Local Safeguarding Children Practice Review

Child Alpha

Executive Summary

This Executive Summary sets out the findings and learning from a Local Safeguarding Children Practice Review of a serious incident relating to Alpha. Alpha at the time of the incident was aged 13.

1) Introduction

1.1 Oldham Safeguarding Children Partnership (OSCP) have carried out a Local Safeguarding Children Practice Review (LSCPR) for Alpha. Working Together 23 statutory guidance sets out the process for LSCPR's. The purpose of the review was to look at how multi-agency services worked together to safeguard Alpha. OSCP conducted a Rapid Review in October 2023, and it was decided at that time that it had met the threshold for a LCSPR. Unfortunately, OSCP were unable to secure a LSCPR Author until June 2024. Most of the multi-agency learning and actions were identified at Rapid Review stage and had been completed by the time the LSCPR commenced.

1.2 The analysis of practice in the Review refers to the duration of Alpha's period of life between August 2021 and November 2023.

1.3 Alpha's School at the time of the incident were asked to contribute to the Rapid Review in 2023 and again extensive efforts were made to engage them in the LSCPR in 2024 (including being a Panel member) but this was not pursued by them. This was a missed opportunity to share relevant information and contribute to the learning of the Review.

1.4 Alpha participated in the Review and chose the pseudonym name that was used. Alpha is her favourite Peaky Blinders character. Alpha's mother was also asked to participate but declined.

2) Story of the child.

2.1 Alpha is the youngest of the 7 children born to their parents. Alpha and her family describe themselves of being proud of their Roma heritage, both parents were born in Romania, and their first language is a dialect of Romani. Alpha and her siblings came to the UK when she was very young.

Alpha recognises she has a long traumatic history of physical abuse and neglect; the family have been known to Oldham children's social care (CSC) for many years. She and her siblings became subject to a Care Order s31 of Children Act 1989 in 2016.

2.2 When Alpha came into care (2016) she was placed with one of her siblings (closed in age) for a settled period of four years within a foster family. She lived in the local area, experiencing routine Family Time with her parents and her siblings. However, Alpha and her sister started to experience feeling unsettled as they became more independent. She experienced numerous missing episodes and agencies acted swiftly to recognise her vulnerability and she became open to the complex safeguarding team which meant her care and protection could be robustly overseen and coordinated. The period of the Review shows how her care experience began to be characterised by placement moves (a total of nine in twenty-five months) and significant periods of instability. Crucially she was quickly separated from her sister and placed out of borough far from home and into residential care. She did return to the region into a residential home for less than a month but her vulnerability quickly increased again, and she returned to the previous residential school and care home out of the region.

3) The incident

3.1 Alpha went missing from this residential school and care home (which was over 70 miles away from her home) in September 2023 along with another 12-yr old young person (from another local authority placed at the same residential school and care home). She was located by Police nine days later with one of her sisters at an address in her home area and taken back to her residential placement. There was an adult male in the property where Alpha was located, who was arrested and has subsequently been convicted of the rape of Alpha. On her immediate return to the residential school and care home, Alpha spoke to staff and disclosed she had had sex with multiple men and that she had been taking drugs.

3.2 Information also came to light by Alpha's sister (with whom she was located with), that both she, Alpha and their older sisters had all been trafficked by their father to various men since they were younger and had experienced significant sexual abuse when they lived with their parents.

3.3 The residential school and care home immediately gave notice on Alpha's placement stating that they could not meet her needs nor keep her safe following the recent incidents. CSC had shared with them that they planned to apply for a DoLS (Deprivation of Liberty Safeguard). The residential school and care home still felt they were unable to meet the requirements of implementing a DoLS. Alpha moved to a residential solo placement where she settled subject to a DoLS. Alpha immediately experienced stability.

4) Good practice

This review identified many aspects of good practice:

- Robust multi agency risk management, which was overseen, when necessary, at the highest levels within agencies throughout Alpha's involvement with services.
- Evidence of continuous trusted professional relationships built with Alpha by police officers and complex safeguarding social workers in particular
- Tenacious actions taken by professionals to work within the means of placement options for Alpha, particularly in emergencies.
- Consistent IRO oversight with some escalations in place.
- Creative and persistent work by professionals

- Positive disruption work by the Police and to those who posed a risk to Alpha

5) Key Learning

<u>Learning no.1</u> **The quality and impact of multi-agency working for Alpha regarding risk including when she went missing from care was mostly effective.**

Identification of risk was broadly at the right time and dealt with effectively. There was evidence that professionals worked relentlessly to keep Alpha safe. For those that posed a risk to Alpha, positive action was taken and disruption work done. It was evident that the professionals across all the agencies knew the family well and worked well together. This was a complex exploitation case. There was opportunistic exploitation of Alpha rather than an organised network of offenders. However, because there was often imminent risk (missing episodes) reactive practice was often in place. Trusted relationships (including with police officers) were promoted wherever possible with Alpha

On the few occasions no GMP care plan was submitted when Alpha was missing, this breached the missing policy. GMP care plans should be submitted for **all** missing episodes.

Secondly it is important to ensure commissioning arrangements are robust for return missing interviews when children are placed outside of the current commissioning arrangements. The information received from these interviews should be recorded centrally and inform not only risk, but the care planning interventions for Alpha.

The Review found there were opportunities for stronger consistency in attendance of relevant practitioners at Alpha's strategy meetings to inform decision making and share the planning. Crucially how the plans were then communicated with Alpha could have been strengthened. It is important to ensure child focused language is recorded.

Whilst risk of harm was managed well and brought agencies together, wider care planning processes for Alpha sometimes became secondary. This meant routine care planning meetings weren't held monthly for her. The frequency of care planning meetings should reflect the needs of the child. This is an area Oldham CSC want to consider introducing for those children in care that require them as standard practice.

When Alpha's foster placements became unstable her assessment should have been promptly updated to understand why this might be, ensuring all domains of Alpha's life are reviewed.

The Review Panel found that a proactive approach to the care planning aspects of Alpha's care did not hold sufficient weight. Her unhappiness about her care plan such as where she lived, her lack of opportunities to undertake off site activities (when she lived in the Residential School and Care Home) and having more Family Time weren't always given proportionate weight in decision making. It was clear to see a direct correlation between the impact of separation from her family, her unhappiness and how these push pull factors increased her exposure to risk and harm.

<u>Learning No.2</u> **The impact of displacement and separation for Alpha from her family, community and local area was hugely significant.**

When the foster placement ended, Alpha and her sister experienced three short term foster placements in quick succession before a decision was made to change Alpha's care plan to one of residential care and to be separated from her sibling. Resultantly, Alpha and her sister were placed in individual placements out of borough, (still in the same region). This drastic change in Alpha's circumstances all happened within a month of her foster placement breaking down. Efforts were made to accommodate both sisters together, but there was no placement availability. The Review Panel felt this was a key practice episode. Separating Alpha from her sister proved to be a significant loss and created additional trauma for Alpha. Alpha's cultural norms were being further severed, which increased her vulnerability and led to relationships in the community that were harmful and transient. The reason recorded to separate Alpha from her sister was due to placement sufficiency concerns. It was known that there were concerns about their risk in the community but not from each other.

Services needed capacity and flexibility to respond quickly and decisively when Alpha experienced placement instability. The significance of moving from a foster family to a residential environment cannot be underestimated. Placement choice is critical with a clear set of non-negotiables within a placement referral which should include facilitating routine family time and placement choice including with siblings.

Sibling assessments (Together or Apart) should be given the highest priority and undertaken when children are at risk of separation to inform planning as early as when they enter care, not await placement breakdowns before they are undertaken. Alpha did not have a sibling assessment undertaken with any of her siblings, in particular her sister she lived with in foster care. Additionally systemic genograms should be completed for all children to support assessment and understanding of complex family dynamics. Despite professionals routinely discussing Family Time there was insufficient weight placed on Alpha's need to have regular Family Time with her family. The reality was she didn't always have consistent Family Time. The Review Panel felt there was learning for professionals to ensure during the process of telling a child they are moving, tell them what the plan will be for Family Time once they have moved. This was missing for Alpha, and she told professionals she did not always know what her plans for Family Time were. This should be shared with all the professionals so they can then reenforce this with children.

There is an opportunity for CSC to consider developing further capacity to promote Family Time in a flexible way and ensure the mechanism of advocacy and complaints processes are readily available to children like Alpha when they need to raise if they are unhappy about their Family Time arrangements. Looked After Reviews (LAC Reviews) need to fully scrutinise Family Time arrangements and the impact they may have on wider parts of the child's care plan and escalating where there is necessary concern. Ensuring advocacy services are promoted with children in care is crucial and the take up of advocacy is in turn monitored through the commissioning arrangements is vital. The themes of what young people are worried should be directly fed back to Corporate Parenting Board and importantly evidence that they are acted upon.

The Review has acknowledged that there were trusted relationships that Alpha had created with some professionals, creating capacity and a culture within the children's workforce to build trusted relationships with children such as Alpha is critical. Professionals need to consider how their practice is trauma informed, and agencies build services that are trauma informed in design and delivery. Developing a psychological framework for working with children experiencing trauma with professionals is a collaborative process that helps people to understand the connection between

experiences, behaviours and characteristics for individuals. This means making sense of a problem with an individual concerned, developing a care plan together and identifying strengths and resources. It also allows a shared understanding around consistency, and not responding negatively when children withdraw which means relationships will be forged over time.

<u>Learning No.3</u> Confident cultural competence across the workforce would have benefited the delivery of services for Alpha.

Assessments and plans for Alpha did not always fully reflect her cultural heritage in relation to her identity and what it meant for her. Alpha said she had to 'adapt' to an unknown culture which was alien to her and she expressed this to professionals sharing that they did not understand her or what was 'normal' to her. Her heritage was always identified in assessments but not necessarily developed to understand what her 'push pull' factors were in relation to her cultural background. Professionals were sensitive to how Alpha's differing family patterns and lifestyles of the family varied, however developing specialist support for agencies could have helped guide professionals. The Panel heard that Alpha's sexual exploiters were not from the same background as hers, nor from the same background as each other. The Panel felt her Roma background culture is still not fully understood.

The Review Panel found that further consideration should have been given to how single agencies accessed the same specialist service and same interpreter if necessary. This would have been person centred and provided continuity for Alpha and communication with her family. There is a requirement to have better cultural competence in day-to-day practice across the workforce. Professional Curiosity training will help promote practitioners engaging in other cultures and cultural competency and consideration of bespoke training. Additionally a service directory mapping across services such as those for professionals working with the Roma, Traveller and gypsy community could have benefited the workforce.

<u>Learning No.4</u> Creating an enhanced model of working together (including multi agency reflective supervision) to balance risk management alongside holistic care planning would have benefited Alpha.

Whilst the Review Panel found multi agency working (in particular risk management and mapping) broadly to have been strong for Alpha, there are always opportunities to strengthen multi agency working. The Complex Safeguarding Team at key points provided a coordinated response across agencies and geographical areas, however despite this Alpha did come to harm. If the practice had included a multi-agency supervision model it may well of supported an 'even better' trauma informed approach for Alpha and supported the staff who were involved in Alpha's care planning.

The Review Panel concluded that a OSCP led multi-agency supervision and mapping model could improve multi agency coordination and decision making and support better outcomes for children like Alpha.

6) Conclusion

This Review Panel concluded that there were numerous examples of good practice by professionals in Alpha's care who in the main worked effectively to try and safeguard her. However, the impact of displacement for Alpha from her sister, her wider family, the local area she had only known in her life, and her School had a significant impact on her. The inconsistent Family Time arrangements with her wider family did lead to compounding her trauma. The 'pull' to see her family and the lengths she went to ensure this happened led to her increased vulnerability and exposure to significant risks in the community. More should have been done by services to recognise and act upon this. Creating an enhanced multi agency model of working together (including a shared reflective supervision model) could support towards improved outcomes for young people like Alpha.

7) Recommendations:

It should be noted that the Rapid Review made a number of recommendations that were completed by the time the LSCPR commenced.

<u>Recommendation 1:</u>

Corporate Parent Panel should seek assurance from the subgroup that a review of the children in care policies and procedures has taken place on the following:

Strengthening child in care policies to support child led decisions- 'you say who'. Ensuring a child centred approach maps together the child's journey from referral processes for placements considering how sibling groups are placed together, through to comprehensive Family Time policies. This will allow a necessary focus on the impact of displacement for children. These policies should also address approaches to placements for those where they are exposed to risk due to contextual safeguarding and missing and considering the importance of family ties.

'Together or Apart' assessments should be completed and reviewed regularly to assess sibling separation.

Systemic genogram should be completed for all children to support assessment and understanding of complex family dynamics.

A social work decision making tool should be developed to support a therapeutic approach to Family Time arrangements.

The reconfiguring of referral forms for placements to be 'trauma informed' and child centred with agreed Family Time expectations and outcomes should be set as standard. This means in turn Individual Placement Agreements (IPAs) with Providers (the child's care provider) should reflect the agreement around Family Time promotion and compliance. These should be agreed on a multi-agency level and promoted across the children's workforce.

<u>Recommendation 2</u>

Childrens Social Care should consider with other relevant agencies:

Care planning meeting frequency (and processes) and updating child and family assessments should be routinely in place and always reflect the updated needs of a child in care.

<u>Recommendation 3</u>

Consideration should be given by OSCP to pilot the multi-agency supervision and mapping model to support effective trauma informed service delivery across the partnership.

Recommendation 4

OSCP to consider how the missing policies (locally) particularly within the context of supporting foster placements should be reviewed to promote better practice. This includes considering how best to support those children in foster placements.

Recommendation 5

CSC to consider ensuring their policies reflects that statutory visits by social workers increase in line with risk.

Recommendation 6

OSCP to review partners approach to cultural competency through its workforce and EDI strategy understanding the workforce's knowledge, understanding and application of practice relating to cultural competence.

Recommendation 7

OSCP to seek assurance from all agencies that practitioners can access specialist advice when working with people from a different culture to ensure they consider the ethnic and cultural needs of Roma community, promoting cultural competency.

Recommendation 8

OSCP to seek assurance that children in care can access routine advocacy information and services. The Corporate Parenting Panel to ensure the feedback from children on what matters to them about their care experiences is shaping service design and delivery.

Recommendation 9

GMP should reshare the MFH policy (updated July 24) within its services

Recommendation 10

The partnership escalation policy to be re-circulated to ensure professional challenge takes place when any agency is unhappy with decision making.

Recommendation 11

OSCP further develop the training offer for professionals who are working with children who go missing from home and care