Warwickshire Safeguarding Children Board

Serious Case Review

‘Sophie’

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July 2018

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1. Introduction

In 2018 Warwickshire Safeguarding Children Board (WSCB) completed a serious case review of the multi-agency professional response to Sophie who suffered serious harm while in the care of Warwickshire Children's Services. The WSCB was keen to find out what this case could tell them about the wider system for children in care in Warwickshire in order to make the system safer for these children. The full review has not been published in order to protect Sophie's ongoing welfare. However the learning and findings of the review are shared in this summary of the overview report.

2. Summary of the case

Sophie became looked after by Warwickshire Children's Services in March 2013 when she was 12 years old. She had lived in a complex and troubled home environment and her emotional well being had been significantly affected. Whilst in care Sophie experienced eight different foster placements over a three and a half year period and was on the roll of two primary schools and seven different secondary schools in five different local authority areas in the Midlands. She experienced multiple periods of missing from care, was a victim of child sexual exploitation and suffered significant harm. Sophie was an extremely vulnerable young person with complex needs.

3. Research question

The review team recognised that there is a small cohort of children in care who are extremely vulnerable and whose needs are the most complex. They are recognisable with:

- a background of chronic abuse and neglect;
- high risk behaviour in pre- and early adolescence (often including being sexually active young, going missing and at risk of sexual exploitation);
- repeat placement breakdowns and;
- emerging mental health issues and self-harm and suicide attempts.

The WSCB wanted to find out what they could learn from this case about how to enable a more coherent and effective multi-agency corporate parenting and safeguarding role for these children. This includes how well the following are helping:

- the child's 'voice' being heard and considered in order to influence practice and outcomes;
- interpreting and understanding what is known about the child's past to inform a coherent care plan;
- the role of Independent Reviewing Officers (IROs) in overseeing the care plan;
- continuity of service provision when children are moved frequently including being placed out of area and;
- placement matching, decision making and monitoring.

4. Methodology

WSCB used the Social Care Institute of Excellence (SCIE) Learning Together Systems model for this review. 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.

Two lead reviewers worked with a review team comprising senior representatives from children's social care, the virtual school, the Clinical Commissioning Group and the Police. The review also benefitted from significant input from a group of practitioners and front line managers who had worked with and knew Sophie well. Sophie herself was also consulted towards the end of the review and her views were included in the overview report.

5. Findings

The Learning Together methodology uses an individual case to provide a 'window on the system' identifying whether the learning that has been identified by one case is more systematic and widespread, thereby leading to a broader understanding about what supports and what hinders processes and practice locally.

This case provides examples of what can happen when the system is under pressure and practice becomes reactive rather that reflective and there is an absence of timely assessment and multi-agency planning. At the heart of this case lies the difficulty of being able to think innovatively about how to meet the needs of a small but significant group of children in care with the most complex needs for whom the regular system does not 'fit' when the majority of practitioners' time and focus goes on delivery the standard 'menu'.

There was a general feeling of helplessness among a group of skilled and dedicated practitioners. There was a pattern of Sophie having settled periods when she first moved to a new placement and school and a sense of optimism on behalf of professionals of 'keeping their fingers crossed' that she might settle. Those who knew Sophie well saw a repeated pattern of 'start again syndrome' where she would be in crisis, move, settle and then concerns and risks would start to remerge. Practitioners were very affected by working with Sophie, they worried constantly and reflected a sense of hopelessness when describing working with her. Sophie's voice is evident in case file recording and statutory review notes but it is not filtered through assessment and analysis in order for her views to inform planning.

The review team found that each separate part of the looked after children system appeared to function well or adequately within the parameters of individual roles; however the system (and therefore the child) did not benefit from the strength of a cohesive and flexible multi-agency system with all elements working together in an integrated way.

The review team prioritised seven findings from the review.

Finding 1: There is no systematic process in Warwickshire for identifying the children in this relatively small group of looked after young people, who need a more proactive and creative multi-agency approach to planning and service delivery, and as the usual processes are unsuccessful for them they remain subject to cycles of crisis and calm.

The multi-agency system for looked after children rests on well-developed processes to streamline activity and manage costs, and for most looked after children these processes are satisfactory. But the complexity of some children's needs and circumstances means that the usual solutions are not effective. Continuing to try and apply the usual processes to these children is not cost effective and results in a great deal of harm for them. However the absence of a mechanism for identifying who these 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. Strategic leaders must create a context in which practitioners and front line managers are better equipped and supported to make effective and timely responses to the children in care with the most complex needs.

Finding 2: The system for children in care in Warwickshire is not designed to require coordinated, multi-agency assessment and

planning for children with mental health and/or emotional well-being issues, akin to the approach for those with physical or learning disabled children. This makes it likely that vulnerable children with the most complex needs will deteriorate and be left with substantial unmet need and at significant risk.

Children in care who have mental health and complex emotional and behavioural needs do not always get the therapeutic support that they need, this is even more likely to be the case if they are placed outside of the local area. There is a lack of clarity about mental health diagnoses for children and how to access and fund the right services for them. The named health professionals did not see mental health as part of their remit and the criteria for children's involvement with mental health services can be confusing and not well understood. The social worker can feel solely responsible for accessing therapeutic assessment and services for children in care with little or no support or flexibility from other agencies.

Finding 3: A shortage of foster carers in Warwickshire and nationally means that children whose needs are the most complex and require multi-agency input are most likely to be placed out of the local area. Their distance from home and difficulties accessing local services increases their vulnerability and risk.

It tends to be the most high risk and vulnerable children who are placed furthest away from home. The 'looked after' system is designed to work effectively within Warwickshire and practitioners struggle to coordinate services and access resources for children who are living outside the local area. Placing children at a distance from the responsible local authority can increase a child's vulnerability and prevent them from accessing suitable services. There are several reasons for this, including the case responsible social worker's lack of local knowledge, eligibility criteria for services prioritising 'local' children, or the child not remaining in the area long enough to make progress up a waiting list before the placement ends, meaning that they are always on a waiting list rather than actually in receipt of services. For a child like Sophie, who moved between and within four different local authorities during the period under review, there can be continual change in the service providers responsible for their education, health and other needs. The review team concluded that it appeared perverse that placement allocation arrangements did not prioritise placing the most vulnerable children in Warwickshire placements.

This means that children with the most complex needs are at risk of having the least well coordinated and supported services. It is particularly difficult for professionals in the placing authority area to effectively tackle sexual

exploitation concerns when a child is placed out of area because they are likely to lack relevant local knowledge about risks. This can result in a focus on managing the child's behaviour and activities, rather than seeking to influence the safety of their environment.

Finding 4: The IRO role and LAC reviews work to review the day to day matters of the placement plan rather than the high level objectives of the care plan. For this cohort of children this leaves no forum where multi-agency professionals review whether the overall care plan is working, and if it is still the right plan.

The Review of Arrangements paperwork completed by the social worker before each review did not invite analysis and thinking about new information in the light of the child's history. LAC reviews tended to discuss the here and now and day to day actions required rather than meaningfully review the care plan and decide on its relevance. The care plan did not change or adapt to changes in Sophie's life or presentation.

IROs have very high caseloads and do not have easy access to information from health and education plans. As an important check and balance of the child's care plan the LAC review system is weak and may not always effectively review the child's care plan or highlight concerns to senior leaders.

The LAC review system and IRO role are intended to provide an independent check and balance for children in care. But if this is under-resourced and/or undervalued it is unlikely to be able to function sufficiently to provide this vital service to the most complex and high risk children. Senior Leaders must be confident that the checks and balances within the systems are able to function effectively.

Finding 5: The multi-agency safeguarding system generates a number of separate plans for a child in care and there is no mechanism in Warwickshire to enable these to be integrated coherently into the overarching Care Plan. This increases the chances of fragmented agency responses.

The different elements of Sophie's care plan were fragmented and were not fully considered at each review. The overarching care plan developed when the care order was first granted was never changed, updated, or meaningfully reviewed.
The health care assessment should be done annually (in Sophie's case they were 15 months apart) with no flexibility for this to be more frequent if the child's needs are complex. The IRO did not have easy access to the health

care action plan and relied on reporting by the social worker. In fact the health care plan was not reviewed at the LAC reviews and actions were not progressed.

If a child in care has a care plan that is not based on up-to-date information and analysis of their needs then they are likely to be failed by the system. Risk cannot be managed because crucial information is not shared or known, for example when a child is at risk of child sexual exploitation all those involved in the child's care need to be aware of the details of the risk and how this needs to be managed. Similarly as a child's needs become more known through time the care plan needs to be properly reviewed in order to make sure that it meets their needs. Too much reliance on one professional holding all the information in their head (e.g. the social worker) is unreliable and fragile if that person is not available and it does not allow for analysis and proper review.

Each part of the system meets statutory requirements to develop plans (PEPs, health care action plans, safeguarding) but these are not well coordinated to effectively contribute to assessment and care planning. The sum of the parts is not greater than the separate elements of the system.

Finding 6: There is a tendency in Warwickshire to focus on placement and care resource options for children looked after, rather than how best to achieve the goal of permanence for a child who cannot return to their family, leaving their need for permanence unmet.

In reviewing the reports, plans and other documentation for this case it is noticeable that the term 'permanence' is absent. The focus on placement and care rather than how to achieve permanence meant that no consideration was given to alternative ways to achieve stability. Permanence planning does not appear to be a golden thread running through work with children in care in Warwickshire. When children first enter care systems are in place to plan appropriately for permanence. However once the child is in care monitoring is done by the LAC review system which does not consistently consider issues of permanence when a child is moving frequently.

There is a lack of focus on achieving stability and permanence for older children in care, professionals in Warwickshire have a limited understanding of what permanence means for children in care and how best to help them to achieve it. The permanence policy and expectations about the importance of life story work for child in care are not well understood

Finding 7: *The Health of Looked After Children team assumes that GPs hold the overview of looked after children's health needs but this does not happen in practice, resulting in a situation where no professional has a holistic picture of the health needs for children with the most complex histories.*

Looked after children have a particular need for a suitable clinician to have a holistic view of their health history, to support social workers and carers to understand and meet their health needs. Unlike a child who has always lived in the same family, the adults caring for looked after children are unlikely to have a comprehensive memory of their medical history. Their needs may also be more complicated as a result of the events that brought them into care, and the challenges of being in care.

The Health of Looked After Children team believe this role is carried out by the child's GP, but there are no specific arrangements to ensure GPs generally, or in Warwickshire in particular, have the mandate and capacity to go beyond physically holding some or all of the medical notes and responding to routine requests for appointments at the surgery. Their capacity to do this is further compromised for children with the most complex histories because recent limitations in file transfer arrangements mean they don't have a complete electronic record. In practice therefore many looked after children do not have a clinician who holds a holistic picture of their health needs, and this may result in incomplete or misguided health plans.