WORCESTERSHIRE
CHILDREN FIRST

Child Safeguarding Practice Review – ‘Sarah’

Publication Date: 5th October 2021

Case Summary

- Sarah was 17 years of age when she sadly died.
- Sarah was first known to Worcestershire children's services from September 2011. Sarah's parents had been struggling to manage her behaviour. A social work assessment was completed, and Sarah and her family were supported through a Child in Need Plan for short periods in 2011 and 2012 before being stepped down to Early Help. Sarah was open to Early Help services between 2015 and February 2016.
- From February 2016 Sarah was subject to a Child in Need Plan until she became a Looked after Child in January 2017. The presenting issue largely centred around Sarah's self-harming behaviour. In January 2017, Sarah became a Looked after Child (LAC) under a voluntary agreement between the Local Authority and her parents. This meant that both Sarah's parents maintained parental responsibility and continued to be involved in care planning for her.
- Initially, when Sarah was 15 years old she was accommodated with foster carers for 5 months, she then resided in residential accommodation until she was 16. Sarah was then stepped down into foster care for 5 months and then aged 17 years old Sarah moved into semi independent living arrangements agreed as part of her pathway plan as she transitioned from child to young adult.
- During Sarah's time in care there were a number of concern identified regarding risk to herself and risk from others.

Case Summary – Con-t

- There were concerns regarding Sarah being "missing" and Sarah's relationships with men who were older than her and the relationship with one male in particular. Sarah was considered at risk of being criminally and sexually exploited. At the time of her death this male was subject of police bail conditions not to have any contact with Sarah.
- Sarah was first diagnosed with Epilepsy in 2002 when she was 1 year old and was prescribed medication. A further diagnosis of frontal lobe epilepsy was made in 2010 and this too was controlled with medication.
- In the early part of 2017 Sarah underwent Stereo Electroencephalography (SEEG) which is a minimally invasive procedure that help doctors find the source of seizures. This procedure identified that Sarah's seizures had damaged part of her brain which were causing violent outbursts, mood swings, self-harming, and Over-dose attempts. Sarah remained on epileptic medication until her death. During 2017 there were concerns regarding Sarah's vulnerability, particularly in relation to the management of her Epilepsy.
- In June 2019, emergency services were called to the home address of the male previously identified as a concern, as Sarah had suffered a seizure and was unconscious. Sarah was conveyed to hospital and subsequently sadly, she passed away.

- The Worcestershire Safeguarding Children Partnership undertook the review in accordance with guidance to identify improvements to be made to safeguard and promote the welfare of children.
- The Practice Review seeks to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account.
- This review was completed by an independent author to ensure appropriate scrutiny and objectivity.
- The author had the opportunity to speak directly with Sarah's family, and all agencies who were identified as involved in the review.
- There were two main areas identified which impacted on Sarah.
  - The first was her medical condition and how this was recognised and managed by professionals, in particular when she became a looked after child.
  - The second was how agencies worked together to identify and manage Sarah's vulnerability to sexual exploitation.

- There were 10 recommendations from the practice review for the WSCP and partner agencies.
- The WSCP have fully accepted the recommendations of the Review.

How will we share the learning?

- A learning briefing is being completed and will be published on the WSCP Website and promoted through their newsletter, this will be shared across Worcestershire Children First.
- A learning presentation is planned for November 2021 at our End-to-End Leadership Meeting, this is a service virtual event, attended by management structure from Assistant Directors to frontline managers – this presentation will focus on key learning and our response to the recommendations.
- Managers will disseminate and present this presentation in their individual Team Meetings throughout November and December.
- Three of the below recommendations focus on exploitation, a dedicated session to share the key learning will be completed with the Get Safe Team to ensure the learning from this review is built into the practice and the support, advice, and resources they provide to the wider service includes this.

Recommendation 1

The Worcestershire Safeguarding Children Partnership should seek assurance from all agencies involved in the review that any single agency learning identified in the review has been appropriately implemented within their organisations.

- The Quality Assurance, Practice & Procedures Group (known as QAPP) is a group of the WSCP, one of the roles and functions of QAPP is to assure learning across the partnership system, in Janaury 2022, QAPP will undertake a targeted survey with agencies and practitioners to assess how and seek assurance that single agency learning, and recommendations have been implemented in their respective agencies.

- QAPP to report their findings to the Safeguarding Executive at the end of 2021/2022 on this work and provide the relevant assurances or next focused activity if required.

Recommendation 2

The Worcestershire Safeguarding Children Partnership should seek assurance from relevant partners that child protection procedures are followed, and strategy meetings are convened appropriately, with health, police, and children's social care in attendance as a minimum, as well as other agencies who should be included. The use of Missing Intervention or MACE meeting must not be used in place of child protection procedures.

- Through our KPIs and Audit Activity we have developed evidence of an improved and sustained quality Child Protection system in Worcestershire, the partnership is well supported through Multi-Agency Training to further embed this learning. We have recently had the independent validation of a Focused Visit by Ofsted, evidencing the work of managers and leaders in this area and positive impact for children.
- In the past 12 months there has been 7 multi-agency audits that have focused on Get Safe Practice, Strategy Discussions and the Application of the Levels of Need. These audits have provided learning for the partnership but has also provided evidence and assurance of the right agencies attending & contributing to Strategy Discussions, they are being held appropriately and the application of threshold is appropriate & proportionate.
- We have seen a significant and sustained improvement in the contributions of our partner agencies to those child protection processes, for example since 2018 we have seen attendance and contributions of partners to strategy discussions consistently at 98% or above for Police and Health attendance.
- The Safeguarding Partnership also provides targeted Training on the Levels of Need Guidance and its application, In the past 12 months, three workshops have been delivered virtually via Microsoft Teams, a total of 118 professionals have attended these workshops

Recommendation 3

- **The GET SAFE initiative in Worcester will allow the identification and tackling of Child Sexual Exploitation to be more effective, the learning from this review should be used to enhance the ongoing development of the initiative, with particular focus on:**

- Ensuring that MACE meetings are convened in a timely fashion, appropriately attended, properly recorded with clear actions that are followed up to ensure outcome.

- That there is a clear link between the missing meetings and MACE and that the reasons for young people going missing is properly considered.

- That the ongoing development of GET SAFE considers the views and input from those with lived experience of exploitation.

- There is a clear link to the police problem solving hubs.

- Development and use of the role of GET SAFE coordinators to work with and build relationships with young people who have experienced CSE.

- In 2019 Worcestershire Children First and the Partnership launched the Get Safe Team and multi-agency response to exploitation, this has been embedded through the development of our Multi-Agency Child Exploitation (MACE) framework, a dedicated Worcestershire Children First Get Safe team which works closely with partner agencies, and weekly reviews of missing episodes. These resources use our multi-agency plan of intervention and support which is based on an approach of prepare, prevent, protect, and pursue to keep safe those most vulnerable to exploitation.

- This is all underpinned by a programme of multi-agency training for practitioners across the partnership. In the past 12 months, eleven workshops have been delivered virtually via Microsoft Teams, a total of **701 professionals have attended** these workshops.

- In July 2021 Social Care had a focused inspection visit by Ofsted under the ILACs Framework, in respect of Exploitation they said *"Children who are at risk of criminal or sexual exploitation in Worcestershire are identified through multi-agency referrals and effective 'Get Safe' risk assessments and reviews. Advice and support are available to all social workers from the 'Get Safe' service, and multi-agency sexual exploitation (MASE) meetings are held appropriately to manage and support those children at higher risk. Senior leaders oversee trends and themes, helping to identify hot spots and ensure disruption activity".*

Recommendation 4

When dealing with perpetrators of CSE West Mercia Police and Worcestershire Children First should give early-consideration-to the use of available civil orders such as Sexual Risk Order or Wardship to provide protection to the young person at the earliest opportunity. Too much reliance should not be placed on criminal proceedings and associated bail conditions, which could be protracted and ineffective to enforce

Worcestershire Children First with the Get Safe Team and partnership focus have developed a range of assessment tools, guidance, and Practice Standards, providing agencies and members of the public easy access to guidance and resources. Agencies have individual champions, and WCF have a dedicated Get Safe Team who can provide the guidance and support to ensure we understand the various civil orders to help protect children.

Recommendation 5

The Worcestershire Safeguarding Children Partnership should highlight through appropriate channels the restriction in the use of Child Abduction Warning Notices (CAWNS) in cases where young persons are vulnerable, under the age of 18 but looked after under section 20 of the Children Act.

- As identified above, the Get Safe Team offers direct support to all WCF staff but is a point of contact for advice and guidance across the partnership and agencies have their own respect SPOC/Champions for Get Safe to contact. This support and resources also include dedicated information and guidance of CAWN Notices. Below is the introduction table of the various resources and tools available to practitioners, this includes Court Orders.

GET SAFE information

Who are the GET SAFE team?	GET SAFE Portal, Assessment Tool and Responses	GET SAFE Resources	Training
Direct work tools	MACE and 4 P Plan	Leaflets and posters	Voice of young people
Court orders	Contextual Safeguarding	Adverse Childhood Experiences (ACEs)	GET SAFE Strategy and action plan

- Bringing together the evidence of our work as an agency and partnership from the last two years of activity, with the independent validation of our recent Ofsted Inspection has evidenced our progress and good practice in this area of work.

- Our work in respect of exploitation and Get Safe remains a key priority for Worcestershire Children First and remains a key focus of our 2021/2022 Business Plan

Recommendation 6

- The Worcestershire Safeguarding Children Partnership should be assured that LAC review meetings are effective by ensuring that:

- There are up to date and complete health assessments

- That the meeting is attended by the relevant professionals or appropriate reports are submitted

- That the milestones set out in the plan are achieved and not allowed to drift

- **Health Assessments:** The CLA Review Minutes Record written by IROs is in line with Schedule 7 (The Care Planning, Placement and Case Review Regulation 2010) asks specific questions in relation to both physical and emotional health. The IRO will review and ask specifically about children & young people's health ensuring the Health Assessment is up to date and the child's individual health needs are explored, and actions given if required.

- **CLA Reviews:** As part of all CLA Reviews, IROs undertake a Quality Assurance Check, this is to ensure the review and planning if effective for the child or young person. IROs answer the question "Was the written information presented to review (SW Report/Care Plan/Assessment) of sufficient quality to justify (evidence) the plan?", ensuring the review has the right contributions to ensure the review has been effective.

- **Partnership Working:** 85% of our CLA had attendance by 3 or more professionals, evidencing a high level of multi-agency practice and contributions. To support practitioners from partner agencies attending CLA Reviews, we have developed a Multi-Agency Meeting Briefing to support their understanding of the review, how to prepare and their role within this, this can be read at: Worcestershire Safeguarding Children Partnership Briefing for Partners on Multi-Agency Meetings for Looked after Children (safeguardingworcestershire.org.uk)

Recommendation 6 continued…

- Social Care & Safeguarding (WCF) has a clear Dispute Resolution Process in place, the Care Planning, Placement and Case Review Regulations (2010) requires the Local Authority to have a 'Dispute Resolution Process' (DRP) to address any disagreement or concern the Independent Reviewing Officer (IRO) has in relation the Local Authority's care planning or practice for a looked after child.
- We track DRPs through a Dashboard which gives us an overview of DRPs being issued and responses. Our monitoring of use of DRPs evidence that the majority of our DRPs are dealt with at an Informal Stage, with 64% being raised and addressed at this point. The remaining 36% were dealt with at the formal stage, only 3 cases escalated to Stage 2 and none went to Stage 3, 4 or 5; evidencing issues are dealt with appropriately and as early as possible.
- In 2020/2021 we undertook 2 targeted audits on DRPs, one on Formal which was jointly completed between the IRO Service and Through Care and the second audit was completed by the IRO Service on informal DRPs. Both audits evidenced an appropriate application of DRP and achieving the right outcomes for Children through this mechanism.
- In 2019 Ofsted completed their ILACs inspection and reported "*IROs are active in ensuring that plans progress without delay in most cases. IROs use a well-developed escalation process to resolve practice issues*", evidencing independent validation of the role of the IRO and the well-established DRP process.

Recommendation 7

The Worcestershire Safeguarding Children Partnership should be assured that pharmacies and practices will work collaboratively to support Looked After Young People with chronic health conditions to encourage regular collection of prescribed medication required to manage their condition.

This recommendation is being led by Ellen Footman, Head of Quality and Safeguarding for the CCG, and member of the Safeguarding Children Partnership Executive Group.

There is a current process in place that if children and our young people do not collect their prescriptions, they notify the GP; the GP will be aware that the child is Looked After. There will be a piece of work to ensure that this process is working effectively, but that the GP then actions this to ensure information is shared with the relevant Safeguarding Partners and the Local Authority as the Corporate Parent.

Recommendation 8

The Worcestershire Safeguarding Children Partnership should be assured that all agencies working with young people understand the requirements of the Mental Capacity Act when considering the ability of young people to make safe decisions

- Over the past two years various resources have been developed to support Social Care and the Partnership, this includes:
  - Learning Briefings
  - Dedicated Newsletters
  - Practice Standards
- Targeted Social Care Training – 126 practitioners and managers have attended the training.
- Adult Safeguarding Week, the Adults Safeguarding Board are running two Podcasts for the partnership on: '*Introducing the MCA for young people, their parents and carers'* and '*Best interests' decisions – good practice in transitions'*. This is for agencies across the partnership to access and develop their understanding and application of the legislation into practice.
- We know this is a complex area of practice and legislation and the QAPP Group are planning a multi-agency learning event/conference specific to MCA and embedding further learning in this area to partnership practice.

Recommendation 9

Worcestershire Children First should ensure that where there is a Looked after Child with a chronic condition or illness that any placement is equipped with the information and knowledge to support and manage the condition and that any placement is appropriate to their needs.

- We have clear Practice Standards and Procedures giving clarity on the information required for a Placement which is incorporated into Placement Searches and Placement Plans and Meetings.
- The Placement Team have developed the Placement Request Form (PRF), the document used for a placement search which details the child's individual needs.
- Looked after Reviews ensure physical and emotional health is always fully discussed and reviewed; all CLA Reviews have a Quality Assurance checklist completed by the IRO which considers that the placement is the right placement for the child and that relevant information and delegated authority is in place.

Recommendation 10

Worcestershire Children First should review procedures to ensure that families are appropriately communicated with when a child who is looked after dies, and the parents retain parental responsibility

- Our Practice Standards have been updated to reflect the most up to date legislation in respect of the timely and sensitive communication with parents when a child who is looked after dies.
- Our Practice Standards is an online resource to support practitioners and managers across the service; this was established in 2017 and is a key resource supporting our staff to give clarity of their role and what good looks like.
- Our Practice Standards are consistently well used, we have the capability to pull analytics, this unfortunately does only go back for 90 days at any one time, however, this tells us for the 90 days leading up to the 17th August 2021 there has been 15,654 individual site visits to the website – evidencing the extensive use of this in supporting practitioners and managers in their roles.
- To understand the effectiveness of our Practice Standards with staff we ask them about this in our Social Care Health Check, this was most recently completed across December 2020 and early January 2021. 123 frontline practitioners and managers responded and 95% said they found practice standards useful guide in their work – evidencing that resource is effective in supporting staff.