no drift in terms of plans, family engagement and progress towards a successful outcome for the young person. This is good practice and its implementation should be audited to ensure that it improves the outcomes for cared for children.

67. Children's Services are seeking to change practice in that there is now an initial meeting when a child comes into care with the IRO, social worker and supervisor to look at the planning for that young person. **Learning:** This practice has yet to be fully embedded and could be further strengthened if at each handover point there was a formal meeting. **(Recommendation: 2).**

68. In relation to her family those at that practitioner's group were divided about the levels of intervention that was taking place. Some felt that there was a huge amount of support and resources being directed into the family whilst others stated that there should have been a greater emphasis on family intervention. No one individual was able to express why C81's 'case went so wrong', although it was felt that on many occasions the family were difficult to engage with.

69. Both practitioners and managers felt that agencies were reactive and failed to fully understand individual and family dynamics. Some felt that there was a failure to fully engage with her father and that professionals had allowed him to manipulate interactions to ensure that these were on his terms. Professionals also lost sight of other influential people in the family environment such as her parents' partners. Those having oversight of her case reflected that these individuals were not considered in the planning, risk and assessment process.

70. The introduction of a restorative practice model in the responsible Authority's area has been seen as a positive development in providing a structure that will enable staff to improve outcomes in terms of family intervention and engagement. Managers felt that the problems highlighted in this case in terms of family management would have been addressed through this model. **Learning:** The outcomes of this model should be reviewed

to ensure that positive changes have been embedded into current practice **(Recommendation 3)**.

71. Professional's thought that in this case there was a lack of systemic family therapy. They stated that the focus of agencies tended to be on C81's dysregulated behaviours which failed to identify that these could be 'help seeking' and there was not enough emphasis on the therapeutic work which is available through CAMHS. **Learning:** Those at the practitioner's event stated that there are sufficient support services in their area to support families with complex needs but on occasions some frontline staff are unaware of what's available to them. Children Services have since provided a list of all therapeutic resources to staff.

72. Family group conferences were being held (May 2016), although practitioners have stated that the number of these were insufficient and that they lacked specific outcomes. There was also a failure to effectively monitor those outcomes that had been identified and documented in plans. Despite records stating that follow ups would be required on some occasions none were generated through the family group conference process. It was also felt that not all relevant family members were invited, and their voices heard in the conference process.

73. The practitioner event and meetings with managers has highlighted that there would now be a greater emphasis on family group conference for those families with complex needs. Those working in the responsible Authority state that C81 would now be referred to the Edge of Care service[6] which involves a greater involvement of specialist commissioned partners who provide intensive family support work. Such a change in practice should be seen as good practice.

74. Whilst C81 was placed out of area it was highlighted that opportunities to conduct further work with her family had been missed. Managers felt that had this work taken place then her return to the area and reintegration with the family could have been expedited. Practitioners and managers felt that often in those cases where children are placed out of area their wider family are often forgotten in terms of remedial work to increase the chances of reconciliation. **Learning:** The Authority has since introduced a 'Becoming Cared for Pack' which includes support plans for each child, their family and carers and these are reviewed on a fortnightly basis by Regulatory Services as part of the care planning process. Systems have now changed to ensure that care planning meetings are held where reunification is the desired outcome and there is Head of Service oversight and endorsement. A family group conference is also now offered in these circumstances. Models and frameworks continue to be developed regarding the re unification process and this should be seen as good practice.

75. There were recorded instances where C81 would decline the support that was being offered to her. There is evidence in the chronology and agency records that show that some professionals would try to continually re-engage with her. These attempts were down to the determination of some of the individuals involved with her care rather than a co-ordinated attempt to engage with her. Current practice and processes were felt to be sufficient to ensure that this interaction takes place, is recorded and then monitored. Poor supervision, case oversight and challenge at case conferences and strategy meetings were seen as potential inhibitors to effective practice.

76. In terms of C81's care plan and welfare need, the exchange of information between agencies was also inconsistent and relevant information wasn't being conveyed to

[6] Provide intensive input to children and family's on a short term basis when in crisis.

professionals. Professionals appeared to rely on Children's Social Services to share relevant information without proactively undertaking this task themselves. Poor partnership engagement and interaction have been recognised in the Authority which now has an improvement plan in place.

77. There was also evidence of poor recording practices. PARIS records were incomplete with managers reviewing her notes stating that key aspects of her case were unrecorded or in some cases poorly written up. Audible records of strategy meetings were also held on file but had not been transcribed and the notes in terms of their contents were poor. **Learning**: The Authority have evidenced that all strategy meetings are recorded, transcribed and passed to the Chair of the relevant meeting. Managers have asked that these minutes should also be circulated to partner agencies **(Recommendation 4).**

78. Cared for children should have statutory yearly health assessments and reviews that enable the identification of any physical and mental health needs that require support or intervention. The 'responsible commissioner' arrangements also clearly state that the responsibility for meeting and funding secondary healthcare lies with the 'originating' area. The review identified that there was a lack of clarity with regards to this within the Authority.

79. Ideally the initial health assessment should have been completed within twenty working days from the young person coming into care. C81's move to Wiltshire delayed this process and she had also made a decision that she did not want to take up the offer of assessment. Agencies were aware of C81's declining mental health, drug and alcohol misuse and her exposure to sexual exploitation. There was therefore a particular need for a holistic plan that met her health needs. The checks and balances within the system to ensure that this took place were not fully adhered to and there was a failure to challenge or to follow this up. Again this would appear to be down to high workloads and poor management oversight. Health representatives involved in the review process have stated that alternative arrangements should have been offered to C81 (such as a consultation with a nurse) to try and engage with her and progress the assessment. Work has taken place in the responsible Authority area to standardise the Health response to assessments but staff still feel that the pathways could be improved and alternative assessments offered.

80. Information exchange and recording specifically in terms of the health assessments was also poor. A psychological assessment that was completed in October 2017 as part of care proceedings was not added to Children's Services database (PARIS). This report was also not seen by her social worker until May 2019 and CAMHS were also unaware of its existence. It is unclear why this occurred. The recommendations within that report had not been acted upon in terms of care planning for C81's emotional wellbeing and this had led to confusion and delay in the procurement of suitable psychological therapy (DBT[7]) and life story work (CAMHs therapist report). The completion of a psychological assessment in cases involving children in care was seen as good practice and frontline staff suggested that they should be completed in all such cases. **Learning:** This has been considered by the Authority and cases monitored. Systems changes have ensured that annual SDQ's[8] are completed and findings are considered in consultation with CAMHS. Children in residential care have an updated assessment as part of moving on planning

[7] Dialectical behaviour therapy (DBT) is a type of talking therapy. It's based on cognitive behavioural therapy (CBT), but it's specially adapted for people who feel emotions very intensely. The aim of DBT is to help you: understand and accept your difficult feelings. learn skills to manage them.

[8] Strength and Difficulty Questionnaires.

but the review has identified that this process can be strengthened further (**Recommendation: 5**).

81. After being placed out of area in February 2017 C81 was due to have a health assessment completed. In April 2017 the host Health team notified the responsible Authority that they didn't have the capacity to complete this. The host team requested her initial health assessment so that they could make informed decisions about her care but they didn't receive it. The team had received a letter in the interim (11th June 2017) but its contents were brief and didn't include the details about her health or social care background. The team didn't have any history for C81 even when they conducted the assessment in January 2018. This meant that practitioners working with C81 didn't have the rich information from her background to inform plans and improve the care provided to her. The multiagency reviews and meetings held in her case and supervision should have identified the gaps in information exchange and ensured that health plans were progressed. **Learning:** There is now a working group in place that has oversight of health assessments and a tracker. Health passports are being used for all care experienced young people. Systems have also been changed to ensure the timely sharing of Health information and training has been delivered to relevant staff. The Children in Care Health Team and Children's Social Care should continue to build on this practice to facilitate engagement of young people in their health assessments. **(Recommendation 6).**

82. Wales have a national Health Care Notification Form which provides all the relevant health information in relation to children in care. This form which is completed at the child's point of entry into the care system is used to transfer the information between Health Teams who deal with children in care and it accompanies the child or young person when they move premises. **Learning:** Such a transfer of information was seen as good practice and a similar practice should be adopted by the responsible Authority. **(Recommendation:7/8).**

83. The contribution by Health to strategy meetings involving cared for children was identified as being poor and inconsistent by Children Social Care managers (**Recommendation: 9**).

84. In terms of best practice, the Health Visitor for the family provided a good level of support for C81's mother and this was clearly documented in records. This Health Visitor recognised her vulnerabilities and appropriately signposted her to mental health and GP services.

## Missing Episodes

85. C81 would frequently be reported missing both within the area where she had lived and also within the areas where she was placed. The responsible Authority has a missing person's protocol and this would appear to have been followed in terms of initial recording, meetings and return to home interviews. Practitioners stated that on reflection the response to those episodes was process driven with little appreciation by agencies to the underlying reasons for C81's absences, the link with exploitation or the additional work required to mitigate risks.

86. Following the early episodes of C81 going missing she did state that her motivation to run away was driven by problems in school. Records from this period appear to show that this was never fully explored with her or her family. Despite C81 continually going missing there was no record of how the multi-agency forums in the Authority responded to support C81 around this particular issue or the added complexity of criminal exploitation.

Practitioners stated that whilst her care plans did have strategies in them to avoid unauthorised absences and missing episodes they failed to fully explore measures that could have been implemented to prevent or at least reduce the frequency of missing episodes through fully engaging with C81.

87. Post management of missing episodes was co-ordinated through staff from Checkpoint who provided advocacy and undertook return to home interviews. On occasions C81 would not engage with the process but there was evidence that professionals persevered with their attempts to talk to her and that they explored risks and consequences of her behaviour.

88. The information gained from return to home interviews in the responsible Authority's area, which were carried out by Checkpoint staff, was being fed back to Social Care. A representative from Checkpoint did however comment that there were gaps in service in that it is not clear how these returns were being recorded and processed. There was also uncertainty as to whether their recommendations were being acted upon. Checkpoint staff also commented that the arrangement was not reciprocal, and that vital information was not being shared with them so that they could effectively carry out their role. Feedback from the practitioners meeting indicate that these notes would have been recorded on C81's records and then should have been picked up by the CSE team although such practice was inconsistent at the time. This process will be explored further in the section on criminal exploitation.

89. Statutory reviews should have had a holistic overview of all information from C81's case and practitioners and managers felt that there was a failure to revise strategies in order to prevent repeat absences and/or missing incidents. Care plans should have also been revised accordingly. In this respect there was poor supervision and oversight of the case and a lack of challenge in relation to these practices.

90. In terms of placement C81's plans should have included comprehensive strategies for preventing her from taking unauthorised absences/going missing, pre-incident risk assessments should have been continually updated and information shared effectively in order to ensure that the host authority was able to manage C81's case. There were recognised gaps in the information that was shared in this case due to poor oversight and management of the case and those involved in the review have reflected that a full chronology should have been passed to the host authorities when C81 was moved. **Learning:** The responsible authority now uses a CSE toolkit which includes details of risks and missing episodes. There is a process in place to RAG rate the toolkits and escalate cases including those placed out of area. The responsible Authority must however ensure that all relevant information is exchanged with host Authority. This should include essential information about all previous missing episodes and a photo in line with national best practice **(Recommendation 10)**.

91. It would appear that during missing person episodes the Authority's policy was not adhered to in terms of liaison with the host placement to manage a co-ordinate response. This response was primarily driven by the host authority and the responsible Authority notified of the outcome. The Authority should have been proactive in ensuring that the host authority was actively managing her case but there is little evidence to show that this occurred. **Learning:** Practice changes have since been implemented and the review of these cases are now held within statutory timescales and follow guidance within the IRO handbook and placement, planning regulations. Reviews that need to be delayed now need to be authorised by the Head of Service to increase oversight and scrutiny.

92. There was also a lack of co-ordinated activity in terms of Health support during that period. This was evidenced after C81 had overdosed on the 8th occasion and there were no plans in place to visit the young person by the responsible health team. **Learning:** Health representatives on the panel acknowledged that the Health team in C81's home area did not have a historical relationship with C81 due to her being moved out of area soon after being accommodated.

93. Consideration should have also been given to alternative strategies of managing C81 in view of the fact that she was repeatedly going missing. Current practice states that where a child is, or has been, persistently absent without permission from the children's home; or is at risk of harm, the children's home should ask the local authority that looks after the child to review that child's care plan. The host Authority had repeatedly shared information but there is little evidence contained in records that care plans were actively updated in light of emerging patterns of behaviour and risks.

94. Best practice also states that Independent Reviewing Officers should be informed about missing/ absent episodes and they should address these in statutory reviews. From records held it is not clear that these incidents were fully reviewed and considered by the responsible Authority although changes in practice have now been instigated to overcome these issues.

95. The return to home interviews that were completed whilst C81 was out of area were processed by the host authority in line with their guidance. There was also evidence of strategies in C81's care plans completed in the host area which sought to avoid repeat occurrences of missing episodes. This should be seen as best practice and should be further strengthened by the Authority. Current protocols recognise that it is essential that liaison between the police and professionals in both the responsible and host authorities is well managed and coordinated. This clearly states that a notification process for missing/absent episodes should be agreed between responsible and host local authorities as a part of the care and placement plan.

96. Strategic oversight was also considered by managers to have been poor with no real oversight and scrutiny particularly in relation to those young people who had been moved out of area. Checkpoint staff stated that they had completed quarterly reports about trends, patterns and themes for commissioners at that time but practitioners and managers were unsure as to whether any forums had actually reviewed this information and challenged practice.

97. The responsible Authority have since changed its commissioned services to undertake return to home interviews and now monitors data at the Partnership board in terms of performance and scrutiny.

98. **Learning:** Those involved in the review felt that there was a need for a more robust local and national protocol around who conducts return to home interviews. They recognised that there should be clear agreements in place prior to placements about the funding and who conducts the interviews **(Recommendation 11).**

## Criminal Exploitation (including Child Sexual Exploitation)

99. C81 was committing offences as a direct result of the exploitation that she was suffering and whilst agencies were working with her to minimise the impact of this on her life there was a lack of co-ordination in the action that was taken due to poor partnership working practices.

100. The risks in terms of criminal and sexual exploitation were known to agencies and clearly documented. Some of the individuals and groups that C81 was associating with whilst she was in her home town were considered to pose a direct risk to her in terms of sexual exploitation. There was limited information contained in records as to what co-ordinated multi agency intervention had taken place in terms of safeguarding her, targeting offenders or undertaking contextual safeguarding activities for prevention purposes.

101. The response to exploitation at that time was disjointed and decisions made based on individual incidents as opposed to the full multi-agency history of C81's case. From records it was also evident that the true nature of exploitation was perhaps not fully understood by those agencies that were dealing with her. Some agencies had better knowledge of such issues than others and from recollection some stated that whilst CSE was a high profile issue at the time and there was a CSE toolkit (which had been completed for C81) it had not been fully embedded into practice. There was an over reliance on the Children's Society to carry out preventative work.

102. There were CSE champions and a lead in place at the time in the responsible Authority and C81's case had been discussed at the MACSE (October 2016). Records include concerns of exploitation and grooming in relation to gangs but also indicate that her disclosures were not being taken seriously. There was also a failure to listen to the young person's experiences.

103. The language used in records would appear to have indicated that C81 was not being believed and there is no evidence that targeted action was being taken to protect C81 and her family who were also being threatened. One manager noted that an operational level it was evident that C81 had been discussed in Missing Meetings, and references had been made to gang type behaviour, county lines, manipulated and exploited behaviour. The response to gang orientated behaviours was under developed at that time and this impacted on service provision. Chronologies and the reflections from practitioners confirm that this was the case.

104. As part of its journey towards continuous improvement the Authority has started to implement changes in respect to its approach to exploitation. In consultation with the National Working Group[9] the partnership has developed a strategy, screening tool and revised its terms of reference for its Missing and Child Exploitation (MACE) panels and its Child Exploitation and Missing Operational Group (CEMOG). CSE toolkits are also reviewed every three months. This should be seen as best practice.

105. Such changes must ensure that children and young people who are placed out of area are regularly reviewed by these forums. The changes that are being implemented do show positive progress and staff within Children's Social Services do feel that they now have a greater understanding of exploitation issues. These changes do need to be fully embedded into practice and quality assured to ensure that they are effective. Strategic oversight has also been improved through a subgroup specialising in exploitation which feeds into a Business Management Group and then into the Executive Group. One practitioner stated that whilst progress is promising 'we are a long way from where we want to be'.

106. Despite the changes that are being implemented there were still cases highlighted during the review which were being closed prematurely by social workers and managers without revisiting the exploitation screening tool or considering the risks involved. There were

[9] National Working Group- Charitable organisation who disseminate information to services and professionals regarding Child Sexual Exploitation.

also gaps identified in cases where there are CSE risks which are not being referred to the exploitation team. Such cases may not come to light until after a strategy meeting has taken place. **Learning:** All out of county placements are reviewed on a fortnightly basis and this includes oversight by an independent Placements Officer. The placements are also reviewed by a panel chaired by the Director of Children's Services which should be seen as best practice.

107. Whilst multi agency practice is seen as improving in the area of exploitation there were quoted examples of where this remains disjointed. One example was where the police had made a decision to introduce a pilot initiative in terms of the 'absent' category of missing persons. This decision was made without full consultation with all partner agencies and there were concerns raised about its impact on the progress that has been made in relation to the strategy and improvements made in terms of exploitation practice.

108. The importance of promoting disruption activity at a strategic and operational level was re-emphasised by practitioners in this case. There was a feeling that moving victims out of an area is not an effective long term solution to protecting them from criminal gangs[10]. Such placements also send a message to perpetrators' that they can continue to abuse children and young people. Without targeted intervention against perpetrators, victims like C81 are replaced once they have left the area. Improvements appear to have been made in the responsible Authority and these need to be promoted further.

109. The procedures followed in the second host area appear to have been more robust. Prior to C81's arrival in that area her risk to exploitation was a central part of the planning process that was conducted there. C81's case was reviewed under their CSE Protocol which included Children's Services, Police, CAMHS (hospital attendance), local drug and alcohol services. Children's Services were updated regularly about the outcomes of these meetings but this arrangement was not reciprocal.

110. There was evidence that safety plans were updated regularly by the host area and that C81 was involved in the discussions and planning. In terms of outcomes from this planning abduction notices were served and police powers of protection were used to safeguard her. This should be seen as good practice.

111. Whilst there was active multi-agency and cross-border cooperation taking place practitioners and managers interviewed as part of the review process accepted that this could have been improved particularly in terms of information sharing and the longer-term planning for C81's return to her home area. This will be discussed later in the report.

## Disclosures of Abuse

112. In this case there were clear disclosures of sexual abuse and yet the response to these allegations did not follow safeguarding best practice and there was a lack of positive action to manage the risks identified. In many instances the outcomes from the processes that were undertaken were unclear and not recorded.

113. In June 2016 the disclosure that was made by C81's sister would appear to have been dealt with in line with safeguarding procedures and a strategy meeting was convened on 24/06/16. The strategy meeting outcome was that the threshold for S47 enquiries was not met and a single assessment would be completed on C81 by the social worker

[10] The Child Safeguarding Practice review Panel – Annual Report 2020.

under S17. The strategy meeting also agreed a visit with the police be made to the family home the following week to review the younger sister's welfare and inform a decision on whether to hold an ABE interview and a harmful sexual behaviour strategy meeting. C81's sister did not substantiate the initial disclosure when seen which led to a continuation of CIN planning.

114. In July 2016 C81 had made allegations against her stepfather. Police and Children's social care had spoken to C81 but she was unwilling at that time to take the matter further. An initial investigation was undertaken but it is unclear whether other lines of enquiry were followed, including speaking to the wider family. At that time a decision was made to take no further action. Although a strategy meeting was held it is unclear from records or from the feedback from professionals involved in the case that safeguarding procedures were followed. C81's stepfathers' risk to her and other siblings in the household was not considered and fully assessed. Records show that there was an over reliance on the family support that was in place at that time.

115. Records show that following agency intervention C81 felt that she had not been believed. In one return to home interview she continued to insist that the sexual abuse had happened and she stated that she had also been frightened of her mother's reaction if she continued with the allegation. This was never explored further or pursued by agencies. The ICPC reports from Children's Service seem to substantiate the view that she hadn't been believed in terms of the language that was used by professionals.

116. The impact of such attitudes on C81's confidence to make further disclosures is unclear. The case does however highlight the need to continue to provide effective therapeutic support services to individuals following any disclosure for sexual abuse. This may provide them with the support required to disclose further information.

117. In October 2016 following contact regarding an overdose, police records show that C81 had stated to a friend it was 'due to her father raping her when younger'. This disclosure was never progressed and would appear to have been lost as agencies had become more concerned about other threats that were being made to C81 in terms of her drugs debts and in managing her presenting behaviours. Recording practice and follow up were poor.

118. In 2018 allegations were made against C81.These allegations matched disclosures made by C81's sister in 2016 as detailed in Section 6.0. C81 denied the allegation and no supporting evidence was pursued. A strategy meeting was held in relation to the child who had disclosed the information but again the wider safeguarding issues in relation to the risks posed by C81 to her siblings were not considered. The host Authority undertook a risk assessment but this related to C81's risk to those in care.

119. Language used in records indicated that as there was "no evidence" found to substantiate any of the allegations that were made. The inquiries made at that time relied upon full disclosures or admissions by those involved. As neither of these were forthcoming the cases were closed. Family members were not interviewed and this was an opportunity that was missed in securing corroboration in relation to the concerns that had been raised.

120. Where there is a decision in a case not to prosecute an individual then those involved in the review accept that there is a tendency not to look at the wider implications of the case and to consider alternative approaches to safeguarding. Current policy and procedures are clear with regards to what is expected from all agencies in such circumstances. There was a failure to follow these procedures and this should have been

identified and picked up at strategy meetings, case conferences and through supervision.

121. As part of the review process a manager from Children's Social Services was asked to review the supervision and oversight of the incidents where disclosures were made. On two occasions there was no direct supervision recorded and only partial oversight on the other occasions. Reflective supervision training is currently being rolled out in the responsible Authority area and practices are now in place to provide critical oversight. The success of this training needs to be monitored by the Strategic Partnership.

122. Reassurance has been provided by managers in the responsible Authority area that the issue of language has been addressed through the training that has been implemented in relation to CSE and criminal exploitation. There remain concerns that safeguarding practices aren't being followed in those cases where the decision is made not to proceed with a case.

## Placement

123. Local authorities have a statutory duty to ensure that there is sufficient accommodation to meet the needs of cared for children in their community. This duty is supported by statutory guidance that makes it clear that children should where possible live in the local authority area, with access to local services. These children and young people should also be close to their friends and family, when it is safe to do so.[11] The guidance emphasises that 'having the right placement in the right place, at the right time', with the necessary support services such as education and health in place, is crucial in improving placement stability, which leads to better outcomes for cared for children.

124. There are considerable pressures on placement availability at present. This pressure comes from the growing numbers of children who are coming into care and the unequal distribution of homes around the country. This has led to a situation where more than forty per cent of cared for children are living outside their home area (Department for Education, 2019). When choosing placements the guidance states that careful consideration should be made as to how the cultural and identity needs of the child or young person will be met.

125. In C81's case, the fact that her family had stated that they were unable to accommodate her, the risks that professionals had raised in terms of her exploitation, and the unavailability of accommodation that could meet the complexity of her needs had led to a decision to place her outside of that area. Accommodation was therefore identified which was considered to cater for C81's specific needs.

126. National guidance states that when a young person is placed out of their local authority area, the responsible authority must make sure that the child has access to the services they need in advance of placement. Notification of the placement must be made to the host authority and other specified services. This point will be discussed further in the following paragraphs.

[11] Sufficiency: securing sufficient accommodation for looked after children (statutory guidance), Department for Children, Schools and Families, 2010;

127. C81's initial placement was unsuccessful. At the time of placement she was described as being at a low place in her life. It was felt by practitioners that there was little opportunity to work with C81 proactively due to her emotional state at that time and as a consequence the only intervention that she received was reactionary to the situations that staff were presented with. Due to C81's behaviour the setting had removed her allowances and freedoms at that time and it was felt that they had exhausted all options. C81 had felt that she was being 'held' in the setting.

128. This initial placement eventually broke down and C81 was then placed with a second host authority. On both occasions it is unclear from relevant documents as to the rationale for such placements, whether they were in C81's best interests, and whether they had been appropriately reviewed in terms of suitability. Some professionals felt that these placements had simply been chosen as they were the only ones available at that time.

129. In C81's case the placement increased her risk of exploitation as she had lost her support networks and had then developed new relationships which continued to be exploitative. The protective factors that she had in place in her home town had been lost. The second setting was also considered to be an area where there were increased risks in terms of grooming, recruitment and exploitation. This factor would appear to have been overlooked by the responsible authority. **Learning:** Whilst a risk assessment is completed within the placement plan current process lacks the analysis of the impact of that placement and doesn't cover escalation of risks in terms of contextual safeguarding **(Recommendation 12).** The Partnership also needs to satisfy itself that contextual safeguarding is understood across all statutory services **(Recommendation 13).**

130. Poor sharing of information at the beginning of C81's placement contributed to little consideration of potential risks. Important written information was not always provided on time and what was shared lacked any detail. The team from the host Authority had tried, through the IRO, to get details of the last assessment that had been undertaken in relation to C81 and a dated plan prior to her arrival. Despite repeat attempts to get this information they stated that they were unable to do so. There are no records or recollections of why this didn't take place. For six to eight months following, placement referrals and information were being passed back to the responsible Authority but there was no feedback received to escalate the support provided to C81. The host team were unaware that C81 had been looked at as part of any CSE protocol. It was only in later meetings that this came to light.

131. The South West Child Protection Procedures state that when a young person like C81 is at risk of coming into contact with the police, preparation work should be undertaken by the placement commissioning service with both the placement and local police. This should inform the placement about the needs of the child and young person, and agreement should be reached about how incidents will be managed, in line with this protocol. **Learning:** A quality assurance placement role has been introduced to complete audits of all placements in line with statutory requirements.

132. Following C81's placement there was a delay in commencing an initial strategy meeting. Once this had taken place and she had been assessed it was felt that C81 had a good response in terms of the services offered to support her. This included referrals to sleep clinics, sexual health advice and CAMHS. The placement was seen as having a positive impact on C81's life with her ability to reflect on her behaviour. C81 was able to attain a qualification and she started part time work. Professionals who did visit her from the responsible Authority identified that the staff working at the home were working from a

strength's based approach and that they had tailored her support package to meet C81's needs. The support provided by the host authority was seen as good practice.

133. In relation to Child in Care visits those working with her did state that there was little time to effectively build and maintain a constructive relationship with her due to the geographical distance between the responsible and host Authorities. This should be a taken into account when a placement out of area is considered.

134. Following the initial issues identified in this report in relation to effective information sharing and co-operation between the host and responsible Authorities there was evidence that processes had become more robust with clearly negotiated terms in respect of Safety Plans and Schedules of Expectations for C81 and her independence. These were shared with all relevant agencies.

135. Practitioners felt that additional work should have taken place with the family both pre placement (in an attempt to avoid her out of area placement) and post placement in terms of returning her to her family environment at the earliest opportunity. Managers have confirmed that there is now a real focus on placement planning and where young people have to be placed more than twenty miles outside of the Local Authority area the Head of Service must be informed and be in agreement. All such placements are also a key feature of the quality assurance framework with regular dip sampling to look at the quality of matching, placement planning and the support provided to children and young people.

136. A webinar has also been created outlining the impact of out of county placements on young people, in particular those at risk of exploitation and this is available to foster carers, social workers and other staff members. This needs to be promoted throughout the Partnership.

## Transition

137. There was evidence that Care Plan/Pathway Plans were in place detailing the journey of transition for C81 to move back to her home area. There was also evidence that there was effective communication and interaction between the social workers who were involved in her case and this should be seen as good practice.

138. Transition services and pathways have been reviewed and changes implemented in the responsible Authority. An aftercare needs assessment was also introduced in 2019 to ensure that a co-ordinated plan of support is put into place particularly during transition. There is now a specialist transition team in Adult Social Care and managers believe that this has created stronger links to Children's Services and has improved planning processes. There is also a 'sixteen plus' working party looking at further improvements. This party has recognised that planning in such cases should start at the earliest opportunity and should seek specialist support outside of the Local Authority area if it's required to assist in the transition process. There is now a new transition process in place and a resource pack has been developed and is now in use. These developments are seen as a real opportunity to support young people in overcoming such issues as CSE and in promoting independent living. The roll out of any such provision needs to be linked in with the overarching CSE strategy.

139. Professionals still feel that the transition process remains resource led rather than needs led. In C81's case some practitioners felt that parts of her pathway plan had been poorly thought through. This included C81 being placed in independent living accommodation

with another individual who had CSE risks. Such a move was seen as unnecessary and would have increased C81's vulnerability to further victimisation. In this case the dispute resolution process was used to raise concerns which was good practice.

140. Despite the level of planning that was put into place it was highlighted that C81 did feel, on occasions, as though she didn't have a voice in the transition process. As she approached her eighteenth birthday C81 felt that she was being not being treated or spoken to as an adult. This had the effect that she would sometimes withdraw her cooperation from a number of the processes that she had been asked to engage with. Again this shows the importance of language and the need to engage with young people throughout their care journey.

141. **Learning:** The Authority now has a tracker for unregulated placements and they are working towards an increase in regulated placements. The tracker is part of a contract monitoring process and there is management and performance oversight that tracks progress including quarterly reviews.

## Conclusions

142. C81 was a young person who had experienced significant adverse childhood experiences in her life. There was extensive partnership intervention throughout that period which had identified increasing risks to C81 and her siblings. Despite the level of support that was put into place and increasing concerns about her family's ability to protect her from harm a decision was made to place C81 into care and place her out of area.

143. Silo partnership and organisational working meant that no one agency had an overall picture of C81's situation and there was no comprehensive plan about how to provide the support that she needed to achieve successful outcomes in her life. This case clearly highlights that professionals lost sight of the child and that on many occasions her voice wasn't heard or used to inform practice.

144. At the time that C81's case was being managed the Authority had introduced practice to address CSE and the risks associated with this type of criminality. On reflection it has become evident that these practices were not fully embedded operationally and therefore there was little oversight and scrutiny of C81's case.

145. The risks in this case were clearly apparent and often documented and yet there was no evidence of a coherent and coordinated risk management plan which had been overseen and driven by the responsible Authority and which would have been readily available to all staff involved in this case.

146. Management and supervisory oversight of this case was poor and as a consequence many of the processes that were in place at the time to effectively manage cases were not followed. There was also a lack of challenge by all partner agencies involved in C81's case and together all of these factors had led to a failure to improve the outcomes for C81.

147. The case has highlighted that the use of language by professionals can have a significant impact of delivering successful outcomes in such cases. Language used by professionals at meetings and in strategy discussions minimised risks and on occasions

was perceived to be victim blaming. This also had a direct effect on C81 in that she believed that those professionals that were working with her didn't believe what she was telling them.

148. There remain concerns that in terms of disclosure practitioners are still failing to follow established safeguarding procedures particularly in those cases were the initial investigation results in no further action being taken by the police. In this case the risks that were evident following the disclosures that were made were not fully considered and mitigated.

149. In terms of placement out of area it has been identified that there was little to no consideration of the likely impact on C81 in terms of her vulnerability to further criminal exploitation. The area that she had been placed in was considered to be a high risk in terms of CSE. Information exchange was initially poor and the responsible Authority failed to actively manage her case. Despite these initial issues the placement was seen as having a positive impact on C81 and interagency practices and cooperation improved over time.

150. Since this case the responsible Authority has been on a journey of improvement in terms of partnership working and changes within Children's Social Services. Changes have included improvements in internal structures, the implementation of a CSE strategy, the introduction of the restorative practice model, improved managerial oversight and changes to accountability processes. These changes have been seen by operational staff and managers as a positive step forward in improving the lives of children and young people in the area. Processes would also appear to now be in place to provide additional scrutiny in relation to those children who are placed out of area.

151. A protocol for out of area placements is being developed which sets out current placement planning, operational process and expectations in relation to co-ordinating and monitoring of arrangements.

152. Despite the changes that have been implemented in the Authority there is still an acceptance by both managers and practitioners that the practices and processes that have been implemented have yet to be fully embedded operationally. There is also a view that current practices are still resource led rather than needs based. It is therefore important that the momentum of change continues and that strategic leaders and managers drive improvements across the partnership.

## Recommendations

This section of the report sets out the recommendations that have come from the learning in this case.

**Recommendation 1.** All statutory agencies should ensure that trauma informed practice is embedded. This includes within the workforce and all systems and processes.

**Recommendation 2.** Children's Social Services to ensure that there are robust handover processes in place to ensure that information transfers to new professionals in all cases of cared for children.

**Recommendation 3.** Children's Social Services to review the restorative practice model to ensure it meets expected outcomes in terms of family and the young person.

**Recommendation 4.** Children's Social Services to ensure that audible records of strategy meetings are transcribed and details fully recorded on the Liquid Logic system. The agreed minutes of these meetings should also be shared with partner agencies.

**Recommendation 5.** Where screening has indicated that a psychological assessment is required, the relevant Health team and Children's Social Care should work together to ensure this is completed and shared as appropriate to inform the care plan for the child or young person. This should be overseen by the relevant IRO.

**Recommendation 6.** The placing Children in Care Health Team and Children's Social Care should work together to facilitate engagement of young people in their health assessments, and ensure there is a flexible offer to all young people wherever they are placed.

**Recommendation 7.** Children's Social Services should ensure that when a child moves into or out of our area, the Placement Planning Meeting reviews and shares all relevant information pertaining to that child's care plan. This should include a clear outline of roles and responsibilities in implementing the care plan for both the receiving and placing services.

**Recommendation 8.** Children in Care Health Team need to initiate a clear process for sharing information when children are transferred to another area to ensure the receiving services are aware of their health needs.

**Recommendation 9.** In line with statutory guidance, processes need to be in place to ensure that the relevant health professional, including those in adult services, attend a strategy meeting for a child/young person who is in care.

**Recommendation 10.** Children's Social Services to review current missing persons practice and ensure that a comprehensive package of information in relation to previous missing persons episodes accompanies a young person when placed out of area.

**Recommendation 11.** Children's Social Services to contact the National Panel to support the development of a national protocol for return to home interviews for children in care who are placed out of area.

**Recommendation 12.** Children's Social Services to review current placement plans to ensure that the impact of the placement and the risks in terms of contextual safeguarding are included within them.

**Recommendation 13**. The Partnership should ensure that contextual safeguarding is understood across all services and develop a model to deliver it.

## Glossary of Terms Used

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| ACE | Adverse Childhood Experience |
| CAMHS | Child and Adolescent Mental Health Services |
| CBT | Cognitive Behavioural Therapy |
| CCG | Clinical Commissioning Group |
| CEMOG | Child Exploitation and Missing Operational Group |
| CSE | Child Sexual Exploitation |
| DBT | Dialectical Behaviour Therapy |
| GP | General Practitioner |
| ICPC | Initial Child Protection Conference |
| IFSS | Intensive Family Support Service |
| IRO | Independent Reviewing Officer |
| IYSS | Integrated Youth Support Service |
| LADO | Local Authority Designated Officer |
| MACSE | Multiagency Child Sexual Exploitation |
| NHS | National Health Service |
| PARIS | Primary Access Information System |
| POEM | Proof of Evidence Meeting |
| SDQ | Strength and Difficulty Questionnaires |
| YOT | Youth Offending Team |