Southampton Safeguarding Children's Partnership

Children's Safeguarding Practice Review

Name Willow Date August 2023

SSCP

Child Safeguarding Practice Review

Learning identified from considering Willow

Contents

1. Introduction

1.1 The Southampton Safeguarding Children Partnership (SSCP) agreed to undertake a Local Child Safeguarding Practice Review (CSPR) to identify any learning with regards to Willow, a 16 year old young person who was under the care of Southampton City Council at the time of allegations of sexual assault against male perpetrators.

1.2 In January 2023, Willow made a number of non-recent reports of sexual assault and rape against adult males. Willow alleged that one male sexually assaulted and raped her in December 2021 and January 2022. One incident reportedly occurred at a friend's address and one at a hotel. Willow had known the male through her friendship group at the time. A third disclosure was made against a previous boyfriend, also an adult male, including domestic abuse which took place over a number of weeks and a violent incident at her foster placement. All of these reported incidents took place whilst Willow was in the care of Southampton City Council.

1.3 A police investigation was concluded and no further action will take place. Willow is being supported by her Social Worker and remains with her foster carer. Willow is being supported to access therapeutic services when she feels able to do so.

1.4 The review has identified learning themes in the following areas:

- The reporting and review of missing child episodes, including appropriate use of the Philomena protocol, the grading of missing episodes, and use of the '3 in 90' procedure.
- The use and grading of the Child Exploitation Risk Assessment Framework (CERAF) tool
- Listening to the voice of the child or young person.
- The convening of strategy discussions and compliance with Working Together to Safeguard Children 2023.
- The support and training of carers with regards to the Risks Outside The Home (ROTH) for vulnerable children or young people.

2. Process

2.1 The SSCP received a referral for consideration of a CSPR on 17th January 2023. The National panel were notified of the Serious Incident Notification and a Rapid Review took place on 27th January 2023. The decision was made to progress to a local CSPR to identify key learning themes.

2.2 The time period under review is from January 2021 until January 2023.

2.3 This review has been informed through information gathered during the rapid review process from agencies involved with Willow, as well as additional information gathered from Individual Management Reviews (IMR) conducted by Southampton Children's Services, Hampshire and Isle of Wight Constabulary, and Solent NHS Foundation Trust.

2.4 The review also gathered information from a multi-agency practitioner's event which involved detailed discussions in relation to the learning themes. The agencies involved in this process included Children's Social Care, Hampshire and Isle of Wight Constabulary, The Youth Offending Service, the Child, Adolescent, and Mental Health Service, and the Solent NHS Trust. The review would like to thank those who participated in this event.

2.5 Willow was invited to participate in the CSPR process to give her views and to help the review understand what has happened from her perspective, but Willow has declined to participate at this stage. She has said to her Social Worker that she is aware that she has a lot she could talk to the review about but understandably does not want to talk about it. Willow has also been asked for her consent for the review to speak with her family, specifically her mother, but Willow has declined to give her consent for this. As Willow is competent and has expressed an opinion, the review will respect this request.

2.6 The review will, where possible and where Willow has provided some insight, seek to reflect Willow's voice in her lived experiences.

2.7 References to the relevant recommendations will be shared in brackets throughout the report.

3. Willow's Background

3.1 Prior to Willow's birth, her siblings were known to Children's Services and were made subject to Child Protection Planning between 2002-2003 due to neglect and physical abuse concerns. The children were placed with their grandmother whilst Willow's mother was in prison, but were returned to the care of their mother following her release in 2005.

3.2 Since Willow's birth in 2006 until 2019, the local authority undertook ten section 17 assessments and five section 47 child protection enquiries due to concerns around physical abuse, neglect, lack of supervision, maternal drug abuse and domestic abuse. The children were also made subject to Child Protection Planning in July 2019.

3.3 Willow was accommodated by the local authority in July 2019 due to contextual safeguarding concerns around poor school attendance, cannabis and alcohol use, missing episodes, and Willow's associates.

3.4 Willow spent a period with three separate foster carers, as well as with her grandmother. She was returned to the care of her mother in October 2019 with ongoing intensive support following a breakdown in her foster placement.

3.5 In November 2020, Willow was again accommodated by the local authority, following an allegation of significant physical abuse being made against Willow's mother and older sister, and a Full Care Order was made to the local authority in March 2021. Since November 2020, Willow has had ten separate placements.

3.6 Willow experienced a change in social worker and transfer to the Pathways through Care Team, which removed the presence of the trusted adult with whom she had built a relationship and felt safe to talk about her feelings. Willow was able to express that she felt that professionals had not always asked the right questions.

3.7 During a hospital Emergency Department attendance in February 2020, it was recorded that Willow's mother reported concerns that Willow was being groomed by an older male, however this information was not shared with other agencies. It is not known why this was not shared as a concern (Recommendation 5).

3.8 By May 2021, further contextual safeguarding concerns were being raised with regards to Willow, with Willow being reported to travel in unknown vehicles, associate with older peers, receive money and deliveries from unknown sources and become involved in altercations with peers. This was during a period where Willow spent time with her family, but this contact was noted to be unstructured and not suitably monitored. There was also a significant delay to a Placement with Parents assessment (Recommendation 2).

3.9 Willow attended the Emergency Department at University Hospital Southampton in June 2021 due to a minor head injury from an assault by a female outside the foster carer's home and reported that she had made multiple previous suicide attempts, the last being 5 months previously. This was shared with the local authority at the time.

3.10 In November 2021, Willow was issued with a Youth Conditional Caution for an assault against an ex-boyfriend.

3.11 There were a number of incidents between January and November 2022 when Willow was at risk of exploitation, particularly sexual. She was having contact with a number of different men, some much older than her and travelling around the country. Willow was mixing with other young people who were known to be at risk of exploitation. She also received a further Youth Conditional Caution in July 2022 for stealing a car and crashing it into a fence whilst at her residential placement, extending her involvement with the Youth Offending Service (Recommendation 2).

3.12 By November 2022, it was suspected that Willow was physically and emotionally abused by her "boyfriend", a twenty-year-old male. He has since been arrested and Willow has expressed her concerns around repercussions from the male and his family.

3.13 Between March 2021 and January 2023, Willow was reported missing on twenty-nine occasions to the police and linked to a further forty incidents on police systems. Each missing episode was graded as a medium risk.

3.14 The Children and Learning Missing, Exploited and Trafficked (MET) Team did undertake Return Interviews when they were alerted to a report of Willow having gone missing, however safe and well visits were not always conducted by police.

3.15 Five CERAF (Child Exploitation Risk Assessment Framework) assessments were completed in respect of Willow. These assessments consider if the young person is at high, medium or standard risk of exploitation. There were two occasions when Willow was deemed to be at high risk, however these were for short periods and one of these, in April 2022 was downgraded to a medium risk based on the professional judgement of Willow's Social Worker (Recommendation 2).

4. Learning Identified

Good practice

4.1 Willow reported her experience of the social care Missing Exploited and Trafficked Hub to be valuable in enabling her to share her feelings in the space provided during the Return Interviews.

4.2 The family are of White British ethnicity. Issues related to race, culture, faith and ethnicity were considered but none were identified which required further consideration.

Missing episodes and CERAFs

4.3 Willow was reported missing numerous times from her placements. There were multiple concerns around with whom she had been associating, both with vulnerable young people and adult males. There is evidence and indicators that Willow has been at high risk of child sexual exploitation. With the reports Willow has made of sexual assault and rape during this time, along with the concerns around domestic abuse in a more recent relationship with an adult male, professionals and carers had significant information to share in order to plan how to support Willow to explore her lived experiences and provide safeguarding planning.

4.4 There are processes in place to support young people who go missing. Had Willow's missing status been graded as high risk by the police, further actions could have been taken to locate her and to consider where she would be safe, who she was with and to map the vulnerabilities and risks posed by those with whom she was associating. Police reports should be completed at the time of the reported episode and again following a safe and well visit (Recommendation 6).

4.5 The police led a series of internal reviews immediately following the decision to undertake a CSPR with regards to Willow. Changes have been made in the way in which missing episodes are graded when the young person is a looked after child and there is close consideration of the

exploitation risks. Processes are now in place where daily sharing of information regarding missing children is shared from police with social care. The SSCP will seek assurance of this being consistently in place (Recommendation 6).

4.6 The Philomena protocol provides additional consideration for children looked after by the local authority. The protocol focuses on the multiagency response to children who are reported missing by carers. Any child in care who is at risk of going missing for any reason is encompassed within this protocol. The scheme focuses on the recording of vital information that is required to assist police with a missing person investigation (Recommendation 2).

4.7 Working alongside partners, it encourages carers, staff, guardians, and families to collate useful information that could assist police in the event of a child going missing from care. This could include information in relation to the child's friends, associates, previous missing episodes and health, all of which will assist in locating the young person and returning them safely and quickly to their care setting.

4.8 The document is owned, updated, and shared by carers to ensure the most up to date information is recorded.

4.9 Treating 'children as children' is at the very heart of this work. Recognising and recording changes in behaviour and documenting these assists with assessing the risk the child could be at and focuses the response accordingly.

4.10 The missing 3 times within 90 days protocol requires a strategy discussion to be held with agencies, to ensure information is shared and plans developed to ensure the correct level of intervention and protection is implemented (Recommendation 1).

4.11 It was noted that if it is felt that there is a risk to a child or young person when they go missing, then the police can add a flag to their case management system so that incidents can be graded as high every time, however this was not done for Willow. Staff at the care home where Willow was placed had been told by the local authority that for a period Willow could not leave the placement without a trusted adult. They were advised that if Willow did leave without a trusted adult that they were to report her missing to the police. On these occasions it is recorded that the care home told the police that they were not concerned about her whereabouts. Willow herself had expressed to one practitioner that on reflection at the time she was in a residential placement, she felt with hindsight that the carers were trying to be more of a friend than acting professionally. She said that they would turn a blind eye to things like Willow going outside for a cigarette, and Willow had said that she took advantage of this at the time. She had commented that when she felt that her freedom was being impacted too much, she was inclined to break the rules. Willow had also said that she had felt frustrated, that nobody was helping her, and now it was too late (Recommendation 2).

4.12 Practitioner's felt that when the Philomena Protocol was first introduced, some good work was undertaken, however this is now seen as more of a tick box exercise. It was also felt that when young people were going missing, the wrong information was being shared with police. Practitioners felt that it would be beneficial for the expectations around the Philomena Protocol and the overall reporting of missing episodes to be discussed at the initial Placement Agreement Meeting (PAM) in order that professionals and carers were aware of the process and expectations if a child or young person goes missing (Recommendation 2).

4.13 With regards to CERAFs, practitioners felt that some professionals were using CERAFs as assessments rather than as a tool. It was felt that some CERAFs were being completed with too much historical information when only information for the last six months should be included, and were not being written and submitted in a timely manner. It was felt that the CERAF guidance was not being consistently used when CERAFs were being completed, and practitioners felt that all staff needed to be reminded of and asked to refresh their CERAF training. Practitioners also felt that it would be beneficial for a small group of staff to get together to have some planning sessions around the meaningful use of CERAFs, and that young people should be involved with this.

Listening to the voice of the child or young person

4.14 Willow voiced that she did not feel that professionals asked her the right questions. Willow had talked to staff about having questions asked by professionals that she didn't want asked. It seems that more latterly she did not have a trusted adult with whom she had built a relationship.

4.15 At the practitioner's event, staff working with Willow said that at the time of some of the incidents, including missing episodes, staff worked on a shift rotation as well as their being agency staff. This meant Willow did not have a continuity of staff with whom she could build a relationship, although it was acknowledged that this was an issue with residential care in general, rather than just in Willow's case. Professionals felt that an Independent Visitor may have been beneficial for Willow whilst she was in the residential care placement. Practitioners also felt that involving advocacy services with children and young people would also allow their voices to be heard.

4.16 It is clear that young people with lived experiences need to be supported to share their feelings and recommendations as to how practice can change to embed their learning into practice.

4.17 At the practitioner's event, staff from the MET Team advised that a new proforma has been developed to capture the voices of young people who are at medium or high risk of going missing.

Strategy discussions

4.18 Strategy discussions were convened following significant incidents, however there is a concern around the compliance with Working Together 2023 which requires that all strategy discussions must include representatives from social care, police, and health services. Ensuring the key professionals are involved to share information and to plan for the safety of Willow is essential. Health services were not in attendance in all strategy discussions. This was a combination of a failure to invite health by the local authority and also when invited a lack of capacity for health to attend. It is important that the health professional in attendance is familiar with the young person

in question. It is noted that the LAC health team were not appraised of the contextual safeguarding concerns when undertaking the LAC medical review. The inclusion of education is also a key partner to be included in such discussions (Recommendation 1).

4.19 At the practitioner's event, professionals discussed how strategy discussions should not just be about a threshold decision, and that it needed to be about planning for young people, and bringing families into decision-making. It was also discussed how social care workers needed to know who to go to within health when arranging a strategy discussion to identify who to invite when the worker is not aware of what health services are involved. Police colleagues also noted that there are limitations on staff availability when the Neighbourhood Policing Teams are involved.

4.20 With regards to education involvement, the review acknowledges the decision not to gather information for this review from education services as during the time period under review, Willow was either not engaging with education or had been permanently excluded from her education setting. It is noted that staff involved with Willow have worked hard to get Willow to engage with education, and there has been some success in this area (Recommendation 4).

4.21 Willow is now receiving therapeutic support and the Partnership will continue to attempt to seek her views.

The support and training of carers around ROTH (Risk Outside the Home)

4.22 Carers require support and training around caring for vulnerable young people who are at risk outside the home. There are records of some of the carers using language which suggests that they may not have fully understood the lived experience of Willow and that they require additional support and guidance when working with such vulnerable young people (Recommendation 2).

4.23 At the practitioner's event, professionals discussed the use of language when talking about children or young people, and it was acknowledged that professionals particularly in social care are now routinely writing records as if to the child, although it was acknowledged that these needed to be at another level for care leavers. Professionals felt that foster carers should be offered training around ROTH and other possible concerns in order that individualised packages of care could be offered to children and young people in their care, and that this would also help upskill foster carers (Recommendation 3).

4.24 The review understands that Southampton City Council have been involved in an initial ROTH pilot alongside the Contextual Safeguarding Team at Durham University which has involved looking at how children at risk of significant harm outside the home can be safeguarded. The pathway has followed statutory child protection processes which has meant that it has not included children looked after. This pilot has now concluded and the local authority are reviewing the learning from this (Recommendation 2).

4.25 Discussions with senior management for children looked after should take place regarding how ROTH support can be extended with consultation and planning so that it can run alongside care planning processes (Recommendation 2).

4.26 The local authority are developing a context assessment/conference pathway which would wrap the process around the situation where children are at risk of or experiencing harm e.g. within a peer group, in a particular neighbourhood location or within a school. Wider community partners will be involved to respond to this and promote safety and well-being. The local authority have advised that this work could include any children and the context conference they have trialled so far did initially have at least one looked after child linked to it.

4.27 Practitioners also discussed how other agencies, such as education, need to have a better understanding of trauma and adverse childhood experiences.

5. Recommendations

Recommendation 1

5.1 The SSCP require assurance from statutory partners of compliance with Working Together to Safeguard Children 2023 to ensure that the appropriate professionals are invited to and are attending strategy discussions.

Recommendation 2

5.2 Allocated social workers and supervising social workers to ensure that alongside generic training for carers, each young person has a package of support in place tailored to their individual needs. Childrens social care to provide assurance to the SSCP that this package of support should include specific interventions and planning for looked after children at risk of exploitation and outside the home.

Recommendation 3

5.3 The SSCP to be provided with assurance that the language used in respect of children, young people and their families is appropriate and not derogatory or victim blaming. Partner agencies to provide evidence of developmental work in this area, including the views of children, young people and their families.

Recommendation 4

5.4 That the Partnership asks the relevant partner agencies to provide assurance regarding what is being done to prevent school exclusion for children who are at risk of exploitation.

Recommendation 5

5.5 University Hospital Southampton to detail the pathway for safeguarding concerns to the local authority with assurance that this is understood and followed by the Emergency Department.

Recommendation 6

5.6 Hampshire and Isle of Wight Constabulary to provide assurance to the SSCP of the processes now in place to ensure a timely and proportionate reporting of missing children and young people.