Oldham Safeguarding Children Board

Child L

Serious Case Review Report

Executive Summary

Introduction

Child L is a child looked after by the local authority and is the perpetrator in this case.

Whilst in the care of the local authority, Child L committed a serious violent offence that will affect them for the rest of their life.

It is alleged that Child L had made threats to harm someone in the days leading up to the alleged offence to care home staff where they were living.

The victim sustained significant physical injures following an assault by another young person which required surgery and intensive care support. Whilst the injuries are not thought to be life threatening, they constitute significant harm.

The Panel agreed to undertake a Serious Case Review on this case with the perpetrator as the focus based on the fact that Child L was a child looked after by the Local Authority and committed a serious offence.

Analysis, findings and learning

Having considered the multi-agency chronology, Single Agency Analysis Reports, plus a range of other information obtained via interviews with professionals and information contained within minutes of meetings, the author has identified four key thematic areas as the focus for analysis, learning and recommendations. The author is clear these themes are not separate, and that they interrelate throughout the period under review. Essentially they provide four filters through which to view the events of this case.

- Child's Voice and Engagement
- Assessment, Intervention and Review
- Multi-Agency Working
- Identification of Offending Risk Issues

Child's Voice and Engagement

This theme has been identified because throughout the review agencies struggled to effectively engage Child L. There are examples of Child L engaging to some extent with professionals, however the overall picture is that agencies were not able to meaningfully engage Child L in a way that served to reduce the risks they were being exposed to.

It is acknowledged by Children's Social Care that Child L was clearly exposed to trauma and abuse in their early life. However there is a lack of assessment and intervention around Child L's early life experiences, specifically in relation to how a lack of early attachment may impact on Child L's outcomes and ability to engage with professionals, including foster carers.

Child L experienced multiple changes of social worker throughout their life and within the period of the review. Between 2016 and 2018 Child L had six different Social

Workers managing their case. This was without doubt a key factor in Child L's resistance to engagement with professionals and most likely confounded Child L's experiences around a lack of early attachment.

It is concerning that the lack of meaningful professional engagement with Child L, and how this contributed to the level of risk they were exposed to, is not highlighted in any assessment or plan. Neither is there any evidence of professionals working together to consider how to engage Child L more effectively so as to reduce risk.

Throughout the time period there are examples of Child L expressing views about what they wanted, for example, to live in their home town. This view was expressed within the context of a catalogue of missing from home incidents, prolonged disengagement with professionals, lack of an up to date assessment, association with and witnessing of serious violent offences involving peers, an allegation of attempted rape, substance misuse and assaults against staff.

However following a positive interaction with Child L which lead to a sense of improving engagement the social worker agreed that Child L could be transported from the Out of Borough placement to the Home Town at lunchtime each day and be collected to return to the placement at 11pm each evening. This was on the basis that Child L remained contactable by phone.

The author acknowledges the challenges faced by the social worker in deciding on the most appropriate course of action at this point, and that the social worker had a genuine desire to engage with Child L and to manage risk.

The Social Worker's view was that by transporting Child L to and from Home Town each day, missing episodes could be prevented and risk more effectively managed, and that this was preferable to a placement move to a distant location where Child L would most likely still abscond, resulting in even greater risk and lengthier periods of missing, due to the distance that would have to be travelled to return to the Home Town, which the Social Worker believed they would undoubtedly do.

It is clear that safety planning around Child L was undertaken with the very best of intention by all parties, with a focus on attempting to hear Child L's voice and to engage them effectively.

The author believes the approach of enabling Child L to visit Home Town each day and return at 11pm at night failed to take account of the fact that Child L was 14 years old at this time. This approach also failed to take account of the risk Child L was exposed to whilst present in Home Town, based what was known about Child L's experiences in Home Town by this point in time.

Safety planning for Child L, especially through February and March 2018, in relation to the transporting of Child L to and from Home Town, in light of what Child L was reporting they had witnessed and experienced at this point was inappropriate. This was exacerbated by the lack of an up to date assessment to inform planning.

This case therefore highlights opportunities to reflect and learn around how professionals balanced the need to hear Child L's voice and engage Child L, against the ultimate priority of protecting Child L from harm.

Assessment, Intervention and Review

This theme has been identified because there are a number of examples of assessments not being undertaken in a timely manner and therefore failing to inform the planning and review process for Child L.

Children's Social Care are clear in their Single Agency Analysis Report that an assessment should have been completed at least every 12 months for Child L and whenever there was a significant change in their circumstances. This is in line with the borough's Local Assessment Protocol. It is therefore concerning that Children's Social Care did not undertake a Single Assessment for Child L between 2010 and 2018. In the review period alone Child L experienced seven placement moves and six changes of social worker.

It is of concern that the lack of an up to date assessment was not highlighted until March 2017 when a new Independent Reviewing Officer (IRO) became involved. There is no evidence that previous Independent Reviewing Officers had raised any concerns about the lack of an up to date single assessment and that it is unclear what previous Independent Reviewing Officers been reviewing as the purpose of a Looked After Children Review is to review the child's care plan. It is also concerning there is no evidence that any other agency raised concerns about the lack of an up to date assessment for Child L.

It is also of concern that undertaking a single assessment was identified as an action in the Looked After Children Review on 2nd March 2017, with a target date of 30th April 2017 and that at the Looked After Children Review held on 10th August 2017 this action was still outstanding and flagged as needing 'actioning as a priority', however an assessment did not commence until the end of March 2018 and was therefore incomplete at the point Child L committed the offence.

There was a lack of Independent Reviewing Officer challenge about actions in Looked After Children Review plans not being complete, and that there was a failure to raise disputes with management when poor practice was identified. There was also a lack of oversight from IRO's in between reviews and a failure to adhere to the Independent Reviewing Officer Handbook in relation to this. It was only when a new Independent Reviewing Officer took over the case that there was oversight in between reviews.

In terms of consistency of assessment this was also lacking due to poor case handover arrangements when Child L's case moved from one social worker to another. There was a lack of effective handover due to the lack of an updated assessment and chronology. There are only two transfer summaries from 2013 and 2016 on record and it is acknowledged that plans were not followed leading to inconsistency for Child L.

There was also a lack of a whole family approach to assessment for Child L in relation to mother and other family members. Children's Social Care acknowledge that there was a lack of assessment of Child L's mother at the point it became know that Child L was having contact with her again in August 2016.

For example, there was a lack of assessment and planning around the impact of mother's mental health issues on Child L. Within the time frame for the review there are two incidents, one on 12th February 2017 and a second on 28th March 2018, of Child L's mother presenting at the emergency department with a reported overdose. There is no evidence that the impact on this on Child L was formally assessed in any way.

Children's Social Care also highlight that from 2016 it was evident that Child L wanted to live with family and that a grandparent had proved to be a protective factor previously. They also highlight how there was limited, if no arrangements with the wider family'. Children's Social Care suggest that a Family Group Meeting could have collectively considered what the family could offer, and although one was not convened in this case, Family Group Meetings should be promoted as good practice for social workers.

There are several examples of the Local Area Guidelines on Children Missing From Home not being followed in this case. This included assessments at the point of each accommodation arrangement, for which there were seven placement moves during the review period; use of missing from home information to inform to placement plan for this child; convening of a strategy meeting for a missing period of more than 24 hours and the lack of information sharing between the Out of Borough missing from home service and Home Town missing from home service.

There were also issues around health assessments for Child L.

It is clear from Looked After Child Review Minutes from May 2016 and October 2016 that the Strengths and Difficulties Questionnaire had not been completed and was not informing planning around Child L's needs. This is concerning as this was at a time prior to the breakdown of their long term foster placement and greater understanding of emotional needs may have proved useful.

Children's Social Care highlight that 'it is not clear how the Strengths and Difficulties Questionnaire and Looked After Child Health Assessments interface;'……this may have allowed services to overlook Child L's emotional needs that could've been identified through the Strengths and Difficulties Questionnaire regular health assessment'.

Children's Social Care also flag that the commissioning for health referrals and assessments is from different agencies and that this remains problematic, especially as Child L lived outside of the home town. The introduction of the Looked After Child Co-Ordinator role is intended to strengthen Children's Social Care responsibility with Health for children who are looked after.

It appears that information sharing between Children's Social Care and the Community Health Trust is an area where improvement is needed

Taking all this into account, the author believes that the absence of an up to date single assessment resulted in no joined up assessment or plan around Child L. If the Local Assessment Protocol had been adhered to then key partner agencies, including Child Sexual Exploitation team, Health, Education, Child L's residential placement, Missing from Home services, and Child and Adolescent Mental Health Services could have worked closely with Children's Social Care to ensure all risk and protective factors were in view, reviewed and planned for. The lack of an up to date single assessment was the main barrier to ensuring that a robust multi-agency assessment and plan was in place.

Multi Agency Working

This theme has been identified because there are numerous examples in the period under review of agencies meeting together to discuss the issues and risks in Child L's life. There is also a clear link between this theme and the theme of assessment, planning and review, as it is through effective multi-agency working that robust assessment, planning and review is achieved.

It is noticeable that some key agencies are not represented at meetings, or involved in assessing and planning around Child L.

The author is therefore interested in the extent to which assessments and plans were integrated, and the extent to which there was a single multi-agency assessment and plan for Child L. As previously highlighted, a major barrier to achieving this was the lack of an up to date single assessment of need for Child L.

These meetings all had a particular focus however there was no single multi-agency forum where all key agencies could meet together to assess and plan around Child L.

In addition there are some omissions in terms of agencies that could have provided a useful insight around Child L. For example at no point were the Youth Justice Service consulted around emerging offending risk issues and how best to address these. There is no evidence that substance misuse services were consulted around Child L's alcohol use.

It was not until January 2018 that the out of borough Missing from Home Service attended a Looked After Child Review Meeting, although they had been undertaking Missing from Home Return Interviews for Child L since February 2017, of which the social worker had been informed.

Community health trust 2 state that 'school nurses were not involved in any of the multi-agency planning or delivery of any intervention in the time period that is being scrutinised, they do not appear to have been invited or asked to be involved'.

Children's Social Care state 'there should be more flexibility to combine meetings to ensure that all services are represented'.

The author believes this case provides a useful opportunity for The Local Safeguarding Children Board to consider how multi-agency assessment and planning arrangements can be streamlined and improved, especially for children who

are looked after and placed out of area, but also for all children and families requiring additional support.

The Contextual Safeguarding approach has been developed at the University of Bedfordshire over the past six years to inform policy and practice approaches to safeguarding. Contextual safeguarding provides a framework to advance child protection and safeguarding responses to a range of extra-familial risks that compromise the safety and welfare of young people.

This theoretical approach is highly relevant in the case of Child L as it was within the peer groups, locations and geographical areas that Child L spent time where they were exposed to the vast majority of risk. It is impossible to state the impact that a multi-agency contextual safeguarding approach may have had in this case, however the author believes this approach may have enabled a wider range of partner agencies to work together more effectively around Child L.

Identification of Offending Risk Issues

This theme has been identified because throughout the period of review for Child L there are multiple risk factors present that can serve to increase the risk of a young person becoming involved in offending, however at no point were the Youth Justice Service, consulted about this risk and how it could be reduced.

The Youth Justice Service acknowledged that whilst the issues relating to engagement with Child L had been exacerbated by numerous professionals being involved it was not warranted for a Youth Justice Worker to be involved in the early stages however the service did feel that better consultation with them as specialists around offending risk could have ensured that these risk indicators were given due consideration in the plan.

The author totally agrees with this view. In addition the author believes that although no professional could have predicted that Child L would go on to commit a serious violent offence, it could have been reasonably assessed that there was a risk that Child L may become involved in offending of some type, due to the number of offending related risk factors present. The following risk factors, which increase the likelihood of offending in young people were present for Child L within the period under review.

Conclusion

The review has identified some areas for reflection and learning around the thematic areas identified, and also some areas of practice that were not in line with statutory and local guidance and protocols. The most concerning example of this being that there was no single assessment of need undertaken for Child L between 2010 and 2018 and the impact this had on achieving a joined up multi-agency assessment and plan for Child L.

This case provides an opportunity to reflect on the robustness of assessment and planning arrangements, specifically in relation to children who are looked after, and the extent to which looked after status is a barrier to broad multi-agency assessment and planning around the child and family.

Recommendations

1. Undertake a multi-agency review focussed on identifying solutions around how to increase levels of engagement with children who are extremely resistant due to previous life trauma and poor attachment.

(a) Identify evidence based approaches and interventions that are effective in supporting adolescent children who have significant early attachment issues.

(b) Consider training requirements for staff across partner agencies, including foster carers, around supporting attachment issues in adolescence.

2. All changes of social worker should trigger an updating of the single assessment and chronology to support effective handover of the case. This should be signed off by the team manager as being complete.

More than two changes of social worker in any rolling twelve month period should trigger a formal review of the case via supervision.

3. Ensure the child is always aware of a change of social worker, the reason for the change, and given the opportunity to give their thoughts and feelings about the change, which should be documented in the updated single assessment and ensure that where possible children are always introduced to their new social worker by their old social worker.

4. The Local Safeguarding Children Board should discuss the barriers and identify solutions in relation to undertaking timely assessments within Children's Social Care, and across partner agencies, and an action plan should be developed.

5. Data on the timeliness of assessments should be presented to the Local Safeguarding Children Board and an action plan developed to ensure that the borough's Local Protocol for Assessment is embedded and adhered to.

6. Review all Looked After Children cases to identify those where the assessment needs updating. Managers in Children's Social Care should know about every case where the assessment needs updating and discuss this in supervision to ensure that assessments are updated in line with the Local Protocol for Assessment.

7. Information sharing arrangements between Children's Social Care and Community Trust 1 must be strengthened to ensure that they are always informed by the social worker when a child changes placement.

8. Chronologies must be updated at least at point of transfer from one worker or team to another. Team Managers must check that this has been done at the point of transfer.

9. Independent Reviewing Officer's must have oversight of cases in between reviews and must also visit children in between reviews in line with the Independent Reviewing Officer Handbook.

10. Independent Reviewing Officers must raise disputes with management when poor practice is identified.

11. Independent Reviewing Officers must ensure actions in Looked After Children Review Plans are S.M.A.R.T.

12. Ensure that agencies who are working solely with adults in the family are able to contribute to the assessment, planning and review process for the whole family.

13. Review the use of Family Group Meetings as a means of focusing on the needs of the whole family and enabling families to identify their own solutions.

14. Review effectiveness of the process put in place for ensuring that children who are looked after and placed out of area can be tracked by the Missing from Home service.

15. All Tier 2 Missing from Home Meetings should be chaired by an Independent Reviewing Officer or nominated Senior Manager and should be attended by a health and/or education as set out in the Local Area Guidelines for Children Missing from Home.

16. Audit the availability of evidence based interventions/approaches that improve outcomes for young people with poor early attachment, with a view to identifying gaps and scoping interventions to be commissioned.

17. Review training needs for professionals, including foster carers around working with attachment issues in young people approaching adolescence.

18. Review the section in the Local Protocol for Assessment, '*the contribution of other agencies to assessments'*, to ensure arrangements are clear around the need for a whole family focus in assessments, even for children who are looked after but where there is come contact with a parent(s). It may be helpful if the review focussed on the following questions:

- *What are the arrangements for effective multi-agency whole family assessment, planning and review in the borough?'*
- *How could these arrangements be improved for all children and families, and especially for children who are looked after?*

19. Review examples of effective multi-agency assessment and planning, so as to identify the elements of best practice and consider how to implement these at scale across partner agencies.

20. The Local Safeguarding Children Board should review the merits of the contextual safeguarding approach and opportunities to implement it locally.

21. Youth Justice Service should lead a review focussed on the extent to which partner agencies are aware of the factors that increase the likelihood of a young person becoming involved in offending.

22. Youth Justice Service should develop an action plan setting out any training requirements for partner agencies and highlighting how and when they must be consulted in cases where increased offending risk is identified for a young person.