Child Safeguarding Practice Review
James

Date: June 2022

Lucy Young

TABLE OF CONTENTS

James Local Child Safeguarding Practice Review Report

1. Introduction

1.1 Succinct summary of the case

This Local Child Safeguarding Practice Review (LCSPR) concerns James who, in February 2021, stabbed his father at home in an apparent act of self-defence. James's father was not seriously harmed but James and his family have been known to a wide range of services over a number of years. He is extremely vulnerable with several complex needs including risk of criminal exploitation[1], mental health issues, self-harm and suicide attempts, a history of traumatic childhood experiences and frequent cannabis misuse. He has missed a significant part of his secondary education.

James experienced chaotic early life experiences and instability in his care arrangements moving between his parents care throughout his childhood.
He has been involved with Child and Adolescent Mental Health (CAMHS) since the age of nine and there is an extensive history of mental health issues including nine recorded episodes of overdose and/or suicidal ideation since. There are 37 recorded attendances at Accident and Emergency departments.

James has been subject to a child in need plan and a child protection plan, and the family have been offered support from several agencies.

1.2 Scope of the review

For this review to learn about current systems issues it focusses on the two years prior to the stabbing incident (February 2019 to February 2021). The agencies and organisations who worked with or had contact with James and his parents during that time were involved. Although the detailed focus is on the most recent two years the local review panel was mindful that previous years of childhood trauma, neglect and mental health issues have impacted significantly on James during his teenage years. The local review panel acknowledges that had different decisions or interventions been made earlier in James's life the outcomes might have been different. The review endeavours to take into account earlier events in James's life where they are seen to have impacted on more recent attempts to work with him and support his family[2].

The period in scope for the review took place against the backdrop of the covid 19 pandemic with three national lockdowns taking place over the two years. This gave an additional complexity to the case.

[1] The Government definition of criminal exploitation of children is "where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child under the age of 18. The victim may have been criminally exploited even if the activity appears consensual" Home Office Guidance 7 February 2020 HMO: London

[2] "An issue with adolescent reviews is that they usually only focus on the recent past and consider at most the last 2-3 years. Much of the harm in adolescents relates to previous childhood trauma and neglect, so that it may be exceptionally difficult to change things for them by the time, for instance, they move into residential care. The key decisions for supporting families when effective preventive action could have been taken falls outside of the review, so we cannot learn from it. There needs to be consideration of how we can ensure full learning from adolescent reviews." *Annual Review of LSCPRs and Rapid Reviews May 2021*

1.3 James's family

James, who is white/UK, was born in October 2004. His parents are separated and during the review period he was living with his mother until October 2019 when he moved to his father's. James has an older brother and sister who both live independently.

James and his father met separately with the reviewer at the end of the review and their perspectives are included in s.3.8.

1.4 Pen picture of James

James's social worker describes him as a likeable and kind young man with a good sense of humour. He likes cooking and playing computer games and is good at putting things together and fixing things. He has been interested in becoming a mechanic or an engineer. He's just under 6 foot tall with a slim build. He takes pride in his appearance and likes to look smart. When he was younger James loved horse riding which he was very good at. Sadly, James's struggles with his mental health can overshadow all his really good traits. He struggles with relationships and has not yet developed the skills required to make friends of his own age easily and he can sometimes show naivety and lack insight. James has strong views about cannabis use for medicinal purposes which he finds helps to calm him down and regulate his mood. He has researched this and can give a well thought out cohesive argument in favour of it.

2. Organisational learning and improvement

A Rapid Review[3] by Warwickshire Safeguarding Children Partnership found that there was evidence of systemic failure in this case which could have contributed to James's deteriorating circumstances. The national Child Safeguarding Practice Review Panel decided there were significant issues and potential important learning from James's case to merit an LCSPR.

The Review Panel thought that this case could shed light on systems issues in the Warwickshire Safeguarding Partnership. It recognised that some children who are extremely vulnerable can have several complex needs such as risk of criminal exploitation, mental health issues including self-harm and suicide attempts, a history of traumatic childhood experiences including neglect and significant cannabis misuse. The local panel felt this case could help the Safeguarding Partnership learn more about how to enable a more effective safeguarding response to these children by looking at the following key lines of enquiry:

1. How are young people's own views captured and recorded and how well does the partnership ensure that the child's voice forms a key element of the decision-making process?

2. How does the partnership respond to children struggling with their mental health?

3. How well does the safeguarding system respond to children when they are at risk of criminal exploitation?

[3] When a possible serious case is identified 'the safeguarding partners should promptly undertake a **rapid review** of the case, in line with any guidance published by the Panel". *Working Together 2018*

4. How does the education system respond to children who present challenges to schools due to their range of behaviours?

5. How did the covid pandemic effect the partnership involvement with GL and his family?

3. Thematic appraisal of professional practice

The appraisal of practice provides an overview of what happened in this case, looking at professional responses and systems learning. It sets out the view of the local review panel of how effective agencies were in their contact with James and his family. It aims to outline what got in the way of professionals being as effective as they wanted to be and, where possible, to provide explanations for practice.

At the heart of this case is a fragmented approach to supporting James and his family where agencies struggled to engage or maintain engagement with this young person with complex needs. There was a pattern of James's risk-taking behaviour escalating and his mental health declining through the years with services dropping in and out of his life, often failing to engage either James or his parents. Practitioners described feeling a sense of paralysis and hopelessness when supports such as drug and alcohol services, education and mental health were not consistent or effective in engaging or supporting James.

3.1 James did not attend full time school throughout the review period

James told professionals that he was worried about his education, he aspired to be an engineer and felt that by missing so much school he would not be able to achieve this. Despite being on the roll of School A until March 2021 he did not attend school for nearly all his secondary school career. The approach to meeting James's educational needs was fragmented and ultimately the system failed James. His Education, Health and Care Plan (EHCP)[4] finalised in November 2017 (when James was in year 8) stated that he should remain at School A which was responsible for meeting his needs until a special school was identified for him. During the time of this review two separate unregistered alternative education providers[5] were commissioned either by the school or the local authority at different times.

Regulation requires the named school to be accountable for all students on their roll and for James this should have involved School A setting outcomes with the provider, monitoring attendance and progress and addressing safeguarding issues. Best practice would be to monitor James at least weekly and to track his attendance through the Central Learning Monitoring system. It is expected that the school would maintain a relationship with James and his family. In this case, as time went on and the local authority failed to identify a special school, the lines of accountability became blurred. School A was frustrated by the lack of progress and felt it became

[4] An **Education, Health and Care plan** (**EHC plan**) describes a child's special educational needs (SEN) and the help they will get to meet them. An EHC plan also includes any health and care provision that is needed. It is a legal document written by the local authority and is used for children and young people with high support needs. (Warwickshire SENDIAS 2018)

[5] **Alternative Provision** is education arranged by Local Authorities for learners who, because of exclusion, illness or other reasons would not otherwise receive suitable education; education arranged by schools for learners on a fixed period exclusion; and learners being directed by schools to off-site provision to improve their behaviour (DfE 2013).

increasingly inappropriate for James to be on their roll. Other agencies felt the school disengaged from him. His EHCP was never reviewed[6] and became very out of date. Not all schools in Warwickshire are effective at supporting children with EHCP who struggle in the mainstream setting and require more specialist provision. In September 2021 Ofsted found; "Schools have not accessed enough training to help school staff understand and provide for children and young people's needs in mainstream settings. Leaders know this and have plans in place to address it. However, the plans are yet to be fully implemented, which means that some schools do not have enough qualified and experienced staff to support children and young people with SEND effectively."[7] School A maintained that James's needs were so complex that it was not possible for him to attend school even on a part time basis.

There were several obstacles to identifying a special school for James; he went to stay with his sister in Birmingham for a few months; his mother refused one school on grounds of distance from home; the family rejected residential school as an option and three schools did not offer places on the grounds of suitability or capacity. For a short time, the local authority amended the EHCP to name a special school but when the offer of a place was withdrawn School A was once again named as James's school. This further blurred the lines of accountability and oversight of James. At the time Warwickshire was experiencing a high number (1800) pupils who were not on any school roll, in September 2018 there were 300 children placed in unregulated alternative provision in Warwickshire. The SENDAR team responsible for managing James's case and identifying a special school for him was over stretched and under resourced. It is a serious failure of the system that having agreed in November 2017 that James's needs would be best met in specialist provision it was not identified nor the EHCP reviewed until March 2021.

There was an over reliance on part time unregistered alternative provision. The position of central government and the local authority is that alternative provision should be temporary and either enhancing registered provision or a short-term intervention to enable reintegration into registered provision. For a short time in 2019 he was attending an alternative provider full time, but this ceased as it was an illegal arrangement with an unregistered provider. To get around this regulation by 2020 James was being offered a combination of part time places at two different unregulated alternative providers. Alternative Provision 1 was commissioned by the local authority in February 2020 to work specifically with him on behaviour and relationships with a view to helping him back to school. Education input (English and Maths) was offered by Alternative Provision 2. It was unusual for the local authority to commission alternative provision for a child who is on a school roll, and this blurred the lines of accountability further. This meant that the alternative provision did not know that he was on school A's roll and school A assumed that the local authority had assumed the lead role in coordinating James's educational needs which contributed to their hands off approach.

James engaged sporadically with the alternative provision and there was some evidence of progress for example developing a good relationship with one worker

[6] The local authority **must** review the EHC plan at least once every 12 months. This **must** be done in partnership with you and your child or the young person, and must take account of your views, wishes and feelings. (Warwickshire SENDIS 2018)
[7] Ofsted Joint local area SEND inspection in Warwickshire September 2021

and the opportunity to attend work experience as a car mechanic. However, these successes were short lived possibly because the alternative provision was short term and part time[8] and there was a lack of monitoring and coordination. The covid 19 lockdown also had an impact on his attendance. A recent review of alternative provision in England concluded: "Children in Alternative Provision are some of our most vulnerable. The education available to them should be of equal if not better quality than for children in mainstream schools. An effective education system must support the most disadvantaged pupils to access the same broad curriculum and educational opportunities as their peers."[9]

James was a victim of the dysfunctional relationship between the local authority and the school, and his needs remained unmet. Research[10] has clearly and repeatedly shown that when children fall through the gaps in a system, such as attending an education provision, then they become more vulnerable. The lack of a full-time special school place for James and the absence of clear accountable oversight by School A or the local authority made him more vulnerable to risks from criminal exploitation, drugs and his mental health and it was harder to monitor his safety and wellbeing. Research[11] into positive responses to support children with adverse childhood experiences identifies the involvement of a trusted adult who a child can talk to and gain support from as being pivotal to supporting these children. Attendance at school can provide children with a sense of belonging and structure as well as consistent and positive relationships with adults. This was not available to James.

3.2 James experienced suicidal ideation and he made a number of suicide attempts.

James has a long-standing history of involvement with mental health services since he was nine years old. Interventions from the Child and Adolescent Mental Health Service (CAMHS) have included psychotherapy, medication for depression, crisis intervention in the form of emergency assessments and attempts to involve his parents.

Troubled young people can respond well to relationship-based work when given the opportunity to establish a connection with a skilled practitioner. In James's case there were few opportunities for this to happen due to a combination of difficulty in engaging the family and the fragmented nature of the services, for example the lack of a full-time school place which is often the place where very regular health and well-being conversations can take place with young people alongside input from CAMHS.

Despite James making three suicide attempts in early 2019 CAMHS closed his case at his and his mother's request. He felt therapy and medication were not helping him. James continued to be at significant risk from his mental health and his daily drug use and lack of engagement with school. With the withdrawal of CAMHS and non-involvement of school the social worker was left as the only professional with a role in supporting the family. With such a complex case it should be expected that key

[8] It is illegal to place a child full time in an unregistered alternative provision
[9] The Centre of Social Justice May 2020
[10] Children's Commissioner 2019
[11] Addressing Adversity: Prioritising adversity and trauma – informed care for children and young people in England. Young Minds NHS England 2017

agencies would make decisions about withdrawing their services in the context of the multi-agency partnership, for example at a child in need review. In effect neither health nor education remained involved with James at that time. The local review panel thought that when key agencies close a child in need or child protection case this should happen with discussion with partners and include a risk assessment to decide the impact of withdrawing involvement. It is not uncommon for children and families with the most complex needs not to engage with key services like CAMHS or drug services, but these services can continue to have a role in supporting statutory partners. The social care team could have considered escalating the non-engagement of partners in such a complex case within the partnership.

James's case remained open to the Neuro Development team as he was on the waiting list for an Autistic Spectrum Disorder assessment. This assessment might have supported practitioners in developing an appropriate care, support, and treatment plan for James. In fact, the assessment did not take place, and, at the time of this review, it has still not happened. In Warwickshire "Area leaders acknowledge that the Neurodevelopmental Pathway (a specialist service responsible for the assessment of neurodevelopmental conditions such as autism spectrum disorder (ASD) and attention deficit hyperactivity disorder) has not worked well enough across agencies. Children and young people wait too long for an assessment. The plans to address the key issues, including waiting times for assessments, have been developed too slowly, are not specific enough and do not have clear targets."[12] This was another missed opportunity for James. The local review panel recognised this as a national issue with a shortage of skilled practitioners to do assessments. Warwickshire's written statement of action in response to the Ofsted findings includes targets to bring the waiting times for assessments down from 5 years to 18 months over the next 2 years.

The approach by CAMHS was at times fragmented and uncoordinated. For example, there was a lack of clarity about the coordination of James's care for a period of five months in 2020 when James and his father only had contact with CAMHS though duty workers and there was a lack of coordination of information about him within CAMHS and with partner agencies.

When James's mental health deteriorated further in January 2021, and he was presenting with paranoia and psychosis he was assessed as being low risk to himself and others. A safety plan included a referral to drug services and he was prescribed medication. With hindsight the CAMHS professionals recognised that it would have been beneficial to provide home treatment for assistance with administering his medication given his history of reluctance in the past. This would also have provided more support for his father who was clearly struggling.

Although James was not detainable under the Mental Health Act CAMHS considered referral for a tier 4 inpatient bed, but no bed was identified for him. This is a national issue and local providers are reliant on NHS England commissioning arrangements and the availability of appropriate facilities.

[12] Ofsted Joint local area SEND inspection in Warwickshire September 2021

3.3 There was no holistic health needs assessment of James

At various times during the review period James was the subject of an EHCP, s.17[13] child in need plan and a child protection s.47[14] assessment and plan all of which require a holistic health needs assessment as part of the multi-agency process. In James's case this did not happen. There was no contact with school health or the GP when James was subject to a child in need plan possibly because School A were not engaged with this process either and the link with school health was not made.

When he became subject to a child protection plan the school nursing service made various unsuccessful attempts to engage James in an assessment, but he was not attending school and his father appeared to block their attempts to see him. In many cases school health can coordinate and develop a plan to address a child's health needs through the school. The GP was not able to engage with the child protection process because of very limited capacity and late notice of meetings. When the school nursing service closed the case due to lack of engagement no one was taking the lead role in coordinating James's health care needs. The review found that in very complex cases where families are hard to engage the best coordinator for health care assessment and planning needs should be agreed on a case-by-case basis. It requires concerted efforts in communication and coordination between GP, school nursing service, school, and alternative providers to agree the best way to engage children and families.

3.4 James was using cannabis daily

James had been using cannabis since his early teens. During the review period he was said to be using it daily which he said was to manage his anxiety and anger. CAMHS practitioners discussed James's cannabis use with him and his father and talked about the impact of this on his mental health. There were offers of alternative medications to support him to reduce his use. However, James was reluctant to engage with Compass, the specialist drug and alcohol service, and the issue was not addressed. James's cannabis use complicated mental health assessments in terms of the impact that it was having on his general mental health.

Research[15] has shown that people using high-potency cannabis every day were nearly five times more likely to be diagnosed with psychosis that those who did not use cannabis. Combined with other risk factors such as adverse childhood experiences (ACES)[16] and attachment difficulties the likelihood of developing psychosis is higher. It was not well understood how James was funding his use of cannabis. Practitioners who were aware of James's cannabis use did not express curiosity about this to James or his father. CAMHS could not effectively assess and support James while he was still using cannabis and there was no stability in his life. The issue of James using cannabis from a young age and the risks it presented raised questions for the local review panel as to whether there was a general resigned acceptance amongst professionals of his use.

[13] Section 17 of the Children Act 1989 imposes a general duty on local authorities to safeguard and promote the welfare of children "in need" in their area.
[14] A section 47 enquiry as defined in the Children Act 1989 means children social care must carry out an investigation when they have "reasonable cause to suspect that a child who lives in their area is suffering or is likely to suffer significant harm".
[15] Association of High-Potency Cannabis Use With Mental Health and Substance Use in Adolescence JAMA Psychiatry 2020
[16] The term Adverse Childhood Experiences (ACEs) is used to describe a wide range of stressful or traumatic experiences that children can be exposed to whilst growing up. There are 10 recognised ACES; examples of ACE's include physical abuse, parental substance misuse, parental criminal activity, neglect, parental mental health

CAMHS have a clear pathway and an early intervention process, working with Compass, for young people from 14 years old at risk of drug induced psychosis James was not involved in this service and was not willing to engage with Compass. Although they make every effort to encourage engagement it is not a statutory provision and unless a young person is detainable under the Mental Health Act CAMHS cannot support young people who do not wish to engage with services.

3.5 There were concerns that James was involved in criminal exploitation

In August 2019 information came to light indicating that James may be involved in criminal exploitation and linked to gangs. At that time there was a concern about gangs in the area and information was being shared about several young people, but James was not one of them although he was thought to be on the periphery. James was subject to a s.17 child in need plan at this time and there was discussion in the Strengthening Families[17] team to consider how the issues of criminal exploitation were to be assessed and whether the child protection threshold was met. There was no assessment undertaken to try to develop a deeper understanding of his daily life, his peer group, how he spent his time, areas he was frequenting, how he got his drugs etc. There was no referral to the Child Exploitation team, and this was a missed opportunity for multi-agency intervention. Instead, the child exploitation tool was completed many months later at a more stable time and contained little of the detail of the previous concerns.

The social worker submitted a National Referral Mechanism (NRM) referral to the Police in respect of James's drug use, associations and potential for him being exploited or trafficked to supply drugs. The NRM is a tool for identifying and referring victims of modern slavery to the Single Competent Authority in the Home Office so that they can receive the appropriate support. The definition of modern slavery (which covers trafficking and exploitation) means that young people who are being criminally exploited are often referred to the NRM in the hope that it will give them protection. Research[18] findings suggest that the NRM's purpose does not always fit well with the circumstance of this group of children.

The Home Office Single Competent Authority (SCA) made a decision that there was reasonable grounds that James was a victim of modern slavery. Despite this it is unclear whether a child exploitation assessment tool was completed, and no referral was made to the Child Exploitation team for consideration of additional support. Warwickshire Trafficking procedures were not followed, in that there was no multi-agency strategy discussion held with the police and other agencies to develop a plan of action. There was an over reliance on using the existing children in need process to manage this risk. In fact, the child in need plan and reviews at the time made little reference to these contextual[19] risks and robust plans to address them, with only

[17] The Warwickshire Strengthening Families Service incorporates Targeted Family Support and Child In Need. The service is for families with children and young people aged 0-18 years old who need support to improve their life chances or avoid issues escalating to child protection concerns. Depending on the level of need they will either receive targeted support or child in need support.

[18] It was hard to escape: Safeguarding children at risk from criminal exploitation. The Child Safeguarding Practice Review Panel 2020

[19] Contextual Safeguarding is a term developed by Carlene Firmin, University of Bedfordshire which describes an approach to understanding and responding to young people's experiences of significant harm beyond their families. It recognises the different relationships young people form in their neighbourhoods. Parents and carers often have little influence over these contexts.

surface level actions to keep James away from the potential harm.

In April 2019 the Multi-Agency Sexual Exploitation (MASE) team and processes transitioned to include criminal exploitation as well as sexual exploitation (MACE).[20] There were procedures in place for assessing and managing risk of criminal exploitation, but the MACE was not fully established within the workforce for another year, and they were not well understood. 'The MACE process is implemented to effectively respond to concerns where a child/young person is groomed or targeted for exploitation. MACE is the established framework in Warwickshire for responding to the contextual challenges of exploitation in all forms.'[21]

Rather than having separate multi-agency meetings, the MACE process aims to integrate assessment and risk discussions regarding exploitation into existing meetings held for the child/young person. The MACE guidance says that section 47 and child protection procedures should only be initiated in exceptional circumstances. Where the risk is external to the family the focus must be clearly on the perpetrator(s) and other contextual spaces of concern rather than on a parent's ability to protect or blame for their child's vulnerability. The local review panel heard that Warwickshire Safeguarding Partnership is now working to embed these MACE processes and a contextual safeguarding approach into the system, but this was not well established during the time in scope of this review.

A criminal exploitation assessment tool completed in May 2020 did not identify a risk at that time. However, it eventually resulted in allocation in July 2020 (delayed because of staff shortages within the team) because of the additional factors of a feud with another young person apparently causing James's father to be stabbed and James driving a car at a young person. James and his father were not aware of this referral and had not been engaged in completing it which would have been best practice and may have helped pave the way to better engagement with the team. The referral to the Child Exploitation team was another lost opportunity, the mistiming of the referral, the considerable delay in the team allocating it and the non-involvement of James and his father were all likely contributors to the team not being able to work with James.

The Child Exploitation team collates information and intelligence about individual young people. At this time the team was struggling with resources having recently added criminal exploitation to the child exploitation role and they were focussing on several high-level operations. In James's case there was no new information or intelligence about him, and the police did not have the capacity for proactive gathering of information and intelligence on young people where, in their view, there was perceived low risk rather than a known risk. Essentially the police were not able to do lower-level proactive investigation work with child criminal exploitation. The police were involved with James on at least 11 occasions over the review period for significant incidents including: being found on a bridge threatening suicide, crashing his father's car into a wall at speed (a few months prior to the review period), NRM referral, James's father was stabbed at home by a young associate of James, James drove his father's car trying to hit the young person who stabbed his father, James being attacked with a knife.

[20] Multi-agency Child Exploitation Team MACE
[21] Multi-agency Child Exploitation risk discussions guidance. Warwickshire Children's Services 2020

The non-proactive police approach dealing with each incident on an individual basis meant that the element of criminality in James's life was not fully known or understood. When it is recognised that a child is being exploited, the detail of their daily lives is difficult to establish and so ascertaining the level of risk and the management of that risk is more difficult. From a child's perspective practitioner involvement might be characterised as being on the surface of their lives.[22]

3.6 James was subject of a child in need plan and a child protection plan
Statutory child in need and child protection processes rely on an engaged multi-agency approach to be effective in improving children's outcomes. In this case, where the family did not always engage with services offered or dipped in and out there were times when the children's social care team felt unsupported by their partners. For example, social care took a role in trying to identify alternative provision for James because in their view School A was not supporting James. For most of the time the school was disengaged from the children in need process. Social care arranged for school meal vouchers for James's father during covid lockdown although this should have been the school's responsibility.

For the social workers this was a very difficult case to be involved in, struggling to engage the family and find out what was happening for James in his daily life. They knew more was going on but felt stuck trying to manage a case with fragmented involvement of other services. In efforts to protect his son James's father was perceived as resistant and anti-authority. Practitioners struggled to get into the house and engage with James. It was very difficult to have open and frank conversations.

Despite multi-agency involvement with James from a very young age there was no robust chronology to contribute to good assessment. The MOSAIC[23] information system did not have an effective chronology tool at that time. The system has since been upgraded and the local review panel heard that work is ongoing to embed new processes that aim for there to be a chronology in the form of the 'child's story' on every child's case file.

James became subject of a child protection plan under the neglect category in June 2020 following a critical incident when James was in a car with his father and drove towards a young person crashing the car and assaulted a police officer on arrest. There was good attendance at child protection core group meetings by agencies and a clear plan for their involvement. James did not engage with the health needs assessment; the referral to the child exploitation team took months and eventually James did not engage with the worker; the neuro development assessment did not happen; police investigations were slow and the EHCP was not progressed. Practitioners talked about the sense of paralysis with not being able to progress the plan while seeing James's mental health decline.

[22] It was hard to escape: Safeguarding children at risk from criminal exploitation. The Child Safeguarding Practice Review Panel 2020
[23] Warwickshire children's information and recording system

3.7 Critical moments in James's life

The National Panel Review[24] explored the systems theory concept of how critical times in a child's life are responded to in order to make a difference to their lived experiences. The National Panel explain that by adopting a flexible and responsive approach in the critical moment in a child's life can have a powerful influence on the direction taken after the event and after conversations have happened. Leaving things, even by a day or two later may be too late to effect change.

There were several critical and reachable moments throughout James's story which could have been acted upon in a timelier way and possibly with a different outcome for him. For example, when James did share concerns about wanting to address his drug use the referral took several months which meant that the moment was lost, and the drug service was unable to engage James. The referral to the Child Exploitation team happened months after a critical time when he was found to be involved in drug debt and threats from other young people. "As agencies, we need to find ways of being flexible and responsive enough to be ready to engage in those moments in real time. Days after the event might be too late. Services have to be constructed to be nimble enough to respond in the right moment, in the crisis.[25]"

The key learning point here is that organisations must be flexible enough to respond immediately to the critical moment when the child is more likely to be open to change.

3.8 Views of James and his father

James continues to struggle with his mental health, and he is no longer living at home. The reviewer was very grateful to him that despite his current complex circumstances he agreed to meet with her (on a virtual Teams call) once the report was completed. James told the reviewer about how distressing and difficult he found it with the voices in his head, he said they made his life hell and he felt like someone was controlling him. He felt that smoking 'weed' made the voices calm down. James did not think that anyone understood what he was going through. He said he had spent a lot of time at home and would get very bored. He wished he could have gone back to school, he loved it when he did mechanics for a few months. He said it would have helped him if people had taken him out to do activities like paintballing or skateboarding, he thinks that it would have helped to 'distract his mind'. He found the covid lockdowns very stressful and difficult and does not remember seeing anyone then.

The reviewer also met with James's father at the end of the review. He said that while James was living with him, he had a mortgage to pay and was working full time. He wishes now, with the benefit of hindsight, that he had stopped work, moved into council accommodation and claimed benefits. Caring for James, who was not attending school, required a full-time parent and he thinks that might have made a difference to the outcome. He could have made sure James spent less time alone, had a routine and got involved in more activities. James's father feels that professionals should have asked him more about his own lived experience as a single parent to James. Practical advice about finance and benefits if he stopped

[24] It was hard to escape: Safeguarding children at risk from criminal exploitation. The Child Safeguarding Practice Review Panel 2020
[25] As above

work would have been helpful. On at least two occasions when James was very unwell the assessments by CAMHS crisis teams took place once he had calmed down and his father felt they did not help to address James's needs or support the family. This is explored in Findings 1 and 3.

4. Findings

4.1 Working together

Finding 1
A fragmented and inconsistent approach to supporting James and his family led to a sense of professional paralysis amongst practitioners and James's complex needs were not addressed

A consistent theme through this review was the sense of paralysis felt by practitioners working with James and his family. This was particularly difficult for children's social care when the fragmentation of the education response and James and his family's disengagement from CAMHS at times left them as the only agency trying to engage, support and keep James safe.

The review team questioned why escalation processes within the partnership are under used and what the barriers are to this. Services should consider escalating concerns about the non-engagement of partners though the partnership where services withdraw and there is only single agency involvement remaining. Children in need and child protection processes can only be effective with the engagement of a team around the child. Key agencies should only close cases or withdraw services in partnership with other agencies, for example at a child in need review, in order to agree how to address unmet need.

The complexity of some children's needs and circumstances means that the usual solutions are not effective and results in a great deal of harm for them. However, the absence of a mechanism for identifying who those young people are at a strategic level prevents the professionals responsible for them from having a mandate to think creatively and make bespoke proposals about how to achieve the outcomes required for these children. James's case would have benefitted from an effective escalation process to senior leaders to resolve the paralysis in the process of identifying a special school place for James. A more flexible approach could have meant being able to achieve a very fast track response during the times when James showed a willingness to engage with drug services.

Recommendation 1
Undertake a comprehensive review to understand what the barriers are to professionals using the escalation process and why it is so under used *(Warwickshire Safeguarding Partnership)*

Recommendation 2
Develop systems and processes to identify those young people with highly complex needs and at the greatest risk so that service responses can be flexible and if necessary, fast tracked to respond effectively to unmet need *(Warwickshire Safeguarding Partnership)*

4.2 How are young people's own views captured and recorded and how well does the partnership ensure that the child's voice forms a key element of the decision-making process?

Finding 2
There is no evidence that any practitioner was able to get a clear understanding of James's daily lived experience, if they did, it did not contribute to the multi-agency work with him

Despite attempts by practitioners to develop a relationship with him it seems that practitioner involvement might be characterised as being on the surface of James's life.

Social workers often felt blocked by James's father in their attempts to meet with James and the covid 19 lockdowns placed an additional barrier in their way. James has had social care involved with him from a very young age and is wary of professionals, his father had a mistrust of authority which made it difficult for practitioners to develop relationships with them. Parental engagement is nearly always a protective factor[26] and parents need effective support in helping them manage risk. Skilled work is required to build good relationships with families.

Since the review period James has become a child in care and the local review panel heard that he and his father had developed a good relationship with the social worker which enabled him to develop a deeper knowledge and understanding of James and his family. Unfortunately, more recently there has been another change of social worker when James was moved to the Leaving Care team, given James's highly complex needs the local review panel was concerned for him at the loss of the relationship with his social worker.

Recommendation 3
Explore opportunities for co-working in complex cases to help support transitioning between teams and enable young people to build a rapport and relationship with a new worker *(Children's Services*)

Recommendation 4
The multi-agency team around the child needs to adopt a flexible approach where the practitioner best placed to develop a relationship with the child and their family takes a lead in ensuring the child's voice is heard *(Warwickshire Safeguarding Partnership)*

[26] It was hard to escape: Safeguarding children at risk from criminal exploitation. The Child Safeguarding Practice Review Panel 2020

4.3 How does the partnership respond to children struggling with their mental health?

Finding 3
There is a gap in service provision for those children with complex needs who do not have a diagnosed mental illness resulting in a fragmented and uncoordinated approach which did not address James's mental health needs.

CAMHS was involved with James for many years and offered different interventions and undertook several assessments although there is little evidence of any significant change or any greater understanding of his mental health issues. At times there was a lack of coordination of CAMHS services and despite the complexity and risk to James, involvement was withdrawn at James and his family's request leaving statutory agencies feeling unsupported. There were differing views about how James's cannabis use impacted on his mental health and no successful strategies were found to address this.

There is a national shortage of CAMHS Tier 4 beds and although James was referred for assessment in Tier 4 provision none was available. During this time CAMHS acknowledges that he may well have benefitted from input from the Crisis and Home Intervention Treatment team.

Crucially a neuro development assessment never took place which may have enabled a more helpful assessment of James' overall mental health needs.

It is recognised that in the UK a lack of capacity throughout the system is resulting in health agencies prioritising children with a diagnosable mental health condition over those with emotional or behavioural needs *"to gatekeep access to rationed CAMHS".* In 2019 the ADCS recommended that *"NHS England should instruct health partners to cease using the distinction between children with emotional and behavioural needs and those with a mental health condition as a means to gatekeep access to CAMHS services. Health partners must take more responsibility for co-commissioning appropriate services for children who have emotional and behavioural needs which affect their mental health.[27]"*

Recommendation 5
Monitor and evaluate the progress of actions to reduce waiting times for neuro development assessments *(Warwickshire Safeguarding Partnership)*

Recommendation 6
Review the availability and use of the Crisis and Home Intervention Treatment team *(Coventry and Warwickshire Partnership NHS Trust)*

Recommendation 7
Undertake a review of the coordination of James's care during 2020 and to implement recommendations from this into processes and practices *(Coventry and Warwickshire Partnership NHS Trust)*

---

[27] *'A health care system that works for all'* ADCS 2019

Recommendation 8
Explore local provision which enables a multi-agency team to provide more targeted levels of support to children with complex needs who have high levels of social, emotional and mental health needs *(Warwickshire Safeguarding Partnership & Health & Wellbeing Board)*

4.4 How well does the safeguarding system respond to children when they are at risk of criminal exploitation?

Finding 4
MACE processes and contextual safeguarding were not well understood or embedded in practice at the time of this review so the risks of criminal exploitation to young people were not addressed effectively

Finding 5
Warwickshire Police did not have the capacity to proactively gather intelligence about young people who may be at risk of exploitation

There is no specific legislation or policies for child criminal exploitation and is therefore mainly supported under legislation including the Children Act 1989 and the Modern Slavery Act 2015. Working Together to Safeguard Children was revised in 2018 to include extra-familial risks as child protection issues. However local authorities have received very little guidance and the research is still somewhat limited to support and inform agencies as to the most effective ways of responding to such extra-familial risks. The impact of this means that most professionals working with children at risk of criminal exploitation did not and arguably still do not know how best to support children or reduce risk effectively in this complex area of practice.

Police in Warwickshire lack capacity for proactive work to develop an assessment of the risk to a young person considered to be likely risk of exploitation. The Police responded to incidents on an individual basis, processes were generally followed with risk assessments based on what was happening at each moment in time placed on the record system. This did not allow for a more comprehensive assessment of risk to James to be developed using all accumulated information available.

There was no contextual approach to assessing the risks to James. The review team heard that there has been a programme of training to try to embed the MACE approach to criminal exploitation since the time of this review.
Children's Services has initiated a project to implement a framework for Contextual Safeguarding and to develop a framework to address extra familial risk and harm experienced by children outside the home such as child sexual and criminal exploitation, peer-on-peer abuse and gang affiliation and violence. The challenge to the safeguarding partnership is to ensure that contextual safeguarding becomes embedded in practice across the partnership.

Recommendation 9
Monitor and evaluate progress on embedding MACE processes throughout the partnership *(Warwickshire Safeguarding Partnership)*

Recommendation 10
Undertake a quality assurance process to assess the progress of the introduction of contextual safeguarding in assessments of young people at risk of exploitation *(Warwickshire Safeguarding Partnership)*

Recommendation 11
Evaluate the capacity of the Child Abuse Trafficking and Exploitation team (CATE) for proactive work to develop assessment of risk of young people at risk of child exploitation (*Police)*

4.5 How does the education system respond to children who present challenges to schools due to their range of behaviours?

Finding 6
The local authority and the school failed to meet James's educational needs which resulted in him missing his secondary education and being vulnerable to exploitation in the community

The relationship between school A and the local authority is fractured and individual children fall through the net when neither appears willing to accept responsibility for meeting their needs. There is a need for restorative work to resolve the fragmented arrangements between schools and the local authority to ensure collective ownership of responsibility for the children with the most complex and challenging needs. There should be no gaps in the system for children to fall through.

The review found that schools in Warwickshire have been using unregulated alternative provision inappropriately rather than meeting their needs within the school setting despite specific funding set aside for them to address this issue. There are insufficient places in special schools in Warwickshire for the children who need to be there because places are taken by children who should and could have their needs met within mainstream school. The local authority SENDAR team is under resourced resulting in very slow progress in identifying school places for individual young people and not reviewing EHCPs.

The local review panel heard from the local authority that since the period of this review there has been an overhaul of processes and panels and the system is now more responsive to young people like James. As these systems are still embedding and given the serious safeguarding implications of children not being in school the review recommends that the Partnership Board request information about the provision and monitoring of education for the most vulnerable children with complex needs who are not receiving full time education. The functioning of the education panels in Warwickshire should be evaluated to ensure that there is no longer a possibility that children like James will be failed.

Schools have a paramount role in keeping children safe and each child who may show challenging behaviours should have an education package in place to address their needs.

Recommendation 12
To seek assurance from Warwickshire Education Services that children with EHCP who are not attending school full time either because they have been excluded or because they are only receiving part time alternative provision are identified and their safety and progress is robustly monitored (*Warwickshire Safeguarding Partnership)*

Recommendation 13
To seek assurance from Warwickshire Education Services in respect of the effectiveness of the new local authority panels to provide timely responses to children in need or children with an EHCP who cannot attend mainstream school for any reason *(Warwickshire Safeguarding Partnership)*

Recommendation 14
Undertake Restorative work with relevant schools and the local authority to improve the collective ownership of responsibility for the children with the most complex needs ensuring timely and appropriate review of EHCP plans *(Warwickshire Education Services and Warwickshire Children's Services)*

4.6 How did the covid pandemic effect the partnership involvement with GL and his family?

The working environment has changed hugely since March 2020. Use of digital virtual meetings has improved capacity to attend meetings and agency's ability to maintain contact with practitioners.

The negative side to this is that in James's case he developed a paranoia of use of virtual meetings and would not engage via zoom which meant that he was even less reachable during covid. James and his father were very anxious about Covid and were even more reluctant to engage with services during this time.

During the covid pandemic lockdowns James remained at home and did not receive in-home support from School A which continued to have a responsibility for James as for any other student on roll. Alternative providers continued to offer support to James throughout the lockdowns when his father agreed to accept it.

5. Summary of findings and recommendations

Finding 1 ***A fragmented and inconsistent approach to supporting James and his family led to a sense of professional paralysis amongst practitioners and James's complex needs were not addressed***
Recommendation 1 Undertake a comprehensive review to understand what the barriers are to professionals using the escalation process and why it is so under used *(Warwickshire Safeguarding Partnership)* **Recommendation 2**

Develop systems and processes to identify those young people with highly complex needs and at the greatest risk so that service responses can be flexible and if necessary, fast tracked to respond effectively to unmet need *(Warwickshire Safeguarding Partnership)*

Finding 2
There is no evidence that any practitioner was able to get a clear understanding of James's daily lived experience, if they did, it did not contribute to the multi-agency work with him

Recommendation 3
Explore opportunities for co-working in complex cases to help support transitioning between teams and enable young people to build a rapport and relationship with a new worker *(Children's Services*)

Recommendation 4
The multi-agency team around the child needs to adopt a flexible approach where the practitioner best placed to develop a relationship with the child and their family takes a lead in ensuring the child's voice is heard *(Warwickshire Safeguarding Partnership)*

Finding 3
There is a gap in service provision for those children with complex needs who do not have a diagnosed mental illness resulting in a fragmented and uncoordinated approach which did not address James's mental health needs.

Recommendation 5
Monitor and evaluate the progress of actions to reduce waiting times for neuro development assessments *(Warwickshire Safeguarding Partnership)*

Recommendation 6
Review the availability and use of the Crisis and Home Intervention Treatment team *(Coventry and Warwickshire Partnership NHS Trust)*

Recommendation 7
Undertake a review of the coordination of James's care during 2020 and to implement recommendations from this into processes and practices *(Coventry and Warwickshire Partnership NHS Trust)*

Recommendation 8
Explore local provision which enables a multi-agency team to provide more targeted levels of support to children with complex needs who have high levels of social, emotional and mental health needs *(Warwickshire Safeguarding Partnership & Health & Wellbeing Board)*

Finding 4
MACE processes and contextual safeguarding were not well understood or embedded in practice at the time of this review so the risks of criminal exploitation to young people were not addressed effectively

Recommendation 9
Monitor and evaluate progress on embedding MACE processes throughout the partnership *(Warwickshire Safeguarding Partnership)*
Recommendation 10
Undertake a quality assurance process to assess the progress of the introduction of contextual safeguarding in assessments of young people at risk of exploitation *(Warwickshire Safeguarding Partnership)*

Finding 5
Warwickshire Police did not have the capacity to proactively gather intelligence about young people who may be at risk of exploitation

Recommendation 11
Evaluate the capacity of the Child Abuse Trafficking and Exploitation team (CATE) for proactive work to develop assessment of risk of young people at risk of child exploitation *(Police)*

Finding 6
The local authority and the school failed to meet James's educational needs which resulted in him missing his secondary education and being vulnerable to exploitation in the community

Recommendation 12
To seek assurance from Warwickshire Education Services that children with EHCP who are not attending school full time either because they have been excluded or because they are only receiving part time alternative provision are identified and their safety and progress is robustly monitored (*Warwickshire Safeguarding Partnership)*

Recommendation 13
To seek assurance from Warwickshire Education Services in respect of the effectiveness of the new local authority panels to provide timely responses to children in need or children with an EHCP who cannot attend mainstream school for any reason *(Warwickshire Safeguarding Partnership)*

Recommendation 14
Undertake Restorative work with schools and the local authority to improve the collective ownership of responsibility for the children with the most complex needs ensuring timely and appropriate review of EHCP plans *(Warwickshire Education Services and Warwickshire Children's Services)*

6. Summary of single agency action plans

Agencies submitted their individual action plans to the review, and these are summarised below. The review recommends that the Safeguarding Partnership Board requests updates on progress of these plans**.**

6.1 Coventry and Warwickshire Partnership NHS Trust (CAMHS)

If there is a child awaiting a tier 4 bed assessment consideration should be given to input from the CAMHS Crisis and Home Treatment Team
CWPT acknowledges that there is a lack of clarity over the coordination of James's care during a set period. This will be subject to an internal review, which we will consider and implement any of the recommendations

6.2 Warwickshire Education Service

Monitoring of children and young people attending alternative provision as the main part of their education for more than 10 weeks.
That education placement decisions are made in a timely manner and not deferred
Expanding specialist education provision for children and young people with SEMH needs
New school opened March 2022
Monitoring of annual reviews and action where this has not taken place
Reforming the annual review process within SENDAR
Finding ways to engage with hard to reach and disengaging families

6.3 Warwickshire Police

To highlight to the wider workforce on the importance of reflecting the risk to children from missing episodes
Raise awareness of the work of the HAU in conjunction with MASH
Awareness and training of the process in respect of the National Referral Mechanism (NRM)
Athena- raise the standards of investigation reports and ensure that there is relevant content on investigation logs inputted in a timely manner with rationale documented for key decisions

6.4 Children's Services

Remind staff to have open conversations with alternative education providers when attempting to engage with hard-to-reach young people
Ensure Social Workers are aware of what the educational entitlement for children and young people is
Ensure social workers are aware of the updated escalation procedure, which includes details of all key agencies and the key practitioners to speak to.
All plans should be formulated with families
All attempts to contact children and Families to be recorded even if they are unsuccessful and clarity in these records as to whether they are planned or unplanned contacts

Ensure all social workers completed relevant mental health awareness training
Ensure all social workers and family support workers have an understanding of the MACE policies and procedures, including early help and children in need
Children's Services to undertake Trauma Informed Practice training

6.5 University Hospitals Coventry and Warwickshire NHS Trust

Professionals should be encouraged to adopt an investigative, questioning and professionally curious approach when considering the history of a case
Professionals to be aware of the specialist services available in relation to substance misuse for appropriate sign posting

6.6 Coventry and Warwickshire CCG

All individuals with a history of overdose should be offered a GP follow up appointment within 2 weeks of being closed to CAMHS
All individuals should be offered a GP follow up appointment within 2 weeks after discharge from A&E/Hospital for mental health issues
The Practice should review their policy of ensuring that children and young people are pro-actively offered to be seen alone in the Practice (where appropriate)

6.7 School A

Link member of staff to make weekly contact with each Alternative Provider that is being used
SENCO / DSL meet with SENDAR monthly

6.8 COMPASS School Nursing Service

To remind staff to have open conversations with alternative education providers when attempting to engage with a hard-to-reach young people
If COMPASS is unable to complete a child protection or LAC health assessment, they should inform the GP

Appendix 1

Methodology

The independent lead reviewer[28] worked closely with a local review panel which comprised of the following:

Agency	Role
Independent Safeguarding Consultant	LSPR Author and Lead Reviewer
Education	Strategic Lead for Alternative Provision
Warwickshire Police	Police Staff Manager, Statutory & Major Crime Review Unit (SMCRU)
NHS Coventry and Warwickshire Clinical Commissioning Group	Head of Safeguarding
Warwickshire County Council	Legal Services
Warwickshire Children's Services	Practice Improvement Manager
Warwickshire Safeguarding Partnership Board	Quality, Learning and Improvement Officer
Coventry and Warwickshire Partnership NHS Trust (CAMHS)	Head of Safeguarding

All meetings including the practitioner reflective workshop were conducted virtually using Microsoft Teams.

The review drew on information and analysis provided by each agency in individual information reports and chronologies. These reports are designed for an agency to analyse their involvement with the child and family. The information was followed up at a Reflective Learning Event. Agencies also provided additional data including assessments and case records where appropriate. Data from reports to the rapid review was also available.

Agencies that provided Information Reports and chronologies
School A
Alternative Provision 1
Alternative Provision 2
Warwickshire Children's Services including Safeguarding Team, Strengthening Families Team, Child Exploitation Team and Special Educational Needs (SENDAR)
Hospital
Coventry and Warwickshire Partnership NHS Trust (CAMHS)
Warwickshire Police
School Health COMPASS
NHS Coventry and Warwickshire Clinical Commissioning Group

[28] Lucy Young is an independent safeguarding consultant with an extensive background in children's social care and safeguarding.

This review has used a systems approach drawing on the Social Care Institute of Excellence (SCIE) Learning Together Systems model[29]. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families, and make it more or less likely that the quality of practice will be good or poor[30].

[29] https://www.scie.org.uk/children/learningtogether/

[30] 'The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and

policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.' (Working Together 2018)