

**SOUTHWARK SAFEGUARDING CHILDREN
BOARD**

**Serious Case Review Report
Child R**

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1. Circumstances that led to this Serious Case Review

1.1 R is a 15-year old girl, who came into care aged 10, and has been looked after by the London Borough of Southwark for the past 4 ½ years. She lives with foster carers in Greater London and attends school locally.

In early spring 2014, R was invited to meet an older, predatory male at a hotel, where he allegedly raped her. The antecedents of this meeting remain uncertain, but R said that a friend of hers had given the man her telephone number, so that he could contact her.

The alleged assault was reported by R to her carers the same day, and police action was taken to find and arrest the man. A criminal investigation and court process have now concluded, in which the perpetrator was found guilty of a separate, lesser sexual offence against another young person. The offence of rape against R remains untried, but is held on the man's records as a not-guilty plea.

1.2 Southwark Safeguarding Children Board (SSCB) decided to undertake a Serious Case Review (SCR), as the following criteria had been met:

*(a) abuse or neglect of a child is known or suspected; and
(b) (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.¹*

2. Terms of Reference and the Welsh Model

2.1 The SSCB drew up its terms of reference for this SCR in April 2014, and circulated them to the DfE and Board agencies. They outline the model and process to be used for the SCR, the agencies involved, the learning areas to be addressed, and expectations about completion and publication of the report.

(The full terms of reference are attached as **Appendix 1.**)

2.2 The Welsh Model for case reviews

2.2.1 The 'Welsh Model' refers to Welsh Government guidance for multi-agency 'child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected'.²

¹ *Working Together to Safeguard Children, 2013, and Local Safeguarding Children Boards Regulations, 2006 (Regulation 5)*

² *Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews, The Welsh Government, January 2013*

It is intended to be used in conjunction with *Working Together*, 2013. The model can be used for all levels of case reviews, including SCRs.

The emphasis is on promoting 'a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs and partner agencies hold responsibility'.³

2.2.2 In a shift from the approach in traditional 'Part 8' SCRs, this model focuses on the involvement of agencies, staff and families 'in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability'.⁴ Other key features include:

- A more focused, streamlined process with a shorter time period to be reviewed
- Consideration of the context in which professionals work in agencies, including 'culture', policies and procedures, and resources
- A **Learning Event** for all those involved in the case
- Exploring not only **what** has happened, but **why**
- Recommendations and actions to improve future practice

2.3 Individual Management Reviews

2.3.1 The SSCB requested Individual Management Reviews (IMRs) for this SCR, as well as a comprehensive multi-agency chronology. Both of these are features of the 'Part 8' methodology under the previous *Working Together* (2010). As a consequence, this SCR is a 'hybrid' of two models for case reviews.

The IMRs have produced extensive data from agency records about their activities in the two-year review period. The IMR authors, who are independent of management responsibility for this case, have also interviewed staff, with a particular emphasis on **avoiding hindsight**, instead trying to get a feeling for what it was like working with the young person at the time, and what was the context for their work.

The scope and quality of the data have resulted in a longer Overview Report than would normally be the case for a Welsh Model review.

³ *Ibid*, Para 1.3

⁴ *Ibid*, Para 1.4

2.4 Time frame for review

The Welsh guidance recommends a review period of no longer than two years. This is so that the learning is about recent, rather than historical, practice, procedures and agency circumstances. In this case, the time span chosen was just over two years:

1st February 2012 to 27th March 2014

This allowed the SCR to include an 'unsettled' period of placement disruptions, as well as the two subsequent longer and more stable foster placements. The end point of the review, just after the alleged sexual assault, was extended briefly to include initial agency actions in response to the incident.

A Summary Timeline of significant events was made.

2.5 Practice and organisational learning areas

2.5.1 The Welsh guidance offers a set of generic practice areas for exploration and analysis, and these have been adopted by the Board for this review:

- *Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child;*
- *Evaluate whether the care plan was robust, and appropriate for R, the family and their circumstances;*
- *Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;*
- *Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. And whether any protocol for professional disagreement was invoked;*
- *Establish whether the respective statutory duties of agencies working with the child and family were fulfilled;*
- *Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).⁵*

⁵ *Ibid*, Para 6.15

2.5.2 Further relevant questions were identified by the SSCB in relation to the individual case:

- *How well did professionals understand and manage the different risk factors influencing this case and the particular vulnerabilities of R, during the two years under review?*
- *How well did professionals hear the voice of the child in their work with R? And to what extent were her unique diversity needs met by services?*
- *Review of the application and use of children missing from home and care protocol and e-safety policy in this case.*

2.6 Lead Reviewers

2.6.1 There are two external Lead Reviewers for this SCR, both independent of Southwark. Sally Trench has a background in local authority mental health social work and children’s social care, principally child protection. She is the author of many Serious Case Reviews, and has also chaired SCR Panels. She has been trained in traditional ‘Part 8’ SCRs and in the Social Care Institute for Excellence systems model ‘Learning Together’.

Victoria Philipson has a background in local authority children and families social work, also principally child protection. She was a regional director for Cafcass, where she completed a number of Individual Management Reviews. She has been trained in conducting traditional SCRs.

2.7 Review Panel

2.7.1 This is made up of senior representatives of the agencies who were involved in the case. The names/roles listed below comprise the membership of the Review Panel for this SCR.

Name	Role
Pauline Armour	Head of Service: Early Help (interim), Education, Southwark Children and Adults Services
Jackie Cook	Head Of Social Work Improvement & Quality Assurance, Children’s Social Care, Southwark
Registered Manager & Head of Compliance & QA	Independent Fostering Agency
Ann Flynn	Southwark Safeguarding Children Board (SSCB) Development Manager
Tina Hawkins	Senior Administrator, SSCB
Ros Healy	Designated Doctor Safeguarding, Guy’s and St Thomas’ NHS Foundation Trust (GSTFT)

Mark Hine	Detective Inspector, Child Sexual Exploitation Team, Metropolitan Police
Interim Service Manager	Safeguarding, Quality Assurance and Learning Development, Greater London Children's Social Care
Gwen Kennedy	Director of Quality and Safety for Southwark Clinical Commissioning Group
Russell Pearson	Specialist Crime Review Group, Metropolitan Police
Child Protection Manager	Children's Charity
Debbie Saunders	Head of Safeguarding Children Nursing, GSTFT

2.7.2 'The Review Panel manages the review process and plays a key role in ensuring the learning is drawn from the case'.⁶ In this instance, the panel have worked with Lead Reviewers, to read and review the relevant documentation and analyse the material from the integrated chronology and the IMRs. The learning generated from the panel was considerably enriched by its mixture of representatives from core statutory services, and private and voluntary organisations.

Panel members are also responsible for supporting members of their agency to take part in the learning event.

2.8 Learning Event

A full-day learning event in early September 2014 was attended by over thirty professionals involved in this case, as well as the Independent Chair of the SSCB. The day was used to gather their information and views, via multi-agency small group discussions.

Written feedback from the participants reflected a general appreciation of the opportunity to reflect on the case with colleagues from across agencies. In response to the question 'What did you find useful about today?', here are two representative comments:

- *Being able to hear the different perspectives from the agencies involved. Being able to reflect on one's own practice – how I can improve it. It enabled discussion without looking at blame in that gaps could be identified. It also allowed for reflection on how everyone can improve.*
- *Being able to discuss with different agencies and colleagues openly and honestly the difficulties and challenges around LAC and Child R in particular. We are all saying the same thing but implementing it is the problem. Finance/IT Systems/ geography being some of the issues.*

Attendees were also asked to contribute ideas about 'key messages', and how to implement the lessons from this SCR. Their feedback was valuable, and demonstrated how multi-agency learning can be generated by such an event.

⁶ *Ibid*, Para 5.20

2.9 Involvement of family members

R and her mother have been informed about this SCR. R has been invited to give her views about the services she received in the review period, and any other messages she would like the Review Panel and Lead Reviewers to have from her. So far, she has not wished to participate. This means that a significant avenue for learning is missing.

3. Family history

Family member	Address
Mother	London
Father	Abroad
Subject R	Foster placement, Greater London
Older sibling	London
Half-sibling	Foster care
Half-sibling	Foster care
Half-sibling	Foster care
Maternal Grandmother	Lives abroad/visits London

Members of the family have settled in the country at different times. Child R and her older sibling lived abroad until she was about 8 years old. At a later date the maternal grandmother settled in this country

A genogram is attached as **Appendix 2**.

3.1 Little is known of R's father. Child R and her older sibling were born in their mothers home country. R was left there in the care of her maternal grandmother as a baby, when her mother came to live in London. The family was fully reunited in this country by about 2007, with three younger half-siblings also being born during this period.

3.2 From 2002:

The family had no secure housing or finances in London, and often stayed with other relatives or friends. This meant that they moved a lot, resulting in instability for the children. Both Police and Children's Social Care (from 2002, when Mother's first child initially arrived in the UK) received referrals about criminality in the household, largely related to drug-dealing and other acquisitive offences, and neglect of the children.

R was the main target of her mother's abuse, which included emotional rejection and physical assaults. She was neglected and left in charge of her younger siblings; she was exposed to many adults who could have posed a risk to her.

R was made the subject of a Child Protection (CP) Plan in 2009. She ran away early in 2010, asking to be taken into care because her mother had beaten her. Her siblings were removed shortly after this, and all the children have been looked-after under Care Orders from that point onwards.

3.3 From 2010 (R's entry into care):

(NB, This summary does not include further information about the other children of the family, save to say that the younger children remain looked-after and are in long-term foster care. R's older brother is a care-leaver and lives independently in London.)

R has had an unsettled time in terms of placements, experiencing eight moves in care. There was a stable placement (spring 2010 to late summer 2011), which was followed by a period of highly unsettled behaviour and placement disruptions. In addition, R has now had a total of ten allocated social workers.

R was well supported for the move from primary to secondary school, and she did well in Year 7. A subsequent dramatic deterioration in her behaviour, both in school and in non-compliance with her foster carers, seems to have been prompted by reconnection with her mother and maternal grandmother, who arrived in the country in this period. School staff reported that R began Year 8 presenting and behaving in an entirely different way. Throughout the rest of 2011 and into 2012, she went missing from her foster carers on a regular basis, and her defiant and provocative behaviour in school gave rise to concerns about her vulnerability to sexual exploitation and to 'gang activity'. R was subject to an increasing number of fixed-term exclusions from school.

R's contact with her family – Mother, Grandmother and siblings – has been fragmented and at times entirely absent. This may be because she was, initially at least, blamed for all the children coming into care. However, especially during 2011, when her grandmother arrived in the UK, R began to return to her mother's home on a regular (but unregulated and unsupervised) basis. She continued to decline the proposed arrangements for contact with her younger siblings.

At the point where this case review begins, the school had made a complaint about the persistent lack of response from CSC to their concerns, in what appeared to be a breakdown in communication. R had had three disrupted placements, and one planned move, in the previous six months.

4. The Review Period (February 2012 to March 2014)

A brief narrative

4.1 At the beginning of 2012, R was in her 4th foster placement since coming into care. All of these had thus far been within Southwark, and this meant she did not have to change schools.

R was going missing on a regular basis from her foster home, and was often out very late – sometimes being dropped off by an older man. Details of her time out of placement were unknown, but it was believed that R was spending regular time at her mother's home, and/or staying out with friends. She had a poor relationship with her single foster carer.

4.2 After a placement breakdown in late February, a similar pattern developed in another local foster placement, with a couple. In addition, R's disruptive behaviour at school meant that she was at risk of a permanent exclusion. The school's concerns about the apparent risks to R – and her own risk-taking behaviour – led them to press CSC for a decision to move her away from London for her own protection. This move eventually happened, via another placement breakdown, in the summer of 2012.

4.3 R was next placed with white foster carers in a shire county, provided by the Independent Fostering Agency (IFA). This was R's first trans-racial placement. Shortly after this move, the carers' pre-arranged holiday meant that R was required to go for a fortnight to respite carers. She refused this move, and instead absconded to stay with her mother – as it transpired, for five weeks. Mother and daughter now insisted that they both wished for R to be discharged from care. An assessment to this end was considered by the local authority, but they argued that R should first be returned, via a Recovery Order, to her new foster carers, followed by an assessment of the viability of R returning to her mother. The Judge in these proceedings granted the Recovery Order, but also recommended that the LA find the means to move R closer to home.

4.4 At this time, Mother stated her intention to make an application to discharge the Care Order. This plan did not in fact transpire, and R stayed in her 6th placement without further disruption for two school terms (until April 2013), with only one further missing overnight episode, early on. She attended local school and appeared generally to settle well, and her foster carers supported her to make some local friends. Her relationship with her foster carers and their family improved and she did not continue to go missing. Contact with her family and home area was infrequent, at her own request.

At R's LAC Review in February 2013, R had written down her wishes and feelings, at the encouragement of her foster carers. She said she was '*unhappy with her life*' and again expressed her wish to return to her mother, or at least move nearer to her. However, she did not want to have 'supervised' or organised contact with her (this was proposed as weekly).

In April 2013, R went missing for a week, during which time she apparently stayed, or based herself, with her mother in Southwark. Upon her return to her foster carers, she made an allegation of physical ill-treatment against the female carer (later retracted), which prompted the end of the placement. R was moved to her current foster carers, in Greater London; this is also a trans-racial placement, provided by the same IFA.

- 4.5 R has remained in this same placement since that time. She attends a local secondary school, and has until recently used a Children's Charity in her familiar part of Inner London once a week. Her school attendance and performance are good, as are her behaviour and general responsiveness in her foster home. It is clear that R has a solid and positive relationship with these carers – the main carer being the male of the couple.

Up to March 2014:

Despite the stability that developed in this placement, R continued to stay out later than allowed on a regular basis, and went missing overnight on 12 occasions, once remaining absent for two nights. Her carers continued to work with her on keeping herself safe, and informing them of her whereabouts. However, in this placement, as in all others before, R remained unwilling to disclose any details about the identity of her friends, or about where she goes when she is missing. Thus, the risk of harm to her has remained unknown, and possibly very high – especially in light of the incident which led to this SCR.

- 4.6 In early spring of this year, R missed school – something which was entirely out of character for her – and agreed to go to a hotel to meet an older man, someone she didn't know. Reportedly, he had telephoned her and said he had got her number from a friend of hers. They met in a hotel, where he was said to have raped her. During this encounter, R made telephone contact with her foster carer, who notified the police; both foster carer and police spoke to R on her mobile phone whilst she was missing, and to the taxi driver who brought her home, thus retrieving some details about where R had been. The police were able to identify the man and to arrest him within the next 3 days.

(The details of how the man knew, or knew about, R and how he made contact with her have not been verified and remain unclear to the Review Panel. R has declined to talk to anyone about this.).

R was persuaded by her foster carers later that same evening to attend one of the Haven centres for the victims of sexual assault; she was seen and interviewed by staff there, but did not agree to full forensic examination.

The following day, R did not attend school, but did leave the foster home for several hours, from the afternoon through early evening. She stated this was because she did not want to undergo further questioning by the police. The same happened the next day, when R was out and not at school. Police were able to establish that the alleged perpetrator had been in telephone contact with her, and had put pressure on her not to talk to Police. Thus, she was at risk of witness intimidation, if not other threats to her safety. When she returned home on that second day, the Police determined that she could not be kept safe in this placement. They had considerable concerns for her wellbeing (especially because the alleged perpetrator was not yet in custody). Thus it was decided that Police should exercise their Powers of Protection, by removing R from the foster home to the police station, and proposing that she should be placed in Secure Accommodation. This was not agreed by the LA, and she was returned the following day to her foster carers. A Strategy Meeting was held to consider the investigation of the alleged sexual assault, as well as how to promote R's ongoing safety.

R had spent the night in the police station (not in a cell, but in a communal area). The LA emergency duty team were able to send a social worker to be with her through the night. Both R and her foster carers had asked for the male foster carer to accompany her to the station, but this was not permitted. The reasons for this prohibition have not been explained within the Police IMR.

5. Practice and organisational learning

A. Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child.

5.1 What historical records and knowledge were available?

Mother moved to the UK in 1999, but most services, apart from the Police, had no contact with her and the family until 2002. At that point, R's older sibling came to join his mother in London; this led to serious concerns about his welfare, due to his exposure to criminality and drug activities in her household. CSC intervened, firstly to accommodate him, and then to return him to his maternal grandmother when she was living abroad.

Details of R's developmental and care history from birth in 1998 to 2007 (care given by her maternal grandmother when she was living abroad) have not been recorded in any agency files and remain largely unknown.

By 2007, there were younger children in the family, when R and her older brother were reunited with their mother.

From this point, the family were known to universal services in London (schools, health), and to CSC and Police because of intermittent CP referrals, investigations and assessments. In 2009, there were reports relating to Child in Need Plans (for the younger siblings) and the CP Plan for R. The Police have records regarding raids on the various households where Mother lived, and charges against her and her partner(s) for a variety of offences, mainly to do with dealing in drugs and theft.

5.2 As often happens, the care proceedings in 2010/11 required the preparation of specialist assessments. In this case, a very full psychiatrist's report was especially useful in that it captured previously unknown information about the family history, obtained directly from the mother, grandmother, and children. It also highlighted the psychiatrist's assessment of R, and the impact of the abusive care she had experienced, as well as her exposure to other traumatic experiences as a young girl – e.g., being used to prepare and deliver drugs to customers, witnessing adult violence, and being left alone to care for her younger siblings. Anyone reading this report, and the judge's use of it in his final judgement, can be left in no doubt about the damage done to R and her degree of vulnerability (including to child sexual exploitation), as well as her need for therapeutic help.

5.3 What was known about R's history, and how was it relied upon in making plans for her?

This question will largely be answered in relation to CSC, where most of the relevant history was recorded and kept. The importance of records was particularly significant, because R was, and continues to be, reluctant to talk openly about her past and her family.

The CSC IMR found that the workers and managers directly responsible for R did not access the relevant records held by them which provide an account of her history. These included key documents: the earlier CP reports for CP conferences, the CP conference minutes, the assessments of R and her siblings, and the legal documents referred to above. As a result, R's psycho-social history, her own and her family's experiences, and the degree and nature of her vulnerability (including to child sexual exploitation) were poorly understood by those acting as her 'corporate parent', as well as by their multi-agency partners.

This affected plans and decision-making, which in many instances appeared to be reactive rather than considered and based on knowledge of R's complex needs.

The social workers relied on the records of R's recent LAC Reviews. These are essential documents, as they include the young person's wishes and feelings, and details of the current care plan. However, they do not include a picture of the child's history before coming into care, or the full journey in care.

5.4 In the view of the Review Panel and the Lead Reviewers, it is good practice for the allocated social worker to read and consider a child's history, especially where that child is looked-after by the local authority.

5.5 Without this basis for his/her care planning, the LA and partners are unlikely to achieve the best possible outcomes for the child.

Learning Point

Knowledge of a child's psycho-social history is essential for effective assessments and planning for children.

Recommendation 1:

CSC managers should use every opportunity (induction, supervision, training) to embed the requirement for the allocated Social Worker to read and understand a child's history, and for the worker's manager to prioritise and protect the time needed to do so. This message should be supported by guidance about key documents and the use of chronologies, to support better understanding of history and patterns.

A means of monitoring whether this has been done should be put in place for all children who are subject to a Child in Need Plan, Child Protection Plan, or Care Plan as a looked-after child.

Recommendation 2:

The audit template for CSC cases should include a question about the consideration of personal/family history in assessments.

5.6 The Review Panel wanted to know whether not reading a child's history had become accepted 'custom and practice', in a busy and pressured work environment. The responses we got suggested that, although this may have been an extreme example, it is not uncommon to work with a child or family without an informed and solid understanding of their history. (Other SCRs indicate that similar practice occurs very widely; this is not a Southwark-only problem.)

Why should this be so?

- Many paper files are archived, so there is a bureaucratic process, and some delay, involved in obtaining them.
- A number of key documents have not previously been scanned onto the Southwark electronic system (CareFirst). This is now improving, with stronger administrative support in the new structure (Social Work Matters).

- Social Workers and their managers are very busy and may not prioritise reading the child's history.

5.6 Specific team factors

(The problems in the Looked-after Children Team, and their impact, are described here, but are equally relevant to several of the other questions posed by the SCR, in the following sections.)

Severe difficulties in the Looked-after Children Team, during the time frame for this review, meant that their work was not carried out as it should have been. Sickness levels were high, and this included one of the two main social workers for R (allocated during 2012), who was off sick for a lengthy period, a practice manager (for several months in late 2012/early 2013) and a service manager (mid-2012). Overall, the team had a sickness rate of 20 to 25%.

Perhaps not surprisingly supervision was irregular for the SWs working with R during 2012 and 2013. This inevitably compounds the difficulties for a worker, who has less opportunity to reflect on her cases and to receive managerial guidance and support to prioritise and complete tasks.

The template for recording case supervision includes a question at the top of the page: 'Have you reviewed the case records since the last supervision?' In the records reviewed for R, this is consistently left blank by the supervisor, and again suggests a lack of the supervisor's time for careful file review.⁷

As a 'knock-on' effect of absences in the team, R's next allocated social worker was assigned an unrealistically high caseload – partly because she was covering cases for several absent colleagues – and was given insufficient guidance about what tasks she was expected to cover. There were no transfer summaries or full chronologies to support this additional work (See Para 5.14.6 below). To make matters worse, the team manager post changed several times during this same period, so that there was little continuity in the supervision and oversight of cases. Two of the acting managers were agency staff who were unfamiliar with Southwark. The Review Panel has not been told how or whether more senior managers took responsibility for assessing the risks to the team (staff and service users) during this extended period.

The impact of staff sickness and serial changes of managers in the LAC Team (2012 and 2013) clearly affected the service provided to R, her carers and other partners – and no doubt others as well. But while these circumstances account

⁷ One other oddity is that several recordings, filed as 'Supervision' on CareFirst, contain a variety of different records, including emails, and minutes of meetings. This means that a list of 'supervisions' on CareFirst can mislead about the timing and number of actual supervision sessions with the worker to discuss the case.

for many of the lapses in practice, they do not suffice as an answer to ‘what went wrong’.

The responsibility lies with the wider organisation to ensure that the highest priority statutory work continues to be carried out, even when services are under strain, and this clearly includes its duties towards looked-after children.

All organisations must anticipate the times when – inevitably – any team may become highly vulnerable, as in this case. This can happen for a variety of reasons, the most common being high sickness levels, or an unexpected degree of turnover, in workers and managers (both were true for this team). These circumstances are risky for all concerned, but especially for service users. It is the responsibility of individual team managers to deal with these matters routinely and to risk-assess the impact on the service provided. Senior managers need to receive reports to enable them to monitor and prepare for more critical situations in teams.

The recommendations given below try to set out what kinds of preparations might be needed. But there will be different circumstances in every organisation, and in every crisis, which means that details will have to be developed as required. This is even more challenging when resources are already under pressure. The main point is that these situations should not come as a surprise to anyone, and that organisations must develop ways to minimise the detriment to service users and colleagues (and the team members themselves). The Review Panel were told of the system in GSTFT Safeguarding Assurance Board, which has a regular item on its agenda about safeguarding team vacancy rates and how these are being managed.

Learning Point

In any agency, high turnover and sickness among workers and managers in a team carry the risk of loss of knowledge about cases and potential failure to carry out statutory duties.

Recommendation 3:

In order to manage the risks which arise from gaps and vulnerabilities in teams, managers in all agencies should have in place the following:

- **Communication to all levels of management (including the SSCB) when a team is experiencing high levels of sickness and/or rapid turnover of personnel.**
- **A template for risk management of work which is not being covered in the absence of team members.**
- **Communication about staff absence to service users and colleagues, in answer-phone and out-of-office messages, with alternative names, numbers and addresses for anyone trying to make contact regarding a case. More pro-actively, a letter should be sent to the child, family and members of the network when a worker is on long-term sick.**

- Support for staff in a team experiencing extreme difficulties, as part of the 'risk assessment' of the team's circumstances.

- B. Evaluate whether the care plan was robust, and appropriate for R, the family and their circumstances;**
- C. Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan; and**
- D. Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. And whether any protocol for professional disagreement was invoked.**

(The IMRs' and the Review Panel's analyses of these three areas of practice overlap to such an extent, that it seems best to comment on them together in one section.)

- 5.7 R's Care Plan was comprised of most of the required elements, touching upon her health, education, practical and emotional needs; a gap has been noted in relation to the attention given to her sense of 'identity'. Both her current and future care was thought about at her LAC Reviews.

In terms of wider planning, a clear and pro-active approach to R's placements was lacking, as most of these were unplanned and appeared to rely on 'what was available at the time'. (See also Para 5.13). There was a muddled decision to proceed with a 'Placement with Parents' assessment when R refused to leave her mother's home for five weeks (August 2012). This appears to have been proposed without a proper risk assessment of Mother's household, possibly because the LA was unsure of obtaining a Recovery Order for R, in order to return her to placement. In fact, Mother was staying in a friend's house, and she was sharing a bed with R. The possibility of Mother applying to revoke R's Care Order continued to be mentioned at R's LAC Reviews for the next year, indicating to all concerned that her future as a LAC was still in some uncertainty.

The Review Panel were told that R continues not to understand her Care Plan, and has a persisting anxiety about whether her current placement will be 'permanent'. It is likely that, while professionals may understand the idea of permanence conferred by a Full Care Order, permanency about a placement can be blurred. And we know that for R, the future security of any placement has become difficult to believe in. In addition, there may be a further obstacle to assuring a young person like R that she will remain in a placement with an IFA, because of funding implications. LAC Reviews should be as transparent as possible about the longer-term commitment to a placement where the child

might remain until age 18, and this message should be clearly conveyed to the child.

R's Care Plan was reviewed at the required frequency. However, there was a delay for most of these in sign-off by the Team Manager, and it must be assumed that they were not uploaded onto CareFirst in a timely way. A section below (Para 5.9) deals with the lack of sharing of these records with relevant partners.

R's LAC Reviews benefited from having a consistent IRO, who knew the case well. It is she who recognised R to be 'an emotionally vulnerable young person...despite her external bravado'.

However, the Review Panel has found that there were significant factors which affected how well the plans for R were implemented. These are described below.

5.8 R's lack of participation

R is of an age and understanding to be an active partner in her care planning, something which can help professionals immeasurably in trying to do a better job for a young person (YP). R has attended her LAC Reviews and listened to what was being said, but she has been unable or unwilling to participate actively in this process. There have been examples of her last two sets of foster carers helping her to write down her wishes and feelings, and these have been important contributions.

In relation to the actions which are proposed in order to meet her needs, she has refused or postponed most of these (counselling, life story work, use of an independent advocate and contact with family members). Working with R to engage her more positively is addressed in more detail in Para 5.22 below.

Many professionals involved with R have commented on her reticence, her lack of engagement, and her stated mistrust of professionals from the core statutory agencies. Perhaps because of her ambivalent feelings about her care status, she has been especially resistant towards her social workers and the IRO for her LAC Reviews.

This has not been helped by R's changes of social worker in the past 4 ½ years (there have been 10). The level of turnover in inner London CSC social work teams is very high (NB, not currently true for Southwark), and we have already noted that the team in question previously had particular pressures which led to even greater inconsistency in the allocated worker. It would be hard for any young person to develop trust and a more open relationship with her key worker under these circumstances.

It has emerged from the Learning Event that R responds better to workers in some settings, such as the specialist staff from the Independent Fostering

Agency, who have conducted many of her 'return interviews', and who have done one-to-one 'life style' work with her. She has also been more open and positive in how she works with mentors from the Children's Charity.

It may be that these organisations are perceived by R as having less authority over her, so that she can retain a sense of her own control and privacy.

Her current foster carers have invested a huge amount of time and effort to building a good relationship with R, on the principles of trust and respect. This has borne fruit, in that R has settled well with the family and is beginning to 'open up' to her main carer about her time outside the home. She now spends most of the time at home with her foster family, and her school attendance continues to be excellent. She has at least one significant local friendship – a new development.

Learning Point

Many looked-after adolescents find it hard to trust and communicate with professionals who are tasked with planning for them, and helping to keep them safe – especially when their key worker changes frequently. This can significantly constrain the ability of workers (and the local authority, as 'corporate parents') to respond to the young person's wishes and feelings, and to meet their needs.

Recommendation 4:

Looked-after children's reviews should identify a named person who is best placed to enable the child or young person to communicate their wishes and feelings. That person should be able to link closely with the child's key worker in children's social care, who represents the local authority's responsibility for the child or young person.

5.9 Care Plan not shared among multi-agency partners

This was a significant finding in this case review⁸. R's last two foster carers received little background information about R from CSC upon her arrival, and were never provided with a copy of her current Care Plan (as reflected in her most recent LAC Review). This left them without the full information they needed to care for R in the best possible way. This changed little over time: although they participated in each LAC Review, they often did not receive a record of the decisions made (although they kept their own notes of these meetings).

⁸ A similar finding was found in a recent review, *London Borough of Southwark Safeguarding Children Board: Child P: An Overview of Services Provided*, Smith F, July 2013 (unpublished report), Para 7.3.3.

Key information was not regularly shared by CSC among the partners working with R, and as a consequence other agencies remained working in their own 'silos' and not in-putting to the Care Plan. They operated without a shared understanding of R's history and experiences of abuse, change and loss, and even of her current circumstances. This was true for health professionals (e.g., the GP who carried out her Review Health Assessment in 2013) and for her schools, especially the school outside London which had no contact from CSC, and inexplicably did not receive R's education file. They relied on R's foster carers for information about R.

Some Personal Education Plan (PEP) meetings were held for R, but none resulted in a written-up plan over the two years covered by this case review. This meant that the record of decisions was not distributed and available for use as a working document for R.

It seems inescapable that many essential partnership activities, not least all kinds of communication, work less well when a child is placed out-of-borough. The IMR for Guy's and St. Thomas's NHS Foundation Trust noted that 'LAC Health Assessments of children placed out of borough in 2011/2012 seemed fragmented', and the Review Panel were told that this continues to be the case. CAMH Services are not offered to looked-after children who are placed out of borough, nor is CareLink, a service which works to support foster carers. Generally, establishing good working networks and reliable delivery systems for these children is a major challenge, given that between 70/80% of looked-after children from inner-London authorities are placed outside of their area.

5.10 Limited membership of LAC Reviews

5.10.1 In recent years, local authorities have aimed to make their practice with looked-after children less formal and more 'child-centred'. As a consequence, LAC Reviews have usually become smaller, reflecting the child/YP's wishes about who should be included in something as personal as their LAC review. This is defined as good practice in the IRO handbook (national guidance).

In this case, we have been told that R was not comfortable with being a 'LAC', and was distrustful and even resentful of professionals, at least those in the statutory agencies. For all these reasons, most of R's six-monthly reviews included only her foster carers, R herself, and her social worker (in one instance, school was represented and Mother also attended). For recent LAC reviews, the Independent Foster Agency carers have completed a set of reports and presented these. Other agencies, including those significant for R (e.g., the Children's Charity involved) were not part of the discussions, and it is unclear what, if any, reports they were asked to contribute.

CSC instigated little communication with the Children's Charity, the agency who probably knew the most about R and her peer group back in Southwark.

What we do know, as noted above, is that the network of agencies involved with R were not made aware of the plans made in these reviews – plans which would almost certainly reflect their actions with R.

R's social worker was said (by the IRO) to have consulted with R's mother before each LAC Review, 'to feed her views into the review, but there is no record of these consultations in the LAC review records and it is not clear whether this actually happened'.⁹

5.10.2 The child-focused format of LAC Reviews creates a systems problem, when a wider meeting of professionals in the network is needed but there is no routine occasion for this to happen. In this case, R was the subject of serious and on-going concerns in several of the agencies who worked with her. The professionals from these agencies – workers and their managers – held often discrete sets of information, and needed an opportunity to share these and their concerns arising from their contact with R or her family. Because the LAC Reviews did not serve this purpose, a separate meeting was required, along the lines of a Team around the Child (TAC), or simply a professionals meeting.

Learning Point

Effective care planning for looked-after children requires input from all partners in the form of either attendance or appropriate reports for the LAC Review process. However, LAC Reviews, as smaller, child-centred meetings, do not provide a suitable forum for the full professional network of those who know about and are working with the child. Thus, there may be no regular opportunity for this network to share significant information and concerns.

In addition, the LA needs to ensure that foster carers and the professional network are given full and good information about the determined needs of the child and the current plans, as well as relevant history. These actions can become more difficult for children placed out of borough.

Recommendation 5:

The allocated Social Worker should provide the most up-to-date Care Plan for a looked-after child to carers upon placement, along with a current risk assessment (regarding missing from care).

⁹ IMR from CSC, Para. 8.3

Recommendation 6:

For each looked-after child, Children's Social Care should maintain a list of partner agencies who are working directly and regularly with the child, in order to a) obtain a report for the LAC Review, where appropriate; and b) send a copy of the child's updated Care Plan after each LAC Review. This should include private and voluntary organisations.

Recommendation 7:

The DCS should undertake an evaluation of the support for and active work with LAC placed out of borough, to establish whether these children receive an equitable service compared with children placed within Southwark.

Recommendation 8:

CSC should arrange for a separate meeting for the child's professional network, outside the LAC Review, in the following circumstances:

- The child's move out of borough (where possible, to include 'old' and 'new' professionals in the child's network)
- The child going missing on a regular basis (as a Missing from Care Strategy Meeting)
- The need to share serious concerns and information about the child, including significant lack of progress in elements of the Care Plan, which means that the child's needs are not being met.

Such a meeting can also be requested by any member of the network.

This meeting could take the form of a pre-meeting in conjunction with the child's LAC Review.

5.11 Lack of progress on actions from LAC Reviews

The Review Panel noted that some elements of R's care plan remained the same, but without any progress, over the time span of several reviews. In some instances, this was because of R's reluctance to accept services. In at least one other case, it was because there had been a delay of several months in the Social Worker making a referral (for additional tutoring for R).

It may be helpful in future to make it clearer in the LAC review records why some items continue to appear over time, without being implemented.

The IRO for R explained that she 'rolled over' a number of uncompleted actions so that they would not be forgotten, and so that they could be discussed at each review. She did ask for the completion of outstanding processes, such as the Review Health Assessment. Where there is lack of progress, the reasons for this need to be made clear, so that they can be challenged or escalated as required.

5.12 Limited communication by CSC with partner agencies

The staffing problems and workload pressures in the LAC Team (described in Para 5.6 above) inevitably affected how well social workers and their managers were able to communicate with partner agencies.

The IMRs from Education and Independent Fostering Agency describe a persistent and depressing pattern of trying and failing to get responses from Southwark CSC, regarding their concerns about R. During Year 8, R's first secondary school regularly contacted CSC about incidents and behaviour by R which suggested that she was possibly involved in 'gang-related activity', and at risk of sexual exploitation. She had a number of fixed-term exclusions and was at risk of permanent exclusion, based on her disruptive behaviour in school. The Education IMR notes seven instances of formal, and increasingly serious, communication about R from the school to CSC, where there was '*no evidence of action and feedback following the sharing of these concerns*'.

After several months, a letter from the Vice Principal of the school, to the CSC Service Manager, and a formal police notice (Merlin) sent to CSC finally resulted in a 'high risk case/strategy meeting', including Police, school and carers. This was an appropriate use of 'escalation', though it could have happened sooner. At this meeting, one decision was that a 'Missing from Care Strategy Meeting' should be held; this did not happen. Shortly after, R moved away from London and from this school.

For those working with R, frustration about not getting a response from CSC staff generally resulted in arrangements for bilateral foster carer/school communication, and this became the default position during much of the next two placements, including the first move out of London. At this point, the concerns about R's behaviour had reduced, and there was perhaps a sense that she was now safer at some distance from London. After the initial Placement Planning Meeting, and a LAC Review, there was no contact at all from CSC with the child, the carers, or the school for a period of almost three months. The school had no information about R's history, either from CSC or from the (missing) school file, apart from that provided by the foster carers.

A recent Southwark case review (Child P, 2013) noted similar 'poor communication between agencies' as a recurring issue. In that case, the placement distance out of borough was even further and more difficult to manage.

The Review Panel discussed why there may be a reluctance to use escalation procedures, perhaps because of reluctance to 'get colleagues into trouble', or a feeling that it wouldn't do any good. This is an issue which needs greater attention, given the impact of letting an unsatisfactory situation continue. The outcome for the child is likely to be worse and relationships among professional partners likely to deteriorate.

Recommendation 6:

For each looked-after child, Children's Social Care should maintain a list of partner agencies who are working directly and regularly with the child, in order to a) obtain a report for the LAC Review, where appropriate; and b) send a copy of the child's updated Care Plan after each LAC Review. This should include private and voluntary organisations.

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- **The child's move out of borough (where possible, to include 'old' and 'new' professionals in the child's network)**
- **The child going missing on a regular basis (as a Missing from Care Strategy Meeting)**
- **The need to share serious concerns and information about the child, including significant lack of progress in elements of the Care Plan, which means that the child's needs are not being met.**

Such a meeting can also be requested by any member of the network.

This meeting could take the form of a pre-meeting in conjunction with the child's LAC Review.

5.13 R's placements

R has had 7 placements (plus two respite placements) since her entry into care in January 2010. The joint authors of the CSC IMR are strongly critical, and comment that

'The clearest failing of the care plan has been in finding a suitable long-term placement for R.' (CSC IMR, Para 8.4)

They suggest that some of R's carers were not suitable to meet her needs, but were likely chosen because they were the only local resource available when the previous placement disrupted.

The Review Panel were told by CSC colleagues that this is often the case for older children, especially those deemed 'hard to place', in comparison with the more careful matching of younger children with their carers.

Such decisions are inevitably constrained by capacity in the service. Resources issues (staff and placements) represent significant challenges to all local authorities, and inner-London boroughs probably contend more than most with a lack of local placements, because of the availability of housing space. There is thus a tension between a desire to keep a child within her local network/school, and the ability to achieve this with suitable and skilled carers for the most vulnerable children. In R's case, her vulnerability was now, as an adolescent, expressing itself increasingly as demanding, non-compliant and aggressive behaviour – something which most of her carers were ill-equipped to deal with. This supply/demand imbalance was reflected in the numbers of older children for whom an IFA placement is sought; Independent Fostering Agency reported that most of their referrals are for LAC aged 11 to 15, with complex needs and challenging behaviour.

Clearly, a proper assessment at the outset of R's high level needs (which were fully explored and set out during the care proceedings) should have guided the choice of placement. This might have led to more stability for R. But even this is hard to state categorically, as R herself was torn between her feelings about her family and friends, and a desire to settle in foster care.

The use of the Independent Fostering Agency for the last two placements has been positive, as this IFA has experience and skills in working with children and young people who are hard to reach, distressed, and affected by experiences of poor and abusive care in childhood. Their carers are very well supported by a team of professional colleagues who provide extra input to the child in placement, if needed. In this case, Return Interviews have regularly been carried out by a consistent person from the Independent Fostering Agency, and the same member of staff has done successful 'Life Style' work with R.

Learning Point

The choice, and timing, of local authority placements available for looked-after children does not always allow a matching of the child's needs to the ability of the carers, especially for more complex and 'hard to place' adolescents.

Recommendation 11:

Every LAC Review should set out the child's needs and how well the

placement is meeting these, including identity and diversity needs. This information should be collated so that the LA can monitor its responsibilities as corporate parent.

- E. *Establish whether the respective statutory duties of agencies working with the child and family were fulfilled; and*
- F. *Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).*¹⁰

5.14 The previous sections have outlined a number of deficits in how (principally) CSC acted as corporate parent to R. The following duties were carried out appropriately.

- **LAC Reviews** were held as required.
- With some exceptions, **boarding-out visits** were made to R every six weeks, as required during the first year of a placement.
- Apart from one extended gap between placements, R's **schooling** has been provided and has been a positive part of her care experience. Her attendance in her last two schools has been excellent, and she is learning well.

Other statutory duties have not been fulfilled, and these are described below, with some analysis of why this should be so.

5.14.1 Annual Personal Education Plans (PEPs) were not completed during the case review period.

PEP meetings were held (apart from during the period in School 2), but the agreed decisions and plans were not written up, distributed to those attending, or uploaded onto CareFirst. There is no explanation for this omission, apart from the workload pressure on workers, or the absence of the allocated social worker on sick leave.

The CSC electronic recording system CareFirst has a section ('Assessments/Forms') which lists the statutory requirements for looked-after children, with templates for recording these actions. This window in CareFirst enables the worker and manager to see what is due to be completed, and whether this has happened, and when.

The Review Panel were unable to discover how or whether this is used as a performance management tool, but consider that it offers a means of supporting effective work both in individual cases and more broadly, and of tracking the completion of required duties towards a looked-after child.

¹⁰ *Ibid*, Para 6.15

5.14.2 Gaps in LAC annual Review Health Assessments

The IMR for Guy's and St. Thomas' NHS Foundation Trust covers the provision of LAC medicals (called either the Initial Health Assessment, or the annual Review Health Assessment, or RHA¹¹).

The author states that:

The statutory duties with regard to R's Health Assessments were not fulfilled. The Designated Doctor's LAC health records had no indication that the 2011 and 2012 RHAs had been completed; this goes against the statutory guidance. This is a systems issue in terms of monitoring and tracking of assessments.'

She goes on to speculate that systems difficulties are greater when the child/YP is placed out of borough.

The LAC Health Team have tried to instigate a system which would allow them to track all Southwark LAC, but have not had the resources to develop a system with CSC.

In relation specifically to R, it appears that she did have a RHA in 2011, but not in 2012. It is the responsibility of the SW for the child to request this from the designated doctor for LAC/community paediatricians or from the GP or specialist LAC nurse as indicated on the child's previous IHA/RHA.

In 2013, R had a further RHA. This was sent to the Specialist Child Health LAC team in a timely way so that the "Part C" health summary could be written, but the Health Summary was not completed and distributed to partner agencies for a further four months.

Similar to the problems in the CSC LAC Team, there were significant periods of sickness absence in the specialist child health LAC medical and administrative teams during the period under review.

These circumstances appear to echo those of a similar Southwark case reviewed in 2013 (Child P). The independent author of that case review made the following recommendation:

Children's Social Care should, in co-operation with Health and Education partners, review current arrangements under the Care Planning, Placement & Review (England) Regulations 2010, for forwarding of child health records to

¹¹ For looked-after children under 5 years old, the RHA is required 6-monthly; for over 5s, it is done annually.

the relevant 'area authority' and arrangements for health assessments (initial and review)...for children placed out of borough.¹²

5.14.3 The Greater London borough where R now lives was not informed of her placement in that area, as is required.¹³

In Southwark, a member of the placements team normally sends the required notification letter to the local authority where the looked-after child or young person has been placed. At the same time, the details of the placement are loaded onto CareFirst, and a record is kept of the letter to the other local authority.

These are routine tasks which were not done when R moved back into the Greater London area; there is no explanation for this omission. An exactly similar omission was noted in the recent case review of Child P (Para 7.3.3). The Head of Social Work Improvement and Quality Assurance has since requested that the Placements Team Manager audit 20 recent placements to find out how compliant the system is generally, and whether there any weaknesses which might lead to omissions, such as occurred in this case.

5.14.4 Gaps in records

The IMR for CSC highlights the following gaps:

- There is no chronology or genogram on R's file. Both of these are expected to be provided for all children who are clients of CSC, but they are often not completed or updated and on file.
- There are no fostering records during R's placement (29/11/11 to 25/2/12). This leaves in doubt the support which the carer at that time was receiving from the fostering service.
- The CSC records, for the critical 5 weeks when R was absent from care (August 2012), are unclear. The plan for this unauthorised arrangement included twice-weekly visits, announced and unannounced, as a way of monitoring the risk to R. The records do not say whether these visits happened.
- Generally, minutes of meetings, including LAC Reviews, were not uploaded onto CareFirst in a timely way. This meant that, in the absence of the

¹² *London Borough of Southwark Safeguarding Children Board: Child P: An Overview of Services Provided*, Smith F, July 2013 (unpublished report)

¹³ Where a Child Looked After is placed in the area of another local authority (regardless of the type of placement), the Arrangements for Placement of Children (General) Regulations 1991 (Regulation 5) requires that notification is made by the placing authority to the local authority's children's social care service where the child is living. (The education service and the relevant health trust for the area in which the Child Looked After is placed must also be notified.) The notification will include the address where the child is placed.

allocated SW or manager, there was insufficient up-to-date 'guiding' information for anyone needing to know about or take action in this case. (The CSC representative on the Review Panel could not comment on whether this was individual weak practice, or more widely the case in the service.)

- There are no written transfer summaries, a real problem for the different social workers who took on R's case. The case review of Child P (2013) recommended that

'The extent to which case transfers are informed by a written handover and briefing requires monitoring, if necessary by means of amending existing case audits schedules'. (Recommendation 4, p.51)

Learning Point

Children and families cases will inevitably transfer to a number of different social workers and managers over time. For their work to be effective, case records need to include a genogram, an up-to-date chronology and a transfer summary.

Recommendation 12:

The CSC case audit template used by the QA team should include questions about compliance with the departmental requirements for genograms, chronologies and transfer summaries. The quality of transfer summaries should be monitored.

5.14.5 Problems in transferring information between schools

The author of the IMR for Education comments on the *'lack of effective systems to document and track the transfer of school files'*. R's moves of schools (she attended three schools during the case review period) revealed various problems in transfer of information. School 1 say that they sent R's education and CP files to School 2 (outside London), who never received these. School 2 did not provide transfer information to School 3. However, the 'missing' files from School 1 eventually turned up in School 3, without material about the intervening two terms in the shire county.

The IMR author for Education has done everything possible to try to find out about how R's files went astray, without success.

Learning Point

The systems for sharing and transferring information about a looked-after child who moves schools do not always operate in a transparent and timely way.

Recommendation 13:

The Director of Education and education team managers should agree and then implement a protocol in relation to the transfer between schools of Looked After Children's education records to ensure that a robust, well tracked procedure is in place across all Southwark schools. The protocol should include a clear line of communication and escalation should information not be received in a timely manner by the admitting school. Ideally transition meetings between professionals from the outgoing and the new school should be built into the process to ensure that learning and support needs are shared prior to the child joining the new school.

5.14.6 Missing from Care procedures were not followed

No Missing from Care Strategy Meetings were held during the two-year period of this case review. The required 'return interviews' were carried out by R's social workers when she lived in Southwark, but these did not continue when she moved out of borough. These issues are explored below, from Para 5.16 onwards.

G. *How well did professionals understand and manage the different risk factors influencing this case and the particular vulnerabilities of R, during the two years under review?*

and

H. *Review of the application and use of children missing from home and care protocol*

5.15 Understanding of R's particular vulnerabilities

The first point, remade here, refers back to the initial question in the Terms of Reference (Paras 5.1-5.6): *Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making?* Because this was not the case, those involved with R had a limited understanding of the degree and nature of her vulnerability.

R was undoubtedly affected by her troubled personal history, contributing to her lack of secure attachments, mistrust of those in authority, and a weak sense of her own worth. All these underlie her vulnerability, which was heightened when she was missing from care, and her whereabouts and her activities were not known. Sadly, she has for some time been resistant to the idea of therapeutic help regarding her childhood experiences. Better engagement by CSC with the Children's Charity (where there was early on a very strong attachment from R) might have allowed the LA to build on R's positive relationship with the workers there in order to facilitate R's agreement to therapeutic help.

There has been little apparent awareness of R's risk of sexual exploitation when missing, despite her previous sexualised behaviour and the concerns this raised at the time.

5.16 Missing from care episodes

5.16.1 Southwark Safeguarding Children Board has a multi-agency Missing from Care policy (2012), which is being updated in response to the Metropolitan Police's pan-London protocol, 2014¹⁴. The current policy covers good practice in relation to reporting missing episodes; the role of carers, CSC and Police in responding to the return of a missing child/YP; the guidance given to children at risk of going missing; and the maintenance of an updated risk assessment for each child/YP.

The section below addresses how well this policy has been followed in relation to R. What is clear is that she has received consistent advice about keeping herself safe, from her carers and other the Independent Fostering Agency staff, her social workers, police officers, her Independent Reviewing Officer (IRO), and staff at the Children's Charity. Arrangements were in place to transport her safely¹⁵ to the evening group she attended back in Southwark on a week-end night (though, oddly, not home again afterwards; this has now been rectified).

5.16.2 During the two years under review, R's patterns of going missing from care varied considerably. From early 2012 until her move away from London, she was regularly outside the care and control of her foster carers. She frequently returned to her placement very late, or was missing overnight (or longer). There was some evidence of potential CSE (R having unexplained amounts of money, being 'dropped off by an older man').

Police responded to all incidents as required – by visiting R and speaking with her, and also by creating a Merlin report for CSC.

However, records from this period suggest that Southwark's Missing from Care Protocol¹⁶ was not being followed in other respects, and this omission was noted in a 'High Risk Case Meeting' held in June 2012. The required strategy meetings were not being held, and return interviews by a social worker¹⁷ were not being carried out consistently, especially when R moved out of borough. The LA was reminded that a strategy meeting is required when a looked-after child is missing for more than 24 hours, and should be considered when there is an on-going pattern of shorter 'missing' events.

5.16.3 R's foster carer (from April 2013 onwards) regularly notified the Police when R was missing. Police records show that they produced Merlin reports and carried out return interviews on every occasion, apart from a handful when they were

¹⁴ *Pan-London Child Sexual Exploitation Operating Protocol*, Metropolitan Police, February 2014

¹⁵ Ladycabs, a taxi firm using female drivers, are routinely used in such instances.

¹⁶ *Southwark Safeguarding Children Board – Multi-agency Protocol for children missing from home and care*, January 2012, Para 8.2

¹⁷ An independent organisation has recently been contracted to provide this service – see below, Para 5.16.5.

informed that she had returned within a few minutes of having being reported as missing (out later than her required time of return)¹⁸, and the record of the report had not yet been formalised.

What was routinely missing was the second, independent Return Interview by the young person's social worker, which is designed to provide a more in-depth picture of the missing episode and levels of risk, as well as giving an opportunity to offer support and guidance to the young person.

In some instances for R, this was conducted by a dedicated worker from Independent Fostering Agency, where this service has been developed (see Para 5.16.6 below).

Major resource implications for Police

The growing incidence of missing episodes – locally, across London and nationally – has major resource implications for the Police. In the case of R alone, there were 20 missing episodes reported between 2010 and 2012; during the review period, there were a further 33 reports, all of which required a police response. Considering the numbers of looked-after children in Southwark alone, as well as around London and across the country, this is a major burden in terms of capacity for Police, not least because it may often involve officers at night when there are other pressing matters to be dealt with.

5.16.4 In August 2012, R was away from her placement for 5 weeks and staying with her mother. This situation was minimally assessed, with a Police check, not from the usual source of CAIT, about the household where Mother and R were staying. This provided a less rigorous and in fact misleading account of potential risks, given Mother's past police record and the findings in the Care Proceedings the previous year. There was no risk assessment completed for R. Guidance for such an assessment is given in Appendix 4 of the Missing from Care Protocol.

5.16.5 There followed the placement outside London, when, with one brief exception, R did not go missing for 8 months. Her school attendance was very good and she settled well with the foster family.

In April 2013, R suddenly absconded for a week, communicating by text with her carers that she was staying with her mother. R was visited (a welfare check) by Police who found her to be safe and well. R was also seen in the local Southwark CSC office once during this period, when she was advised to return to placement. She was not visited at home by a SW, nor was there a 'return interview' by a SW upon her return to placement. Was this because she was not seen as 'missing'? As before, there was no risk assessment of the care Mother was providing, or indeed whether R was actually staying with her mother most or all of her time. (In fact, R absconded from her mother's home for 24 hours during this week, and the records state that 'no one is aware of her whereabouts' – CSC files.)

¹⁸ Agreeing definitions of 'missing' and 'absent', and the respective roles and expectations of different services should be clarified within the local Missing from Care protocol.

The current Southwark Missing from Care policy describes who should carry out Return Interviews ('an independent person...who is able to build up trust with the young person'¹⁹).

Recent change: Southwark CSC has just commissioned this service, commencing 1st October 2014, from St. Christopher's, a voluntary organisation experienced in working with young people in this area.

5.16.6 In R's next (current) placement, in the 12 months to the end of April 2014, she stayed away overnight 11 times, and was away for 2 days on one occasion. The management of these episodes has included an agreed rule about reporting R missing ('when she is 10 minutes late home'). This was based on her continued refusal to tell her carers or anyone else where she goes, and with whom, when she is absent from her placement.

Her foster carers reported her missing scrupulously, and Police carried out welfare visits when she was returned (and sometimes telephone 'debriefs' with her while she was missing).

As already stated, return interviews have not been consistently undertaken by the local authority Social Workers. The Independent Fostering Agency uses a specialist worker on a regular basis to conduct these, and two members of their staff have offered this service to R and made a good connection with her. However, the Independent Fostering Agency have not viewed this as a substitute for the local authority's responsibility to conduct such interviews.

5.17 Assumptions made

The Learning Event highlighted what had already been suggested in the IMRs, which was a belief that 'R wasn't really missing'. For one thing, her behaviour was in many ways typical of most teen-agers, who want more independence and who are not always obedient to their parents' wishes. In R's case, the lower sense of risk seems to have been because a) she always (almost always) returned to her placement; b) she kept in communication with her carers (usually) ; and c) she had a plausible and consistent story about where she was – either with her mother or with friends. But these stories were not verifiable, and none of these circumstances meant that R was known to be safe.

There are two other flaws in the assumptions about what was happening to R when she was absent from her placement:

- Information about Mother and her care of R described a poor relationship and abusive and neglectful care. R was at risk of exposure to criminality relating to drug-dealing. There should not have been an assumption that Mother could act as a safe carer in a safe household.
- R's friends were not identified, so it was not known where she was staying and in what circumstances.

¹⁹ Southwark *multi-agency protocol for children missing from home and care*, Southwark Safeguarding Children Board, January 2012

Various partners, including the Police and possibly foster carers, may take a different view of risks, depending on what they have been told about the child's likely whereabouts. The Review Panel were told that Police may see a child as lower risk if they go missing a lot, but also regularly return to placement. These different views need to be discussed in a multi-agency forum in order to be shared and challenged – especially in the light of increased understanding (e.g., from the Rotherham Inquiry²⁰) of the risks for looked-after children who are regularly away from placements late at night or overnight, as was true for R.

5.18 Lack of risk assessments and Strategy Meetings

Perhaps partially as a result of the assumptions above, the required 'Missing from Care' Strategy Meetings were never held, and an up-to-date risk assessment regarding Missing from Care was not placed on R's file. (A similar failure was identified in the case review of Child P²¹, where missing episodes were not recorded on CareFirst.) This seems an extraordinary omission, given the frequency of R's time away from placement (either coming home very late, or staying out overnight), and her degree of vulnerability. It seems that each incident was regarded in isolation, and the pattern of going missing was not understood and evaluated by the network.

LAC Reviews discussed R's time out of placements, and the IRO recorded that her 'frequent unplanned contact with Mother and grandmother was a cause for concern'; but this did not lead to a risk assessment of the contact or any other related action. The reasons for this are not known, apart from the (already outlined) lack of capacity in the LAC Team.

When R was still placed in Southwark (2012) and when concerns about CSE were emerging, a referral was made for her to be discussed at the Multi-Agency Sexual Exploitation (MASE) Panel. This was turned down because at that time, a case without a named perpetrator would not be considered. The Review Panel has learned that the way the MASE operates has been altered, in response to the Metropolitan Police Operating Protocol, 2014. There are now two levels of this structure: a multi-agency strategic group, and a multi-agency panel which will continue the work of the previous group. The remit of the latter panel is being revised to include general concerns and patterns suggesting risk to children like R, even though there may be at that point no suspected perpetrator.

The Southwark Missing from Care Protocol provides a very helpful template for both independent return interviews and risk assessments, both of which are part of the process of safeguarding vulnerable young persons.

²⁰ *Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997-2013*, Professor Alexis Jay, August 2014, Para 6.37

²¹ Para 7.3.3

Learning Point

Children missing from care are at greater risk of sexual exploitation, not only because of being outside of (corporate) parental control, but also because of the power and reach of social media.

Recommendation 14:

Every looked-after child should have an up-to-date 'missing from care' risk assessment on their CSC file. Carers, CSC and Police should contribute to this, as appropriate, and it should be shared within the LAC Review group and any other key safeguarding partners involved with the child.

Recommendation 15:

In particular, high priority should be given to making sure that there is a risk assessment on the file of every child at risk of sexual exploitation.

(This recommendation is taken from the Rotherham Inquiry)

Recommendation 16:

The internal CSC audit and the SSCB multi-agency audit should include a question about compliance with Missing from Care procedures for every looked-after child.

5.19 How the incident of alleged rape was dealt with

5.19.1 The Review Panel for this SCR were initially gravely concerned about how R was dealt with by the Police, on the second night after her alleged rape. The Police IMR has been helpful in explaining the Police's assessment of risk and why they decided to use Police Powers of Protection:

- R had decided not to cooperate further with the police investigation (possibly because of threats from the alleged perpetrator, with whom she was known to be in contact).
- She continued to leave her foster placement and refused to let her carers know where she was going. This was at a time when the alleged perpetrator was still at large and was believed to be intimidating R as a witness, and to offer further risks to her safety. She was in contact with him.
- In these circumstances, the foster home was not deemed to be a secure placement for her.

The Police IMR author sets all this out clearly and takes the view that the protective actions were correct. However, the use of the police station (not the initial intention of the police) overnight was in his view **not appropriate**.

He makes no recommendation about this. The Review Panel have discussed the impasse which arose between Police, who were asking for a different placement to keep R safely on this night, and the local authority refusing either to place her in Secure Accommodation or any other unit. It was their view that she had a perfectly good placement to which she could be returned.

This is a situation which is likely to occur again, and these agencies need to consider how disagreements about high risk young persons can be mediated and dealt with in a child-focused way.

A concern from the Review Panel: was R dealt with differently because she was a looked-after child, rather than someone living with her own parents?

Learning Point

There are potential tensions between Police and Children's Social Care, regarding their respective roles and responsibilities in relation to a looked-after child at high risk of harm. This can result, as in this case, in an impasse and an outcome which is not appropriate for the child, even in the short-term.

Recommendation 17:

The relevant senior managers from Police and CSC should explore the options for keeping children and young people safe in emergency situations, in particular considering how differences between agencies about appropriate placement can be resolved.

It may be useful to use case studies to illustrate the most contentious and complex situations, and how they might be handled.

5.20 Looked-after children and the risk of CSE

5.20.1 The known link between going missing from care and CSE is highlighted in much research evidence and key reports. For example, Barnardo's 2012 report about the risk of CSE provides a list of 'Key indications of vulnerability (to CSE)' ²². First on its list is 'Going missing for periods of time or regularly returning home late'. (p.5)

This link has provided a focus for this SCR, and was already a priority for the work of the SSCB. In August 2014, the Rotherham Inquiry was published, giving an abundance of useful data and analysis, not only about the cases in that area, but more generally about the risks of CSE to young girls who go missing from care. This will add to the learning from this SCR and support the work of the SSCB in this challenging area of safeguarding.

5.20.2 In early 2013, based on the outcomes of seven earlier Management Overview Reports, Southwark Safeguarding Children Board identified three priority areas for strategic development:

- Safeguarding of adolescents and older children
- Safeguarding issues pertinent to looked-after children
- System-wide understanding and practice regarding sexual exploitation and abuse of young people.

²² *Cutting them Free: How is the UK progressing in protecting its children from sexual exploitation?*, Barnardo's Policy, Research and Media, January 2012

The Reports clearly pointed to the greater vulnerability of looked-after children, compared with their adolescent peers: a message which is significant in the case of R, and needs to be further disseminated regarding the cohort of Southwark's adolescents in care. The link between going missing and risk of CSE needs to be embedded in the thinking and practice of staff at all levels, including front-line practitioners, who are working with looked-after children aged 10 and upwards.

5.20.3 In September 2013, the SSCB produced a comprehensive review of data, both locally and nationally, to inform their safeguarding work in relation to CSE. The links with 'going missing from care' were very clear – both within Southwark and elsewhere:

- Numbers of LAC going missing for over 24 hours was up 36% in 2012/13, compared to the previous year. (However, this rise has now been wholly attributed to a different way of recording missing episodes. The number of LAC going missing has remained steady for the past two years.)
- The amount of time spent missing, by the same cohort, rose by 100%.
- Over 80% of missing episodes were among children placed out of borough.

An audit of 5 young women (LAC) who were believed to be at risk of CSE found that, like R, the majority had experienced multiple placements, including out of borough. Again like R, the majority had been removed from families at a late stage, after on-going histories of neglect.

As we become more aware nationally of the nature of such 'familiar stories', a more pro-active and protective response should be adopted at a strategic level – across the local safeguarding children network – to reduce the risk to this group.

Work already commenced

The Review Panel were told that the SSCB is considering and responding to the recommendations of the Rotherham Inquiry, including Recommendation 3, which suggests that

'Managers should develop a more strategic approach to protecting looked after children who are sexually exploited. This must include the use of out-of-area placements.'

The SSCB are using the 'See Me, Hear Me'²³ principles and framework for protecting children from CSE to guide the work in this priority area for the SSCB.

I. How well did professionals hear the voice of the child in their work with R? And to what extent were her unique diversity needs met by services?

5.21 Professionals have tried to listen and respond to R's wishes and feelings, whilst needing to balance these with their responsibility to make decisions which support her and protect her from harm. This has not been a straightforward task, for a number of reasons: R was not always consistent in her stated wishes and feelings

²³ Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, Final Report, November 2013

(e.g., about contact with her mother, or returning to live with her mother), and she has been reluctant to talk at any length about these. This has limited her input into her LAC Reviews, which have generally heard from adults rather than from R. Nonetheless, the LA and partners have continued to fulfil their corporate parental duty to her, in the following ways:

- R's links to her family are clearly important, and the LA has consistently tried to arrange for safe contact between R and her mother, grandmother and siblings.
- R's wish to live nearer to her mother was supported by the Judge who made the Recovery Order, and by R's IRO. R's move to her current placement was also noted to be a better match for R, providing a greater degree of diversity than the shire county where she was previously placed. (But it remains less diverse and less like 'home' than Southwark, where R, until recently, continued to return on a regular basis.)
- R's links with her familiar area of inner London have been supported by safe arrangements (taxis) for her to attend the Children's Charity weekly.
- R's experiences of bullying – in all three of her secondary schools – have been addressed by the schools and carers, and she has been enabled to attend and achieve well.

5.22 As has been noted elsewhere, there were gaps in the SW service offered to R, largely but not entirely related to sickness and lack of capacity in the LAC team. R is an adolescent who was already unlikely to trust those in authority over her, and who has had a sequence of changing social workers, then some who did not visit her consistently, and some who were slow to follow up on actions agreed on her behalf (e.g., a referral for extra maths tuition, which took several months to progress). In these circumstances, R has remained disappointed and resistant to communicating with professionals within CSC.

The Review Panel have speculated that, had R had the same SW from the time she came into care aged 10, this relationship might have flourished and allowed R to trust and tell her wishes and feelings. Sadly, the turnover in the SW workforce has not allowed for this to happen.

R's most recent SW was chosen because of her noted ability to 'get through' to young people; in addition, she is a black woman like R (as is R's IRO). She has sought the advice of CAMHS colleagues to help her develop the relationship, and has been advised to persist in offering R an attentive and reliable service – even though rebuffed. This has so far not succeeded, but it is regarded as the best way to demonstrate the role of a responsible parent: one who does not give up on the child, but who sometimes has to take decisions which the child doesn't like.

5.23 Like all young people, R would benefit from a trusted and consistent adult whom she can tell her wishes and feelings.

This role has been slowly and painstakingly developed by her current foster carers, especially the main (male) carer. They have worked hard to build a relationship with R, based on trust and – very slowly – on her willingness to give more information about her time spent out of the home. This remains a work in progress.

Other workers, from the Independent Fostering Agency and from the Children’s Charity, have described R’s willingness to talk to them more freely than to her SW. This may suggest that she naturally views these private or voluntary agencies differently from the LA, with its unwelcome authority over her. In particular, the Education Advisor/Special Project Consultant from the Independent Fostering Agency has made a good professional link with R, within which messages about her self-worth, welfare and safety can be conveyed.

However, it remains the case that R does not readily share her wishes and feelings with the adults in her life. In this, she is no different from many adolescents living with their own families, who only confide in their peer group.

5.24 Professionals who attended the Learning Event for this review speculated about whether social workers tended to have more skills and confidence for working with the birth-to-12 year age range, than with resistant teen-agers. It was suggested that a ‘tool kit’ would be helpful for trying to engage with adolescents.

5.24 The consideration of R’s identity and her ‘unique diversity needs’ has not been clearly recorded in her LAC Reviews, or elsewhere, apart from the acknowledgement that the diversity of the London area provides a more suitable environment for her placement. But it is clear that the LA has tried to match black carers and workers with R.

R’s first five placements were local (Southwark) and were a racial match for her. Unfortunately, the last two of this series of placements were with very elderly carers who struggled to work with R, who at that time was increasingly troubled and disruptive – and was spending more and more time out of the placement. The choice of these last two placements was quite likely to have been because they were ‘the only ones available’. This is a real resource issue, common to all inner-London authorities.

5.25 R’s last two placements have been with white carers, and she herself has expressed her preference for a trans-racial placement. Her last two SWs, on the other hand, and her IRO are all black women. Thus, the local authority has tried to ensure R’s heritage is reflected by those representing her corporate parent.

J. Review of the application and use of the e-safety policy in this case

5.26 The sources and means of possible CSE have expanded hugely as a result of the technological revolution in social media. This worldwide phenomenon shows no signs of slowing, and it undoubtedly leaves many adults – professionals included – far behind in their awareness and understanding of increased risks for children and young people.

Barnardo's 'Cutting them free' report describes why those in positions of care towards young people – including all parents – need to be concerned about the role of technology in exploitation. The following passage describes their experience in this field:

Exploited young people and children are typically abused in person, but sexual exploitation also takes place over the internet, through mobile phones, online gaming and instant messaging. This is not surprising given how central technology is now to young people's lives, and the issue has long been a major concern for our services. However, the services reported that the scale of online and mobile abuse has markedly increased even since 2010. Almost all services reported it as an increasing priority, and some have identified that the majority of their service users were initially groomed via social networking sites and mobile technology.

...Young people, parents/carers and professionals need to be more aware of how such technology can be used by abusers. (p.7)

5.27 It has been very hard to comment about the application of an e-safety policy in this case. We do not know its specific relevance in relation to the trigger incident for this case review. This is because the circumstances leading to the alleged attack on R remain unknown, and R is unwilling to say any more about this matter. She has previously stated that the man contacted her on her mobile telephone, the day before they met, and that a 'friend' of hers had given him her mobile telephone number.

Police have been unable to uncover any communication between R and the man online, or any evidence of a process of grooming.

5.28 R's foster carers have put in place sensible precautions regarding her use of mobile phone and the internet. Her phone is on a contract which allows professionals to track calls when necessary (as in the recent incident); and her oyster card also enabled them to see where she was travelling. R's telephone is not allowed in her bedroom at night, but is left in the kitchen of the foster home. These actions are in line with the guidelines in the Independent Fostering Agency e-safety policy.

Those responsible for R are aware of the power and lure of the internet and social media more generally, and have talked to R about the risks arising from these. As for all young people, it is impossible to know whether, how and when R continues to use the internet, and potentially to place herself at risk of harm, especially from CSE.

Learning Point

The power and lure of electronic social media carry a risk of harm, particularly to vulnerable young people, which cannot be removed by professionals working with these young people.

Recommendation 18:

The SSCB should co-ordinate the e-safety ‘statement of principles’ across the local safeguarding children partnership. These should focus on supporting and educating young people to keep themselves safe.

6. Conclusion

- 6.1 R is a young person in care who has struggled with the status of being ‘looked after’. She entered care as an older child, with a complex history which included neglect and abuse by her parent, and which left her with powerful feelings of rejection and blame by her family. She went on to have a series of 10 different social workers and 7 placements – a difficult and increasingly unsatisfactory experience of being looked-after and cared about, which would only further diminish her sense of self-worth.
- 6.2 R is like most other teenagers in many aspects of her behaviour, wishes and feelings: the importance of her peer group of friends, her mistrust of adults and her desire to push boundaries. These make it hard for parents and carers generally to keep their adolescents safe and to know what is happening with them. But R is also different, and more vulnerable, because of her earlier traumatic experiences and her number of moves in care. She continues to suffer from the loss of her family, including her siblings, and misses the closeness of friends in her home area.
- 6.3 This case review has found that the professionals responsible for R’s care as a looked-after child have not had a sufficient understanding of her history and of her level of vulnerability – a vulnerability which continues to expose her to significant risk of harm, especially when she is missing. One consequence has been a lack of alertness by these professionals about the risk associated with R’s patterns of going missing. It seems R was often regarded as ‘not really missing’, because she was believed to be visiting her mother or staying out with friends. These stories were perhaps usually true, but the reality was that no one in CSC really knew where R was for most of the times she was missing. This meant they could not know that she was safe.
- 6.4 The Review Panel has explored the explanations for the inconsistent service by CSC to R, and why Missing from Care procedures were not followed.

The principal reason given is that the team in which R's case was held underwent a period of many months when both SW staff and managers were off sick, and the work of the team suffered as a result. There were periods of time when R was not visited at the required frequency. Partnership work was neglected, and communication across agencies suffered from there being no multi-agency forum for sharing vital information and concerns about R.

These omissions, and their consequences, should have been picked up by more senior managers, and one of the main messages of this report is that organisations must anticipate and plan for periods of serious weakness in parts of their service. Other agencies, when they experience the lack of partnership working and the response to their concerns, should more readily and positively use escalation procedures, in order to achieve a better service to the child.

6.5 The major issues of safety for children and young people raised in this case review have been highlighted on the national stage in the past two years. As a result, there is a renewed focus on children missing from care, linked to a much keener awareness of the risks of CSE, especially for looked-after children and even more so for LAC placed away from their home area. In Southwark, the emerging lessons will hopefully be reflected not only in a better handling of the risks for R, but for all adolescents in their care. The LA and partners need to work together to help these young people develop the appropriate tools to protect themselves, and to offer non-punitive responses when they return home. Sadly, no parent, corporate or otherwise, can achieve this without the young person's engagement and their wish to keep themselves safe.

6.6 In R's case, it is encouraging that she now appears to have found a home where she would like to stay until she is 18, and carers to whom she can attach and trust. Schooling continues to be very important to her, and her attendance is excellent. These are the building blocks which may allow for a better understanding of recent events for R, and therefore further means to increase her safety in future.

The professionals involved in her care have participated very positively in this SCR and by doing so will have already changed their perception and understanding of the issues of going missing from care and risk of CSE. More widely, it is hoped that the lessons from this SCR will contribute to the SSCB's learning and improvement in its priority areas for safeguarding adolescents and older children, including the children for whom the local authority is the corporate parent.

REFERENCES

Berelowitz, S., Clifton, J., Firimin, C. MBE, Gulyurtlu, Dr. S., Edwards, G., 'If only someone had listened', Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, Final Report, November 2013 (This report includes the 'See me, hear me' material.)

Cutting them Free: How is the UK progressing in protecting its children from sexual exploitation?, Barnardo's Policy, Research and Media, January 2012

Jay, Professor A. OBE, *Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997-2013*, August 2014

Local Safeguarding Children Boards Regulations, DfE, 2006

London Borough of Southwark Safeguarding Children Board: Child P, An Overview of Services Provided, Smith F , 2013 (unpublished report)

Multi-agency Protocol for children missing from home and care, Southwark Safeguarding Children Board, January 2012

Pan-London Child Sexual Exploitation Operating Protocol, Metropolitan Police, February 2014

Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews, The Welsh Government, January 2013

Working Together to Safeguard Children, DfE, 2013 (and previous editions)

GLOSSARY

Cafcass	Children and Family Court Advisory and Support Service
CareFirst	Electronic recording system for Southwark CSC
CP	Child Protection
CSC	Children’s Social Care
CSE	Child Sexual Exploitation
DCS	Director of Children’s Services
DfE	Department for Education
GSTFT	Guy’s and St. Thomas’s NHS Foundation Trust
IFA	Independent Fostering Agency (operating as a profit-making business)
IMR	Individual Management Reviews (for a Serious Case Review)
IRO	Independent Reviewing Officer (for looked-after children)
IRO Handbook	Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review of looked-after children (DfE)
LA	Local Authority
LAC	Looked-after child
LSCB	Local Safeguarding Children Board
MASE	Multi-Agency Sexual Exploitation Panel
NHS	National Health Service
PEP	Personal Education Plan
School 1	In Southwark
School 2	In shire county
School 3	In Greater London
SCR	Serious Case Review
SSCB	Southwark Safeguarding Children Board
SW	Social Worker
TM	Team Manager
YP	Young person

Appendix 1: Terms of Reference

Re: Serious Case Review – Child R

Southwark Safeguarding Children Board has decided to undertake a serious case review following a serious incident affecting Child R aged 15 years old. The review was agreed under guidelines within Working Together (2013) and regulation 5 of the Safeguarding Children Board Regulations 2006.

Reason for the serious case review

Child R alleged she was held at a hotel by an unidentified male.

On Sunday 16th March Child R reportedly agreed to meet with friends she had met via the Children's Charity. She returned late to her placement which she said was due to losing her phone. She then returned to SE London on Monday 17th March to retrieve the phone. She did not go to school on the Monday and did not return to the placement and was reported missing. On the phone she informed her carer that she was being held at a hotel by an unidentified male. The police were informed and via mobile phones Child R and the man were tracked. The male put Child R in a cab to return to placement. When she returned she disclosed to her carer that she had been raped.

Child R was supported by her carer to disclose to police, provide forensics and attend Haven. She refused an ABE interview.

A strategy Meeting was held on 20/3/14 at a Sexual Exploitation Unit, linked to the Metropolitan Police. The police subsequently arrested a male, alleged perpetrator. He is said to have been on Bail for a similar offence.

Child R is currently being supported in her foster placement.

Family structure:

Mother	35	London
Father		May live abroad
Subject	15	Foster placement
Sibling	19	London
Sibling	11	Foster care
Sibling	8	Foster care
Sibling	5	Foster care

Family Background

Child R and her family have settled in the country at different times. Child R and her older sibling lived abroad until she was about 8 years old with the maternal grandmother. At a later date maternal grandmother settled in the country.

Southwark social care involvement with Child R and her siblings started in December 2008, following receipt of a police notification stating that a member of the public had reported concerns about Child R's older brother drug running for his mother, and that she was dealing drugs and prostituting. This triggered an initial assessment.

During the assessment Child R made a disclosure that she repeatedly got hit by her mother with a mop and belt.

She said she was treated differently to her siblings, and presented as sad and withdrawn. A subsequent medical examination found evidence of physical abuse including bruises and burns.

Child R was subject of a Child Protection plan from 03/06/09 to 03/11/09 under the category of physical abuse.

On 02/01/10, Child R presented herself at a care home saying she had been beaten by her mother, had packed and escaped out of a window. Following this she was accommodated with her mother's consent on 4/01/10 under S20 CA 1989

On 19/03/10 Child R was made the subject of an Interim Care Order CA 1989, 'following a series of events involving her mother, drugs, the police and her siblings.'

She was made subject of a full Care order on 22/07/11.

Her three youngest siblings are all currently in foster care. Her older brother was previously looked after.

Care History

Child R has had around 9 different foster placements since being in care. Her placement breakdowns were largely attributable to her behaviour – she has a history of returning late from school and going missing from care. In addition she has been reported in the past as being rude, disrespectful and occasionally intimidating to carers.

Child R has been in her current placement, which is an Independent Foster placement, since 24/04/13. She had to move from her previous placement following making an allegation that her previous carer had pushed her in placement. She then went missing from 12/04/13-19/04/13.

In a Looked after review in March 2012 she was described as showing sexualised and gang-related behaviour in school.

Child R has had regular supervised contact with her mother and grandmother. When she absconds she is often found at their home.

Decision making by the SSCB

The serious incident relating to Child R was discussed at a meeting of Southwark Safeguarding Children Board on 1st April 2014 and a decision was made to proceed with a Serious Case Review on the basis Child R was a Looked After Child who was 'seriously harmed and there is cause for concern as to the way in which the authority, board or partners or other relevant persons have worked together to safeguard the child.'

This is specifically in understanding the management of Child R's episodes of missing from her care placement.

The purpose of the Serious Case Review (SCR)

The purpose of the serious case review will be to cover the key areas of inquiry as set out in Working Together (2013) and to follow these principles and those of the Welsh model (2013)

<http://wales.gov.uk/docs/dhss/publications/121221guidanceen.pdf>

Electronic guidance for arrangements for multi agency practice reviews.

This is to identify improvements that may be needed and to consolidate areas of good practice. Any findings from the review should be translated into programmes of action leading to sustainable improvements.

The SCR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than just using hindsight
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings

The serious case review will:

- Seek contributions to the review from Child R and appropriate family members and keep them informed of key aspects of progress
- Produce a report for publication available to the public and an action plan

The report will include an analysis of the following, including what happened and why:

- Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child;
- Evaluate whether the care plan was robust, and appropriate for Child R, the family and their circumstances;
- Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;
- Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. An whether any protocol for professional disagreement was invoked;
- Establish whether the respective statutory duties of agencies working with the child and family were fulfilled;
- Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Further relevant questions in relation to this case

1. How well did professional understand and manage the different risk factors influencing this case and the particular vulnerabilities of Child R, during the two years under review?

2. How well did professionals hear the voice of the child in our work with Child R? And to what extent were her unique diversity needs met by services?
3. Review of the application and use of children missing from home and care protocol and e-safety policy in this case

Action required

Relevant agencies to secure and check their records to see if they have any contact with Child R and her family, and inform the SSCB development manager.

An independent management review should then be commissioned by senior management, based on a chronology and analysis of the agency's involvement for agreement by the single agencies chief management team and submission to the SSCB serious case review group, within the agreed timescale.

The Welsh model is a new methodology to this Board. There is a need for a **timeline** (in this case for a period of two years before this incident) and a **genogram**. Family history is important in this case and agencies are asked to review information from the time of their agencies involvement as a brief summary up to 01/02/2012, the beginning of the period under detailed review. The focus on the preceding 2 years will help understand how this information was taken into account for current decision making. **The period in scope is 01/02/2012 to 27/03/2014.** It has been extended to the date of arrest of the alleged perpetrator following the traumatic incident. For this final period, there will be a particular focus on whether the police support a protection and expectation that Child R attend school the following day was proportionate to the concerns raised. The panels concern was that her post incident care was informed by her care status.

The timeline should be submitted to Ann Flynn SSCB development manager by **23rd May 2014**

The agencies final agreed independent management review endorsed at Chief Officer level should be submitted to Ann Flynn SSCB development manager by **21st June 2014.**

Agencies that need to contribute to the review

Independent Fostering Agency
Child and adolescent mental health services (CAMHs)
Children's Charity
A Greater London Children's Social Care
Met Police
Met Child Sexual Exploitation Unit Met police
Southwark Children's Social Care
Southwark Education Department
Southwark looked after children doctor

Review panel and reviewers

There will be a review panel managing the review process and will play a key role in ensuring understanding about the case.

There will be two reviewers. Both will take responsibility for scrutiny of the issues and one reviewer will take responsibility of completing the report. Working Together (2013) requires the SCR to be completed within six months and will be published.






Learning event

At a later date there will be a learning event facilitated by the reviewers. This event is planned for 8th September from 9.30 – 3 pm and further details will be advised at a later date. The event will seek to engage differing levels of staff who worked with the family. The purpose of the learning event will be to start the process of learning and improvement at the earliest opportunity.

Final Report

The date for completion of the final report will be by **31 October 2014**

Appendix 2: Genogram

Family Tree - Child R compiled by D Phillips SCRG v6 anon 11/06/15	 Date of Birth	 Female Figure	 Male Figure	 Siblings	 Confirmed Link
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