0123 Child X Local Child Safeguarding Practice Review

2023

This Local Child Safeguarding Practice Review (LCSPR) concerns 'Child X' a 15-year-old child in care with complex emotional and behavioural needs

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LCSPR Report Child X

Contents

Introduction

This Local Child Safeguarding Practice Review (LCSPR) concerns 'Child X' a 15-year-old child in care with complex emotional and behavioural needs who was subject to a Deprivation of Liberty Order and was cared for on a 5:1 staffing ratio in an unregistered placement. Child X became pregnant whilst in this setting, thought to be the result of grooming and sexual abuse by a male carer, raising significant concerns about the level of supervision, safety, and quality of her care.

Methodology and key lines of Enquiry

An independent lead reviewer[1] worked with a review panel comprising senior representatives from key agencies involved with Child X). The report builds on the information provided for the Rapid Review. Agencies and professionals contributed to the review via reflective workshops, individual conversations, and agency critical analysis reports.

The reviewer has met with Child X and with her mother. During the review further allegations were disclosed to review panel Officers. These new disclosures were reported to the head of service and to the Gloucestershire Safeguarding Children Partnership (GSCP) and were formally shared with the senior investigating officer and the LADO[2].

The events covered in this review are subject to a police investigation and have also been subject to LADO investigations and internal investigations by the care providers. Several of the staff and managers who were involved no longer work for their organisations and were not available to take part in the review.

The review looks at the year October 2021 to October 2022. The key lines of enquiry focus on what this case can tell us about:

- how Gloucestershire commissions placements and care packages for children with complex needs,
- the quality of governance and decision-making in care planning for children and young people with complex needs,
- Gloucestershire's quality assurance arrangements for placements and care packages including the quality and competence of professionals commissioned to look after children with complex needs and,
- the interface between commissioning and operations services, how effective it is and how well it meets children and young people's needs.

[1] Lucy Young is an experienced children's safeguarding and social care professional.

[2] The Local Authority Designated Officer (LADO) is responsible for co-ordinating the response to concerns that an adult who works with children may have caused them or could cause them harm. The LADO works within Children's Services and gives advice and guidance to employers, organisations and other individuals who have concerns about the behaviour of an adult who works with children and young people.

Pen picture of Child X

Child X is of mixed black Caribbean and white UK heritage; she is quite tall and looks older than her age. She loves music and is always listening to afro beat and dancehall. She likes makeup blogs on Instagram and TikTok and is really good at doing makeup and hair. Her cultural needs are important, for example hair and skin products and she loves Jamaican food. She enjoys swimming and all activities that are thrill seeking e.g. Thorpe Park, Ninja Warriors. She is a master at Monopoly, and she likes playing Uno and other card games. She has recently started volunteering in a homeless shelter, she would like to own her own care company one day and she would also like to have a dog.

Privacy is very important to Child X and she doesn't like people having personal information about her. She appreciates people being kind to her and thoughtful about her and 'holding her in mind'. She has a great sense of humour and sees this as a key to helping her to be calm. Friends and family are very important to Child X and she likes to keep in regular contact with them. People who work with Child X say that she can be a pleasure to work with, she has a fantastic sense of humour, has a loving caring nature and can be thoughtful at times. She does not like rules but responds well when boundaries are kept. She does not like feeling that her needs are not being met or having to go through social care for decisions to be made. She does have another side when she can be very challenging and threatening to staff and she knows how to 'push people's buttons' and she will try to get an answer that she wants by contacting various people.

Child X has experienced a traumatic childhood and has complex behavioral and emotional needs which can mean that she poses a risk of serious harm to herself and sometimes to other people who are caring for her. She first entered care when she was nine years old. Her mother was young when she had her children and struggled to cope as a parent. Child X and her siblings have all been or are currently in care. Child X has lived in 38 different placements including foster homes, secure unit, and residential care.

Appraisal of professional practice

The appraisal of professional practice provides an overview of 'what' happened in the year under review, looking at professional responses and systems learning. It sets out the view of the review team of how effective agencies were in discharging their professional responsibilities to Child X and ensuring that her safety and wellbeing needs were met. 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.

Child X 's move from secure accommodation to an unregistered placement

In October 2021 Child X was subject to a secure order.[3] The aim of secure accommodation for Child X was to provide intensive support and safe boundaries to help to manage her behaviours and enable her to move safely to a placement in the community. However, the

[3] A Secure Accommodation Order is made under section 25 of the Children Act 1989. The order allows children's services to place a looked after child under the age of 16 in secure accommodation on welfare grounds if one of two conditions applies:

- The child has a history of running away. The order may be made if the child is likely to run away from any other type of placement, and they would be likely to suffer significant harm if they did run away.
- The child is likely to injure himself or someone else if they were kept in any other form of placement.

secure unit struggled to care for Child X safely and required Gloucestershire to commission additional external agency care staff for support. There was a ratio of 5:1 secure unit and agency mental health nursing care staff working with her. The secure unit gave notice on the placement but there were no alternative secure or suitable regulated community placements available for Child X. Finally, things came to a head when the secure unit gave 48 hours' notice to move Child X citing the need for a local child to occupy Child X's place in the unit.

Despite making representations to the local authority responsible for the secure unit and to the High Court, Gloucestershire had no choice but to move Child X. With no other secure or regulated placements available Gloucestershire put together an emergency bespoke care package for her at Placement 1 and as an alternative to the secure order a Deprivation of Liberty order[4] (DoL) was granted by the High Court.

There is a national shortage of secure welfare placements for children in England and there are now as many as 60-70 children waiting for a secure bed each day. This can be further exacerbated when some children's needs are so complex that they take up increasing resources.[5] For example in Child X's case the secure unit was using a 3 bed unit just for her and given the acute shortage of beds, it was not surprising that they gave notice. This case is not unique, there is a cohort of children in England and Wales who are in extreme crisis to the same degree as Child X. The Independent Review of Children's Social Care highlighted that there is a small but growing number of children[6] that meet the criteria for a secure order who are being deprived of their liberty in unregistered settings because of a lack of registered secure children's home places. Courts do not take such decisions lightly. Deprivation of liberty orders are often made following a nationwide search for homes, and often after the child has experienced multiple home breakdowns.[7]

Recent analysis of the increase in the use of DoL orders has confirmed the complexity and severity of risk faced by children subject to DoL applications and highlights an urgent need for increased resource, creativity, and collaboration across all systems responsible for the care of these children to better meet their needs.[8]

Setting up the crisis placement

In unregistered settings there is no external regulatory oversight of the suitability and experience of the staff, the facilities, or the care arrangements. The growth in the use of these provisions for children with complex needs and challenging behaviour is being driven by two interrelated factors. The first is that demand for registered places is currently outstripping supply. The second factor is that registered children's homes are becoming increasingly reluctant to accept children with highly complex needs and challenging behaviours due the risks this may pose to their Ofsted registration.[9]

[4] When a place for a child cannot be found in a welfare, youth justice or mental health setting, the High Court can use the powers under its inherent jurisdiction to make a Deprivation of Liberty Order, which gives permission for a child to be deprived of their liberty in an unregulated placement.

[5] Children are in 'extreme crisis': top judge berates DfE's six year failure to tackle gross lack of secure units. Community Care article 31.01.23

[6] Applications for use of Deprivation of Liberty orders have risen by 462% in the last three years

[7] The Independent Review of Children's Social Care May 2022

[8] Legal outcomes of cases at the deprivation of liberty court. Nuffield Family Justice Observatory June 2023

[9] Use of unregulated and unregistered provision for children in care DfE Research report February 2020

Multiple reports and court judgements in recent years have highlighted the lack of availability of appropriate care for the small cohort of children with complex and extreme needs. As a result, local authorities have no option but to create a highly bespoke placement in the community with intensive wrap around support, while suitable alternatives are sought, costing tens of thousands of pounds per week and requiring court authorisation. The courts will only authorise such unregistered placements in an emergency and if providers are taking steps to secure registration with Ofsted[10] The independent review of children's social care[11] found that there is a lack of flexibility in existing care standards and regulations allowing for the creation of bespoke packages of care that can be registered.

The placement identified for Child X was an empty assessment unit which is part of but separate from a semi-independence care provision. The care staff from the two nursing recruitment agencies that had been working with Child X at the secure unit were commissioned to continue working with her on a staffing level of 5:1. Although this setting was not deemed appropriate (clinical, sparse, no kitchen) and it was unregistered, part of the rationale was that the building was designed to limit possibilities for self-harm which was a risk for Child X. However, the review heard that despite the imperative for Gloucestershire to secure Ofsted registration as soon as they could there was no possibility of this because of the unsuitability of the accommodation.

The nursing recruitment agencies understood they were supplying temporary care staff who would be under the 'supervision, direction and control' of Gloucestershire Council. The staff who moved with Child X had been trained and supervised by managers at the secure unit. It is understandable that in the first 24 – 48 hours of the placement structures and management systems were not established. This was an emergency with the focus on ensuring as stress free as possible a move for Child X. However, this situation continued for the next nine months.

Records of the commissioning process for the care staff are poor (relying on stored emails) and staff and managers in the agencies and in the Commissioning Team have now left their organisations, so some key managers were not available to contribute to this review. There is no record that Gloucestershire undertook their own due diligence checks on the agency care staff, presumably relying on the secure unit to have done these previously. The Commissioning Team noted that CAMHS and social care provided training to the agency care staff but there is no evidence that this happened, and the review was told that the social worker would not have been in a position to do this. This demonstrates the level of misunderstanding and miscommunication between commissioning and operations.

Agency 1 has two teams that provide different levels of support to their staff within its organisation depending on what type of service commissions them. The Mental Health team provides staff to work in a registered mental health setting (e.g., hospitals, residential care) It seems extraordinary that two national nursing recruitment agencies provided staff for nine months with little knowledge of the management arrangements for these staff. There are lessons to be learnt for both these agencies and they have undertaken their own internal reviews. Both have committed to sharing their internal reviews with the GSCP once completed.

[10] In September 2021 amendments to the Care Planning, Placement and Case Review Regulations, made it illegal to place children under 16 years of age in any kind of unregulated placement. The types of placements that are now banned for under-16s are ones that are not registered children's homes.

[11] The independent review of children's social care Josh MacAlister May 2023.

This highlights the importance of very clear expectations, communication and information sharing between commissioners and commissioned services. There was no outcomes-based contract or service level agreement with the care agencies outlining the roles, responsibilities, and expectations of the staff and how they were to be supervised and managed. Each shift had a senior (grade 8A) nurse from agency 1 who had a remit to oversee that shift but there was a lack of clarity about their role, how they were expected to oversee staff from agency 2 and no consistency between shifts with different staff taking on this role. Agency 1 has no records of any meetings between the agencies. No one could tell the review who was responsible for supervising the shift leader and what the lines of accountability were. The commissioning process, quality assurance arrangements and management oversight during the nine months appear to be at best very poor and at worst non-existent.

Child X's stay at Placement 1

There was a high turnover of managers and staff in Gloucestershire commissioning and social care, most of the key staff and managers at that time were temporary. The temporary agency social work team manager had been in post for two months and the social worker was also temporary and relatively new to the case. In recognition of the complexity a newly qualified social worker was allocated as additional support to try to develop a relationship with Child X. None of the staff and managers from Children's Services who were there in October 2021, apart from the IRO, are still in post. Consequently, there are very few professionals in Child X's life who know and understand her story.

Social care was responsible for managing the placement, but the team manager made it clear she would not perform the role of a residential unit manager in addition to the team manager role. In fact, she did not visit Child X in placement after receiving a threat from Child X. There was no equivalent to a registered care manager to fulfil the range of care management duties including overseeing the daily operations and supervising the staff, it was effectively unmanaged.

Health professionals for children in care did not feel valued and they were concerned about the effectiveness of multi-agency working, poor communication and delays in involving them. The children in care nurse was concerned that the placement could not meet Child X's health needs and they struggled to obtain information to formulate assessments and plans for her. Health staff found that frequently when children were returned from out of county, often with little notice, none of their medical history was available for local health providers to ensure a timely response to their needs. For example, with no medical history it is not possible for hospital emergency departments to develop management plans for these children with complex needs. The named nurse found that the lack of a care manager in the placement meant that there was not sufficient attention paid to Child X's health needs, her health care plan had not been shared with the care staff and there were specific concerns about the storage of her medication. There was a long delay in registering her with a local GP and difficulties in arranging appointments and getting information.

Gloucestershire had commissioned a specialist psychologist assessment while Child X was in the secure unit which was not shared with the multi-disciplinary team in Gloucestershire. This meant that the assessment and planning for Child X's health needs was fragmented and not well understood by key professionals. The children in care health team has highlighted the lack of governance and joined up approach to commissioning private health assessments that sometimes do not lead to effective outcomes or input from the health professionals working with the child as part of the multi-disciplinary team.

CAMHS offered advice to support Child X's emotional needs through discussion at the weekly multi-disciplinary meetings but was not able to work directly with Child X because she was unable to engage. It was not surprising that given her past trauma and adverse childhood experiences she would struggle to form a therapeutic relationship with a CAMHS professional while living at Placement 1. Children with complex needs and extreme behaviors often struggle to engage with direct therapy and respond best to a therapeutic approach being embedded in their day-to-day care with skilled and supervised carers providing a therapeutic framework of care. The review heard that the current commissioning arrangements for CAMHS do not allow for a flexible approach to providing services to those caring for children in care with extreme and complex needs where mainstream approaches are not appropriate. At one time Gloucestershire had developed an Intensive Recovery Intervention Service (IRIS) for children in care with complex needs but this service no longer exists.

Even the basics of safety and containment were not achieved, she had access to cannabis and tobacco[12], she absconded at times. She was groomed and sexually abused resulting in pregnancy. In the absence of clear boundaries, it appears that Child X took control of the unit. She would choose which staff she would 'allow' on shift and make others stay outside in their cars for their entire shift. This need to take control is often a response to a lack of stability or feeling contained. Child X's mother highlighted the irony of Placement 1 being selected as a building that could minimise self-harm but in fact Child X was abused by the staff who were meant to be caring for her.

Research[13] highlights how crucial high-quality leadership is in residential settings to ensure children are safe and all their needs are met. They outline the risks if a 'closed culture' is allowed to develop within a residential setting. A closed culture implies a poor culture that can lead to harm, which can include human rights breaches such as abuse. The five key risk factors set out in the review were all factors in Placement 1:

- Weak leadership and management.
- Children experiencing poor quality of care, support, and outcomes.
- Poor skills, experience and training of the staff providing care and support.
- Staff not encouraged to raise safeguarding or wider practice concerns and not supported if they do so.
- Lack of external oversight.

This case demonstrates all these elements of a closed culture at Placement 1 that led to Child X being harmed.

Poor communication hindered the progress of education assessments and plans. For example, the simple matter of obtaining social worker consent for an educational psychologist assessment was delayed for weeks. SEND[14] was not invited to multi-disciplinary meetings initially so were kept out of the loop and there were significant delays to the review of Child X's Education, Health and Care plan.[15]

[12] A subsequent disclosure revealed that she was provided with cannabis and tobacco by some of the agency care staff

[13] Safeguarding children with disabilities and complex health needs in residential settings. The Child Safeguarding Practice Review Panel 2023

[14] Special Educational Needs team

[15] An **Education, Health and Care plan** (**EHCP**) 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.

There was a lack of emphasis on the importance of education for Child X. The Virtual School was not kept fully informed or included in care planning. The Virtual School needs to work closely with SEND to review the progress of all children in care not on a school roll and all those in bespoke placements. The Virtual School and SEND must be recognised and valued as a key part of planning to ensure better outcomes for children and they should be involved in planning meetings as a matter of course.

Move to Placement 2

In January 2022 the Commissioning Team found a local provider, Placement 2 willing to care for Child X but it took several months to find a suitable building for her and then for the provider to be registered with Ofsted with Child X finally moving in June 2022.

Child X refused to move unless her care staff team moved with her and it was agreed that these staff would initially go with her but gradually be replaced by the provider's own staff. Placement 2 undertook due diligence checks on all the care staff and provided training on a trauma informed approach. They employed a behavior support specialist and therapist to work directly with Child X and to support the care staff. Relatively quickly after she moved several of the agency care staff left, possibly as a result of the increased scrutiny and management oversight.

Placement 2 effectively took back control from Child X. Commissioning advised them that Child X refused for a manager to be on site, but Placement 2 found this untenable and insisted on putting very clear boundaries in place including a manager. They also did not tolerate Child X dictating which staff were 'allowed' to come into the house. Placement 2 believe that the presence of a manager exposed several concerns about the agency staff and resulted in several referrals of care staff to the LADO. It is notable that during the previous nine months that Child X was at Placement 1 there was only one referral to the LADO.

Clear boundaries were put in place, daily care records kept, and an attempt was made to be very clear with Child X about who was accountable for day-to-day decisions. The unit manager and the social worker were the first line of communication for her. Placement 2 found this difficult at times because a pattern was established of managers up to Assistant Director level being directly involved with Child X.

In July 2022 Child X disclosed she was at least three months pregnant. Further information and disclosures raised concerns that a member of the care staff had abused Child X resulting in the pregnancy and this matter is now the subject of a police investigation. Agency 2 withdrew all their staff and agency 1 was not able to provide any more staff willing to work with Child X. Placement 2 found it untenable having staff on shift who were not trained and were not known to Child X and concerned about the viability of their Ofsted registration, they gave notice on the placement.

Placement 2, the new placement (Placement 3) and the midwifery service worked sensitively with Child X and her mother during the transition between placements to support her through the pregnancy and subsequent decision making.

Move to Placement 3

In September 2022 Child X moved to a third placement out of area. This was registered by CQC[17] as a supported living placement for young people 16 years and over. A house was identified, and a staff team recruited for Child X (now 16 years old) and she has remained there since the move. This placement has seen some positive progress for Child X, the DoL Order has been removed and the staffing ratio reduced slightly. As this was not a crisis emergency move there was the opportunity to carefully plan it. The location and property were selected to meet her cultural needs and took account of previous risks such as noise complaints and racially abusive threats towards neighbours to minimise the likelihood of this happening.

The behaviour support specialist and therapist moved with Child X to the new placement and there is a therapeutic framework for her care. Communication and decision making is clearly defined, and clear boundaries are in place. There are weekly meetings with the social worker and Child X which has prevented the teams around Child X from splitting. The approach of changing to a supported living approach with goals to promote Child X's independence has been positive. All staff receive non-violent resistance (NVR) and trauma informed training. This placement has identified consistency in the response of all professionals as crucial to the success of the placement for Child X. The importance of clear communication, strong governance, integral therapeutic and behavioural support and meeting the child's cultural and identity needs should inform the future development of placement provision for children with complex and challenging behaviours.

The child's voice, culture and identity

Child X told the reviewer that when she was at Placement 1 the staff did not keep her safe, in fact there were no boundaries in place. She was sexually abused by staff. She felt she was given anything she asked for, trips out often far afield, expensive meals out, takeaways three times a day and even cannabis. There was no one that Child X felt she could talk to, the care staff were always there. In fact, getting all the material things that she asked for while on a DoL order felt ok in her situation. She asked the reviewer, "if so many professionals were worried about me being at Placement 1 why did no one take me out of there?" She did not recall any professionals doing unannounced visits as a way of checking the placement. During the year under review Child X had two temporary agency social workers and for a very short time a newly qualified social worker was allocated as additional support. The social workers at that time complied with statutory visiting frequency of 6 weekly visits but she refused to see them if they went unannounced. Given the high risk and vulnerability of this placement there should have been more frequent social work visits and oversight.

The review found that (apart from the IRO) there were no professionals involved with Child X during this period with whom she could have had a trusting relationship or who knew her and her story well. Research[18] has highlighted that the value of children in care having at least one trusting relationship is undermined by the high turnover of social workers.

[17] Care Quality Commission

[18] Children's Commissioner report on improving provision for looked after children January 2022

The Child Safeguarding Practice Review Panel[19] recommends the provision of independent advocates for children with disabilities and complex health needs. A recent GSCP review[20] recommended: "Where there is little or no evidence that a child feels they have a trusted professional all efforts to understand and improve that situation must be considered and acted on…… professionals should ensure that the role of the trusted professional or adult is explicit within the children in care planning process."

There was little evidence of her cultural identity needs being considered in care planning and placement commissioning until she moved to Placement 3. Research has found that often placements are unable to promote black culture and identity. Young people said that this "has an impact on how we see ourselves and on how our hair and skin is cared for. Placements are often unable to prepare us to return to and be a part of our community, impacting on how we see our community. These placements also fail to prepare us for the racism and discrimination we may face in the world we live in and can often not be seen as a safe space, where our voice in regard to our culture and identity can be heard and understood."[21]

Within her placements Child X was highly vulnerable but also powerful, and the lack of boundaries enabled her to dictate who she would see and when but also left her largely unseen and unsafe. The review questioned whether there was an element of unconscious bias taking place with Child X in the sense that she was perceived as having more understanding of her actions and the consequences of her actions than she did. Adultification is a form of bias where 'children from Black, Asian and minoritised ethnic communities are perceived as being more 'streetwise', more 'grown up', less innocent and less vulnerable than other children'.[22] Adultification can lead to a victim-blaming narrative, which implies Black children are somehow complicit in the harm experienced. This narrative can be complex and challenging and requires organisations to promote environments which "embrace critical challenge and safer spaces for all professionals to engage in potentially new and uncomfortable conversations about racism and discrimination".[23]

Child X's mother tried to voice her concerns about Placement 1 and challenged her access to cannabis but in fact she felt blamed and suspected of providing the drugs herself. She recognises the challenges in caring for Child X and is concerned that by missing out on education Child X has not been able to develop basic academic skills or normal peer relationships and has many challenges ahead of her in adulthood. Child X's mother has not felt listened to or involved and is not entirely sure about how much of a role she can play in her child's life in care. She told the review that she is not routinely involved in child in care reviews. There was a high turnover of social workers and managers in Child X's life, and, like Child X, her mother was not able to develop trusting relationships with professionals. There is no evidence that her own experiences, personal history, and cultural identity were considered by professionals in their interactions with her.

[19] Safeguarding children with disabilities and complex health needs in residential settings. The Child Safeguarding Practice Review Panel 2023

[20] Gloucestershire Safeguarding Children Partnership 2023 CHILDCLCSPR0220

[21] The Black Care Experience Report Denton L. 2021

[22] Safeguarding children who come from Black, Asian and minoritised ethnic communities NSPCC April 2022

[23] Adultification bias within child protection and safeguarding Jahnine Davis HM Inspectorate of Probation Academic Insights 2022/06

Clearly, she has struggled as a parent, but she desperately wants to be involved with and supportive of her children. Unconscious bias might lead practitioners to interpret behaviour differently depending on the ethnicity of the person displaying it.[24] Reflective supervision is important to support staff to consider their interactions with children and their families and identify strategies to engage them meaningfully. There is little evidence of such reflection by the professionals in this case.

How Gloucestershire commissions placements and care packages for children with complex needs

The referral section of the Commissioning Team, comprising 3.5 staff, is responsible for commissioning all placements and care packages using the profile completed by the social worker. This form (P2) outlines the care plan and the child's needs, but it does not specify the required outcomes from the placement. Providers told the review that the P2s for Child X were inaccurate with out of date or missing information. In such a high-risk complex situation the P2 should be updated on a very regular basis to ensure that commissioning are fully informed of what they are being asked to commission. Gloucestershire is part of the Southwest consortium which has a list of pre-approved providers in its framework. Outside of the framework the team approaches other providers and does its own due diligence and quality checks. The team can be looking for 70-80 placements and packages each month and their time is taken with finding, commissioning, and processing contracts. There is no capacity to focus on quality in any detail.

Health and education were not consulted in the commissioning of placements or support packages for Child X despite her very complex needs. The rationale or the reason for the care staff to be mental health nursing staff was unclear and not subject to review although there were no identified psychiatric needs. CAMHS advised that Child X needed staff who were experienced in supporting young people with chronic and complex emotional dysregulation.

The Commissioning Team did not work in partnership with the SEND team who had responsibility for commissioning specialist education provision. The Virtual School use of pupil premium and educational psychologist to commissioning education packages was not integrated into placement commissioning.

Recent research highlights the importance of taking a multi-agency approach to commissioning for children with complex behaviour and health needs and that the children in care health team should be included in quality assurance visits to placements and decision making as a matter of course.[25]

The longer-term plan was for Child X to move from the crisis placement to a refurbished property in Gloucestershire where a bespoke care package would be provided for Child X which could be Ofsted registered.

[24] Safeguarding children who come from Black, Asian and minoritised ethnic communities NSPCC April 2022

[25] Safeguarding children with disabilities and complex health needs in residential settings. The Child Safeguarding Practice Review Panel 2023

This plan was led by senior managers in commissioning. There was no multi agency approach to planning this, for example education was not consulted on the design of the proposed bespoke newly refurbished placement where, given she was not able to be educated in a conventional setting it was likely education staff would be asked to provide alternative education within the new unit as they attempted to do at Placement 1. The timescale for this plan was unachievable and the building work did not get off the ground. There was a tunnel vision approach to this planning in that, under pressure people tend to narrow down their focus to make a task more manageable. By focusing on this refurbishment, commissioning and social care were slow to notice that the plan was unfeasible or to formulate a contingency plan. When concerns were expressed about placement 1 the response from commissioning was that this was the best that could be provided, and that the placement was short-term pending the move to the bespoke placement.

Individual placement agreements are not outcomes based and they tend to be generic rather than specific to the needs of the child. There were no such agreements with the care agencies 1 and 2.

Placement commissioning for Child X was (and still is) done in 3-month blocks. This means that the current placement provider has secured the rental of the property she is housed in for a 6-month block and a care staff team on temporary 3-month contracts. This restricts how they can recruit and drives up the cost because they use agency staff rather than recruiting on a longer-term basis. Constant short term planning means that Child X and her care staff are always planning for the next move. Child X has become accustomed to this and although she says that she wants a permanent home she is unable to look beyond the very short term.

This short-term planning also makes it impossible to plan for or to meet Child X's post 16 educational needs. SEN further complicates this because responsibility for SEN moves with the child and if they are in a temporary placement the receiving local authority will not assume responsibility, so the child remains in limbo in terms of educational provision. Placement 3 is out of authority and the virtual school and SEND are unable to put a post 16 education plan in place for her because her care plan continues to be on a 3 monthly basis which means they do not yet know where she will be living. Child X's express wish is to be placed within the area that her mother lives, but no placement has been identified hence the continued temporary nature of her care plan.

The quality of governance and decision-making in care planning

Over the course of nine months Placement 1 did not progress from being a crisis placement to having clear structure, defined outcomes and a framework of management and accountability. One explanation might be that there was a 'drift into failure'[26], when what, with hindsight looks like negligence with respect to expected policies and procedures looked at the time like an acceptable way to behave as a way of coping with excessive demands and, in this case, a highly complex case and a chronic lack of resource.

Child X 's placement and care plan were monitored and overseen through several different processes, meetings, and panels. The review found that lines of accountability and responsibility for planning and decision making was unclear which resulted in confusion and lack of action with staff being unclear about their roles and responsibilities.

[26] The Field Guide to Human Error Investigation Dekker S 2002

Ultimately this led to a fragmented approach to Child X's care where she took control of her immediate environment and decision making herself.

Weekly multi-disciplinary team meetings, chaired by the social care head of service, lacked structure. Professionals described them as a 'talking shop' with no clear purpose and no smart actions or follow up. The meetings seem to have covered day to day decision making, heard concerns from agencies and discussed the plan to build a new placement for Child X. Decision making tended to be reactive rather than pre-emptive. This might explain why such significant omissions such as training and supervising the care staff, appointing a unit manager and the lack of daily records were not resolved. Notably staff or managers from the care agencies rarely attended these meetings. Professionals had a sense that there was no one in overall control of this case.

The High-Cost Placements Panel, chaired by the Executive Director and attended by directors of Children's Services, commissioning and education and latterly a representative from health, was the forum for directors to receive updates and recommendations about the case. SEND managers were concerned that this panel focussed on the care needs of the child rather than taking a holistic view to planning and oversight. Clearly these meetings serve to inform senior managers of the most complex and high-cost cases in the local authority. However, there are no terms of reference, and the review was unable to establish their role in the overall governance of Child X's placement and future planning.

Gloucestershire's quality assurance arrangements for placements and care packages including the quality and competence of professionals commissioned to look after children with complex needs.

Commissioning had no formal quality assurance arrangements for Child X's placements or the care package at Placement 1. There is no record that even the most basic due diligence checks were undertaken on the staff when she moved from the secure unit to Placement 1.

A commissioning quality assurance team (CQAT)was established in 2020 situated outside of Children's Services with a remit to undertake due diligence checks on providers of a range of commissioned services including but not exclusively children's placements. Despite its name this team has neither a remit nor the capacity and expertise to quality assure complex individual placements and packages of care for children with complex needs. For example, currently there are 528 commissioned care packages in place of which about 25 -30 are very high cost for young people with complex needs. There is a lack of clarity in the organisation and even within commissioning as to the exact function of the CQAT team. The brokerage function and the quality assurance functions sit under two different heads of service within the commissioning service with no operating procedures or established communication between each of these.

The Independent Reviewing Officer (IRO) has a responsibility to quality assure care plans and their delivery. It is positive that Child X's IRO was one of very few consistent professionals in her life who has known her family for four years. Aside from statutory child in care reviews Child X's IRO attended multi-disciplinary team meetings and discussed her care plan with the CAFCASS[27] guardian.

[27] Child and Family Court Advisory and Support Service

Health and education professionals were not involved in the review process and while it may not have been appropriate for them to attend Child X's review meeting there is no evidence that the IRO involved them in the process to assess how her health and education needs were being met. The IRO expressed concerns at the multi- disciplinary team meetings about the lack of a care manager at Placement 1 and the lack of progress in achieving the long-term plan (refurbishing a property from scratch). The IRO shared his concerns with the CAFCASS guardian but did not escalate them formally.

There was a litany of concerns about the suitability of Placement 1, the quality of the care staff and their ability to keep Child X safe and meet her needs. These were raised by social workers, the police, youth justice, education staff and health with the head of service usually at the multi-disciplinary meetings but they were not addressed. The review questioned the lack of formal escalation about this case. The newly qualified social worker raised specific concerns about the quality of the placement at Placement 1 in an email to the Director of Safeguarding and Care, but this was not regarded as a formal escalation. There was minimal response from the director with a sense that all the concerns were already known at a senior level, and nothing could be done to improve Child X's care. This social worker told the review that she felt compromised by her position in the local authority as a NQSW and undermined by the hands-on nature of director level involvement in the case. Although she continued to have concerns about Child X's care, she did not feel empowered to raise these externally.

At the time in scope for this review there had been a high turnover of senior managers and directors, and several temporary interim managers were in post. The review found that there was a culture of leadership where senior leader's involvement in the day-to-day decision making for this case meant that the staff involved became disempowered and were unable to use existing escalation polices to voice their concerns.

Understandably it was important for senior leaders to be fully aware of Child X's needs and to have some involvement in the decision making. The decisions for her to be placed in secure accommodation and subsequently to be moved to an unregistered placement required the endorsement of the director. The Director of Children's Social Care and the Assistant Director for commissioning submitted statements to the court outlining the decision making and the provision and plans for Child X at Placement 1 and the longer-term plan. Their involvement went beyond this to direct contact with Child X at times. Child X was visited by and in mobile phone contact with the Assistant Director of commissioning on several occasions. There are differing accounts of how well these interactions were communicated but practitioners found this contact unusual and felt undermined and disempowered by this level of involvement. The contacts were not recorded on Child X's electronic file, and it had the effect of blurring lines of accountability and at times gave mixed messages to Child X and her carers. While there was little effective therapeutic input or clear boundary setting for Child X at that time the fact that she felt able to go directly to senior managers with concerns or for day-to-day decisions disempowered the social work team and contributed to a sense of dysfunction and splitting of professionals.

The blurred lines of accountability between operational staff and senior leaders undermined many efforts to escalate concerns about this case. For example, a police officer was told by a social worker that there would be no point in escalating concerns because directors were already aware of the situation. Agency concerns about Child X were not raised externally through the Gloucestershire Safeguarding Children Partnership

Within Children's Services internal escalation of concerns are considered at director level and the Executive Director would refer concerns escalated to him back to Directors. There was a sense of paralysis amongst the professionals that nothing could be done to change Child X's situation and that escalation would be pointless. There was a lack of clarity about escalation policies (internal and external) and whistleblowing policies. There is no evidence that the professionals used reflective supervision or a multi-agency reflective process to assess and analyse the situation at placement 1 placing Child X and her needs at the centre of this reflection.

The CAFCASS guardian had been involved with Child X and her family for several years and was critical of the lack of key worker or manager at placement 1 and the absence of daily logs. As a result of her raising these concerns in court she was asked by the court to visit Child X weekly at placement 1 which is highly unusual. The CAFCASS guardian escalated her concerns to the local authority via the team manager as well as reporting them to the court, but they did not achieve the changes that were needed at placement 1. Efforts appear to have been focussed on explaining to partners that there were no alternatives to the situation that Child X was in while she was at placement 1.

The Interface between commissioning and operations services, how effective it is and how well it meets children and young people's needs.

The staff and managers in commissioning did not have professional social care knowledge and expertise. Is it apparent from this case that there was little understanding between commissioning and operational services of each other's roles and responsibilities. Roles in the commissioning team were not clearly defined. The weekly staffing rotas for placement 1 were compiled by the commissioning team from the list of available agency care staff. This meant that communication with the agencies and any information about care staff went through the commissioning team giving a false impression of their role and responsibility in day-to-day operation of the placement.

At times senior managers in the commissioning team went beyond their remit in their contact with Child X, making care decisions which had the effect of undermining the care planning process. For example, commissioning agreed for Child X to have an iPad at her request, she was allowed to retain key fob access to placement 1 after she had moved and, at Child X's request, commissioning reinstated Staff A onto the rota despite him being identified as unsuitable. The lack of recording in the commissioning team and the absence now of the managers who were involved at the time has meant that it has not been possible to unravel exactly by who and how these decisions and interventions were made but it was clear to the review that this involved senior leaders at director level.

The review found evidence of frequent communication between operational social care and commissioning about this case at the highest levels of management. This is evidenced in copious emails but there was a lack of formal recording of decision making and agreements. Commissioning did not have a clear record keeping process, information was stored in various folders on emails. They do not record on the child's Liquid Logic record. There was no single manager within commissioning charged with overseeing this case and keeping a central record.

Managing allegations against staff working with children

Placement 1 was a high-risk environment for Child X and for the staff and with no care manager in post it was difficult to have an overview of risk and concerns. During the nine months at placement 1 there was one referral to the LADO following an allegation by Child X of assault by a member of care staff which was subsequently unsubstantiated. Despite the concerns that professionals expressed to the social worker and to the multi-disciplinary team about the quality of Child X's care the LADO was not involved. When the police witnessed on more than one occasion what they described as a lack of compassion or support to Child X these concerns were not investigated.

The police were called out to placement 1 by staff on numerous occasions when they were assaulted by Child X or felt threatened. Police noted that the staff seemed to be unsupported, and they witnessed staff being uncaring and negative towards Child X. They were also concerned that despite being cared for on a 5:1 ratio she was able to access cannabis. When they raised concerns with social care though the formal route of a Vulnerability Identification Screening Tool (VIST) sent to the MASH[28] about the poor oversight of Child X and the staff attitude that they witnessed towards her there was no follow up by social care. The police were not able to account for why they did not request a strategy discussion and refer these concerns to the LADO.

Police officers complete a VIST when they are concerned about a potentially vulnerable person. These have become widely used and there is a sense that the number of VISTs being completed has reduced the effectiveness of this system. In effect an officer might feel that they have somehow dealt with a vulnerability issue through the process of using this tool and submitting it into the system. Any VISTs that identify a high risk are emailed to the social care help desk. In this case the VIST was emailed to Child X's social worker, but no action appears to have been taken.

The police vulnerability officer attended the multi-disciplinary meetings but did not have the operational information from the VISTs and so was not able to share police concerns at that meeting. The police have since rectified this procedural issue so that this officer always receives copies of VISTs.

In December 2021 the social worker raised specific concerns about Staff A from agency 2 who was found to be sleeping on his night shifts and asked commissioning to remove him from the rota. In May 2022 the team manager was concerned to discover that Staff A was back working night shifts. Evidence from emails shows that Child X had complained directly to commissioning about staff A being removed and it appears that he was reinstated on night shifts without the knowledge of the social worker. There were further allegations that Staff A was providing Child X with cannabis and another urgent request was made to commissioning to remove him from the rotas. Staff A was still on the rota when Child X moved to placement 2 and he was still sleeping on shifts. When this was discovered by placement 2, he was removed from shifts and a referral made to the LADO regarding 'professional neglect'. Despite numerous concerns raised about Staff A there is no evidence of any investigation or referral to the LADO. The concerns are documented in emails and case notes but were not taken further. The review was concerned at the lack of understanding by professionals in this case about their responsibility to identify and investigate concerns raised about staff working with children.

[28] multi-agency safeguarding hub.

The DfE is currently reviewing aspects of the LADO function and will publish a handbook setting out the necessary key requirements of the role. The National Panel[29] has recommended that these should include an understanding of the inherent safeguarding risk factors associated with residential settings, the risks associated with 'closed cultures', and the importance of multi-agency advice to the LADO to support decision making about whether thresholds for LADO intervention have been met.

Conclusion and recommendations

While this case is extreme and highly complex it is not unique. It reflects the national problem of a growing gap between the complex needs of children in crisis and the range and availability of services to meet their needs including secure accommodation and children's tier 4 mental health services. The Department for Education is responding to national reviews and the judiciary with some additional funding for secure homes and regional commissioning pilots[30] it will take time to see if these proposals have an impact on the situation.

Children who are subject to DoL applications are extremely vulnerable. They typically have multiple and complex needs that are evident in behaviours that can make them a risk to themselves or others. Most have experienced significant adversities such as rejection, bereavement, abuse, and neglect during their childhoods. There is an urgent need to develop new provision, at a local level, with joint input from children's social care, mental health services and schools. Gloucestershire's Placement Sufficiency Strategy recognises this and is undertaking to develop in-house, registered provision through their capital project.[31] Ensuring sufficiency at a local level is increasingly difficult given the challenges that exist nationally, and recent research and reviews have highlighted the need for local initiatives like this to be supported at a national government level[32].

Placement commissioning in Gloucestershire is under resourced and fragmented, there is no effective quality assurance, contracts are not outcomes based and there are no individual service level agreements or contract monitoring. Record keeping is inconsistent and not linked with the child's electronic record. There is no multi agency approach to placement commissioning which means that relevant professionals felt undervalued and struggled to play a key role in ensuring that Child X's education and health needs were met. Operational social care teams and commissioning do not fully understand the range and limits of each other's roles. Decision making and care planning were fragmented, and lines of accountability were blurred, there was a high number of new and/or interim staff and managers involved in this case and an underdeveloped approach to children's placement commissioning which resulted in a failure of leadership and a lack of clear governance and accountability.

[29] Safeguarding children with disabilities and complex health needs in residential settings. The Child Safeguarding Practice Review Panel 2023

[30] In response to this and the rising number of Dols orders being requested by local authorities for children who have experienced years of trauma and instability in their lives the government intends to create 50 new places in secure homes as part of a £259m investment in residential childcare from 2022-25. The Department for Education also plans to trial the establishment of regional care co-operatives (RCCs), groupings of local authorities that would take over the commissioning of care placements from individual councils, as part of its response to the care review.

[31] Placement Commissioning Strategy 2022 -2026 Gloucestershire Children's Services (to be published)

[32] How local authorities plan for sufficiency of accommodation that meets the needs of children in care and care leavers Ofsted November 2022

Recommendation 1

Undertake a comprehensive review of children's placement commissioning to:

- Ensure regular and robust quality assurance in partnership with social care, education, and health to ensure that providers can meet the needs and desired outcomes identified in the child's care plan as well as providing good quality care and value for money,
- Develop a framework of good practice to ensure that children's safeguarding, care education and health needs are addressed when creating crisis care packages, that may be unregistered, for children with complex needs,
- Develop the commissioning team's knowledge and understanding of children's social care and the role of multi-agency partners,
- Develop clear, auditable record keeping processes with decisions about children included on their individual electronic record,
- Consider the role of the wider multi-disciplinary team in planning, commissioning and quality assuring placements.

Recommendation 2

- There is no regulatory oversight of the suitability and experience of the staff, the facilities or the care arrangements in unregistered placements and the Safeguarding Children Partnership Executive should have knowledge and oversight of all children placed in unregistered settings and ensure that there is good quality governance and accountability.
- Across the Safeguarding Partnership governance and accountability should be strengthened so that it is clear who is responsible for day to day and longer-term planning and decision making for children in care and all multi agency meetings and panels need clear terms of reference, SMART actions, effective record keeping and regular review.

Recommendation 3

- Develop the CAMHS commissioning arrangements to enable a more flexible and responsive therapeutic response to children in care with complex needs and extreme behaviors that is underpinned by a trauma informed approach.

Recommendation 4

- The Virtual School should always be involved in planning placement moves and procedures to inform them (issuing a placement notification letter) must be followed.
- All transitions should be planned for and captured where possible and included as part of the Personal Education Plan. Any school (education) move should also have a school move protocol completed and the EHCP review should take place for those children who have a school move planned.

Recommendation 5

- The children in care nursing service must be involved when a child is placed out of authority to support careful and consistent health and care planning particularly in times of transition. Depending on the needs of the child, CAMHS should also support at points of care transfer (either in or out of area), aiding information sharing, careful planning, and the development of a shared approach to meeting children's needs.

Recommendation 6

- All agencies must develop a more robust and informed approach to assessing and meeting children's cultural, race and identity needs in placement commissioning and care planning.
- All agencies must ensure that there is an understanding of racism and bias that can lead to the adultification of some children where their vulnerability and support needs are not understood.

Recommendation 7

- Develop the role of independent advocate for children in care who do not have a trusted professional who knows them well. This will require a review of the current provision and its remit to assess its fitness for purpose including how the service is presented to the child as an option for support.

Recommendation 8

Strengthen the role of the IRO:

- Ensure all relevant agencies are involved in child in care reviews and as a matter of course, consult with children in care health teams and the virtual school as part of the review,
- Review and monitor the use of external escalation processes in challenging IRO concerns about care plans,
- Always consult and involve parents in the review process.

Recommendation 9

- The Safeguarding Children Partnership should challenge agencies on how they respond to escalation of concerns about children and to what extent within each agency there is a culture of openness to healthy challenge amongst senior leaders.
- Staff should be involved in reviewing and strengthening the Escalation of Professional Concerns Policy and the distinction between this and whistleblowing policies should be clear.
- Professionals should be empowered to seek external scrutiny of concerns where they feel these have not been addressed by senior leaders.

Recommendation 10

- Raise awareness of the role of the LADO and ensure that all partners understand their role and responsibility in contacting the LADO when there are concerns that an adult who works with children may have caused them or could cause them harm through abuse or professional neglect.