Lancashire Safeguarding Children Board
Serious Case Review Report

Re: Child LA

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Concise Review √

20 July 2016

Review Process

This serious case review was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) on 6th October 2015, in agreement with the recommendation of the LSCB Serious Case Review Sub Group that the circumstances surrounding the death of a child met the criteria for a serious case review.

Subject of the review: **Child LA: Aged 17 years.**

History and circumstances resulting in the review

Child LA was born in 1998 and at the time of death was living at home in Lancashire with birth mother. Child LA had two siblings, one was younger than LA of late primary school age at the time of the death, and an older sibling who was a young adult. All of the siblings had lived with LA and the birth mother for a large part of their lives, however other close family members, notably a maternal aunt and uncle had also provided care and support for LA and the younger sibling. For the purposes of the review the younger sibling will from now be referred to as Sibling 1, and the older sibling as Sibling 2. Significant adults involved will be referred to as their relationship to LA, so Mother, Aunt, and Uncle. LA's birth father had very limited involvement with LA but the two had recently met. He will be known as Father in this review.

It should be acknowledged early in the report that a key finding is the judgement that can be applied to children and young people in terms of their age and when they are considered by professionals and wider society to be classified as adults. This judgement can impact on the way they are treated and consequently the services which are offered and put in place. Children are children until aged 18 in law; *the Children Act 1989 defines a child as any person under the age of 18 (section 105(1)).* Therefore in this review Child LA will be referred to as a child to reinforce the fact that at age 17 and at time of death, LA was still a child.

The timeframe for the review period commences in April 2014, and methodology used and rationale will be explained later. There was involvement of services, particularly Children's Social Care, with Child LA and the family prior to 2014 but the focus of analysis on agency involvement and how these services worked together has been on more recent events. Prior to 2014 LA and Sibling 1 were in receipt of services from Children's Social Care as Children in Need, Section 17 Children Act 1989.

A child is defined as a child in need in law, if he or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services form the local authority; his or her health is likely to be significantly impaired, or further impaired, without the provision of services from the local authority; he or she has a disability, Section 17 Children Act 1989.

Previous concerns had related to Mother's capacity to parent the children, neglect and emotional issues.

Circumstances leading to this serious case review are summarised here:

The significant event at the start of the timeframe in 2014 was an incident in school when Child LA made an allegation, later withdrawn, that another student had been sexually assaulted by a member of teaching staff. The outcome of the investigation was, as well as the allegation being withdrawn by LA, the Police and school were able to corroborate that the incident could not have occurred. There was a history for LA at the school of absence and truancy, and one incident of suspected misuse of drugs. Consequently, after consideration of all the circumstances Child LA was transferred to a local medical school. The school supports children who have been, or who are at risk of exclusion, and also has a self-contained site for students who have medical difficulties, mainly associated with social, emotional and mental health issues. The move to the medical school was with the Child and Mother's consent, and a referral was made to the Child and Adolescent Mental Health Service (CAMHS) for LA to receive support.

In the spring of 2014 Child LA was twice reported as missing from home (MFH) to Lancashire Police by mother on consecutive days. LA was found each time in the company of another child who was well known to local services as being involved in child sexual exploitation (CSE). On the first MFH occasion the Police did not complete a Protecting Vulnerable People (PVP) report which would be shared with Children's Social Care and the Deter team, which is a multi agency specialist team responding to CSE in the area. A PVP was completed and shared by Police after the second MFH incident and as a result a joint Police and Children's Social Care visit took place and the child was seen and spoken to and advice was provided.

Within a month the Aunt of LA had contacted Children's Social Care to be considered as the primary carer for LA as she had concerns about LA's mother's parenting capabilities and was worried that LA was self-harming. As a result Mother, Aunt, the Children's Social Care support worker and LA met together to discuss options, after which Child LA went to stay with the Aunt. Soon after, the decision was made to close LA's case to Children's Social Care, therefore she was no longer considered to be a 'Child in Need'.

In relation to LA's education, at this time after taking all the examinations expected to have been taken, LA left school. In addition around this time CAMHS had decided to discharge LA from their service due to non- attendance of appointments.

In the Autumn of 2014 Mother reported to Police that Child LA had been raped the previous

evening. This allegation was quickly retracted by LA once enquiries had commenced and LA said sex had taken place with consent (LA was now aged 16), with a known partner. Police recorded that LA "admitted to telling lies all the time" and the investigation was closed with no arrests made. A PVP was submitted and shared with Children's Social Care, and Health partners due to mental health concerns relating to the fabricated allegation.

Children's Social Care received a referral as a result, as Child LA had been made homeless by Mother due to the retracted allegation. A social worker visited and spoke to both the Child and Mother separately. Records indicate that LA asked for support regarding being untruthful. Also noted was that due to LA's self harm Sibling 1 had gone to live with Aunt so as not to be exposed to the behaviour. There were other concerns over LA and Mother possibly drinking alcohol together, and home conditions were noted as generally poor. As a result of the visit LA was able to stay at home briefly but then went to stay with Uncle on a temporary arrangement.

One day later a referral was received by Children's Social Care from Sibling 1's primary school regarding possible neglect. A strategy discussion took place and a joint Police and Children's Social Care home visit was undertaken as part of the Section 47 investigation.

A Section 47 investigation: where there is reasonable cause to suspect that a child has suffered or is likely to suffer Significant Harm.

The concerns were substantiated but the children were no longer considered at risk of significant harm as they were safeguarded, staying with extended family members. The social worker at this time made a referral to Adult Mental Health Services as Child LA was then aged over 16 hence was required to be seen by the Adult Service rather than CAMHS. An initial assessment appointment took place within one week. Around the same time the social worker also arranged a visit to a local college for LA and they toured the complex together.

The short term arrangement that Child LA would stay with Uncle then broke down due to a missing episode and limited space at Uncle's home. Enquiries with other family members for accommodation included contact being resumed between LA and LA's birth Father, which had not taken place for six years. A number of care planning discussions took place within Children's Social Care and eventually, due to a suitable family placement being unavailable, LA was placed on a temporary basis with a *Barnardo's Nightstop* host family but the placement did not last. *Nightstop* provides short term emergency lodging accommodation. Sibling 1 was still residing with Aunt at the time but was subject to a further strategy discussion. This focussed on other concerns Sibling 1 had disclosed regarding emotional abuse when at Mother's home. Child LA was mentioned at the strategy meeting but the focus was on Sibling 1.

The emergency accommodation was short term and not a fostering placement, and as a result of this ending the availability of family accommodation was re- considered. Neither birth Father's home nor Aunt's, were an option, and eventually it was agreed that LA would return to the Mother's care at the family address. The wishes of Child LA were noted as to be at home with Mother.

An initial Child Protection Case Conference took place towards the end of 2014, as a result of the ongoing concerns and investigations regarding LA and Sibling 1. This was attended by a number of multi-agency professionals and both Mother and Aunt were present. The outcome of the conference was that Sibling 1 would be subject to a Child Protection Plan under the primary category of emotional harm with a secondary category of risk of neglect. Minutes from the conference show the outcome for Child LA as not being made subject to a

Child Protection Plan but to be supported via a Child in Need Plan. However other records regarding the conference outcome for LA state that support would be provided by universal services.

A week after the conference, information was shared by Adult Mental Health Services that LA had missed the last three counselling sessions. The Social Worker requested that the Child was not discharged from the service. There was a subsequent discussion as to whether LA had learning difficulties but this was discounted on previous history.
Around Christmas time Mother reported LA as missing from home and the Child was later found and disclosed having been in company with a child suspected to be at continuing risk of CSE, and a male. No offences were identified by the Police and a PVP was completed.

At the end of 2014 a case management decision was made in Children's Social Care that LA's case would close as a result of the Child Protection Conference's perceived outcome relating to support by universal services. However frequent contact with LA did continue due to the Social Worker being involved with Sibling 1, Mother and Aunt. A different Children's Social Care manager was then providing oversight of the case and as a result the new manager with the Social Worker reviewed then revised the status of Child LA to Child in Need. This was not shared with partner agencies who were involved.

Early in 2015 concerns for Child LA and risks of CSE became more apparent and LA was discussed at a multi-agency meeting held regarding risks of CSE to an associate of LA. *Safelink*, a local voluntary organisation which used to work in the area, were providing some support to LA regarding keeping safe from CSE and through this intervention shared information provided by LA that a new partner was involved with LA. It transpired the partner was a much older adult known to Police and other services. Concerns were also raised that LA was drinking alcohol with the new Partner and possibly taking illegal substances. Mother was aware of the new relationship.

A review conference took place for Sibling 1 with a unanimous decision that Sibling 1 would remain on a Child Protection Plan. LA was mentioned at this conference as being categorised as a Child in Need but there was no additional discussion or outcome for LA.

In the Spring of 2015 concerns continued for Child LA and the relationship with the Partner with a pattern of vulnerability emerging including missing incidents, association with older males and potential substance misuse. On one occasion Child LA did admit to using cocaine but this was not substantiated by professionals. Concerns were raised for LA's cognitive ability to understand danger and risk at a core group held for Sibling 1. The Police attempted to use preventative measures regarding the Partner's association with other younger children at risk of CSE, due to LA being over sixteen at the time, and some preventative legislation being not applicable to that age group.

A heated argument took place between Mother and LA, after Mother tried to prevent the relationship of LA and the partner. This resulted in Police attendance at the home who noted that the child admitted some substance misuse jointly with the Partner, but also some concerns that LA raised regarding other adult visitors who Mother allowed into the home resulting in alleged bullying of LA. A PVP form was completed and shared by the attending officers. Temporary extended family accommodation was arranged for LA after this incident but soon after LA did return home.

The relationship with the Partner continued and Mother appeared to approve, sharing her own rationale that at least LA's whereabouts were known. Home conditions at Mother's address were noted by professionals to be poor as were the home conditions at an address where LA was found to be often staying with the Partner. Sexual health advice was provided

to Child LA by Children's Social Care but LA denied that the relationship was sexual. This was confirmed by the Partner when LA and the Partner were seen together by a Family Support Worker.

In the Summer of 2015 Child LA called the Police regarding an allegation of assault and false imprisonment by the Partner. This was quickly retracted by LA and the investigation stopped. The relationship soon resumed and the Mother discussed her concerns about the relationship and LA's general demeanour with the Family Support Worker. A Child in Need Review meeting for LA was held and the concerns discussed by multi-agency professionals. The decision was that LA would remain on a Child in Need Plan. The voice of the Child was shared that LA wanted a relationship with the Mother and to return home. The Plan from this meeting indicates that LA would be supported to return home and to improve their relationship with Mother.

Child LA, just prior to their 17th birthday, attended the GP for contraception advice. Notes for the appointment indicate LA openly discussed the involvement of other services and the relationship with the older Partner.

A week before the date of LA's death the Mother informed the Family Support Worker that LA had returned to live at home and appeared unwell due to "withdrawing from drugs". The Support Worker visited and spoke to LA who claimed to have been taking illegal substances before the Mother had collected LA from the Partner's address. After the home visit a date for a professionals meeting was arranged by Children's Social Care in order that information could be shared (sadly, LA died before this took place). A referral to Young Addaction, a specialist drugs service was also made.

On 12th September 2015 Mother contacted the Primary Health Care Centre Out of Hours Service regarding LA who was said to have diarrhoea, vomiting, and was not eating. Mother also declared that Child LA had previously used drugs. Advice was given to take LA to the Centre but Mother said LA has panic attacks so could not attend. Advice was given to see the GP.

On 13th September Child LA was found collapsed, and died at home. The death was due to natural causes resulting from bronchopneumonia and pulmonary infarction, pulmonary embolus and femoral vein thrombosis. The interpretation of the toxicology results from LA was that there was no evidence to suggest that any drugs (within the scope of testing) or alcohol, were directly implicated in the death of the Child.

Legal Context:

A serious case review was commissioned by Lancashire Safeguarding Children Board, following agreement at Lancashire Serious Case Review Sub Group in accordance with Working Together to Safeguard Children (Department for Education 2015).

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulation 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
   (2) For the purposes of paragraph (1)(e) a serious case is one where:
   (a) abuse or neglect of a child is known or suspected; and
   (b) either (i) the child has died; or (ii) the child has been seriously harmed

and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The methodology used was based on the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final report of the review or in an action plan as appropriate.

Methodology:

Following notification of the circumstances of Child LA in this case, and agreement by the Chair of the Lancashire Safeguarding Children Board to undertake a Serious Case Review, a Review Panel was established in accordance with guidance. This was Chaired by Victoria Gibson, Business Manager for Lancashire Safeguarding Children's and Adults Board and included representation from relevant organisations within Children's Social Care, Health, Education and the Police. Amanda Clarke, an independent reviewer from Derbyshire was commissioned to work with the panel and to undertake the review.

The time period for this review is between 25/04/2014 and 14/09/2015 to reflect the period when the need for service involvement intensified for LA. Full terms of reference for the review are included in Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement. These were considered by the panel and provided opportunity for panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The Reviewer spoke to the Aunt of Child LA in April 2016 to gain an understanding of her viewpoint of the child's experiences and of the services offered. Account was taken of the views when writing the report and recommendations, and the Reviewer is grateful for her contribution. An offer was made by the Reviewer to meet with the Mother of LA but after numerous attempts to contact her no response was received.

The learning event was held in early April 2016 and was attended by 17 professionals who had had direct involvement with Child LA and/or the family, in addition to the Reviewer who

facilitated and chaired the session, and a LSCB officer. The learning event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded of the event. With the support of panel members and the Lancashire Safeguarding Children Board team, further enquiries were made with professionals who were unable to attend the learning event, and this information is included in the report.

Following the learning event, the Reviewer collated and synthesised the learning to date for discussion with the panel. Practice issues originally identified by the panel were re- examined in the light of the findings of the review. This provided opportunity to identify issues requiring further clarification with practitioners or managers. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the panel in advance of the panel meeting in May 2016.

The Reviewer will offer to meet with significant family members to provide them with the opportunity to see a copy of the report when agreed by the Lancashire Safeguarding Children Board. Learning from the full report will be made publically available after consideration by the Lancashire Safeguarding Children Board Serious Case Review Sub Group and the Board.

ANALYSIS: Practice & Organisational Issues Identified

Child LA was engaged with a number of services during the period of this review, including Children's Social Care, Education, Child and Adult Mental Health Services, the Police, the GP, the Young People Service and the voluntary sector. Scrutiny of the timeline, information shared and reflections at the panel meetings and the learning event have highlighted areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together. The following is an analysis of the issues identified:

1. Age of the child

Child LA was seventeen and one month at the time of death. At the beginning of the review timeframe (April 2014) LA was aged fifteen and eight months but it should be acknowledged that professionals had been involved with Child LA, Sibling 1 and the family since LA was at least twelve years old. LA's age, and some professionals' views of what the age meant, had an impact on much of the interventions offered or attempted to be put in place throughout the timeframe of the review.

There were concerns that LA was at risk of CSE and professionals from 'Deter', the multi agency specialist team responding to CSE in the area, worked together to try to minimise the risk, protect the child and where possible investigate any criminal behaviour. CSE is a complex issue and Lancashire as an area has been commended numerous times locally and nationally for the work of individual professionals and for partnership working in response to CSE.

In this case creativity was used in terms of disruption tactics; Section 2 Abduction Notices for adult perpetrators were considered, although not applicable to LA as a victim due to age and circumstances but were applicable to other children present with LA in concerning scenarios and relevant to those children as they were under sixteen.

Child Abduction Warning Notices are issued to suspects / associates who are believed to place the subject at risk of offences being committed against them. There are two types of Child Abduction Warning Notices – one for a child under 16, who is not in the care of the

local authority and one for a child under 18, who is in the care of the local authority under section 31 Children Act 1989.

In other episodes involving LA, reported to the Police and Children's Social Care in particular, the Child's age was the overriding factor as to what the outcome was for the episode. It is positive that LA was identified as being at risk of CSE, however due to LA's age intervention did not always follow the highlighting of risk factors for LA. Professionals then faced the barrier of LA being over the age of consent, losing sight of the vulnerability of a child aged under eighteen.

Barnardo's Guidance on CSE: a Practitioner's Resource Pack states*; It is important to remember that just because a young person is over the age of 16, whether they are subject to a statutory order or not, it does not mean that they cannot be victims of CSE. A young person who has been subject to a complex pattern of life experiences does not stop needing support and protection when they reach the age of 16. They remain a vulnerable young person with on-going needs. A person's vulnerability will depend on their circumstances and environment and each case must be judged on its merits. Practitioners should take notice of their local child protection/vulnerable young person/adult protection procedures when considering 16 and 17 year olds. (February 2014)*

Child LA was five years older than Sibling 1 but both were still children for the purposes of the Children Act 1989 and should have been treated as such by Children's Social Care. Analysis of records regarding Children's Social Care intervention, and information from professionals at the learning event, suggests that LA's age was a substantial influence on decisions made regarding the level of needs which LA presented and subsequent service provision. The home conditions and parenting capacity of Mother for both children were the same and yet the outcome of the Initial Child Protection Conference in late 2014 was considerably different. This will be examined later in the report.

The Aunt of LA when contributing to the review shared a similar view that services "seemed to think, because LA was over sixteen, that they couldn't do much (for LA) because of the child's age".

The age of consent for any form of sexual activity in the United Kingdom is sixteen for both men and women, therefore in LA's circumstances, once becoming sixteen the age of consent had been reached. When LA attended the GP for contraception advice this was days before LA's seventeenth birthday. GP notes show, however, that LA disclosed being in a sexual relationship with a thirty year old Partner, and that Police and Children's Social Care were involved in aspects of LA's life. Days before, on the advice of the Family Support Worker, LA had also attended the surgery on another sexual health matter. Neither visit prompted the Health professionals to attempt any further information gathering or identification of risk. This may have been due to LA's age and this being over the age of consent. It is positive that the Named GP for Safeguarding in the area has already undertaken a training session for GPs in the surgery including awareness of CSE and the grooming process.

Identification of learning disabilities/ learning difficulties

A learning disability is a significant, lifelong condition that starts before adulthood, affects development and leads to help being required to understand information, learn skills, and cope independently;
A learning difficulty is any learning or emotional problem that affects or substantially affects, a person's ability to learn, get along with others and follow convention; mindroom.org.

Child LA was not known formally to have a learning disability or learning difficulties. That said it is evident throughout the timeframe that a number of professionals suspected that a learning difficulty was a possibility for LA, although LA managed to achieve grades for a number of examinations (GCSEs), and also pass an assessment during a visit and tour to a local college.

At the learning event the first secondary school where LA had attended suggested anecdotally that there had previously been an 'assessment' of LA's educational needs around 2012/2013 prior to the review's timeframe, and that a CAMHS referral had been made at the time but the family did not engage. The Social Worker for LA was unaware of this information and, if correct, this was a missed opportunity in terms of future interventions being informed by all available facts. Extensive enquiries to trace a formal assessment have proved negative, including with the local Special Educational Needs and Disability (SEND) team and the Young People's Service (YPS). The YPS work with children and families to support transition from school to other education and training. Professionals from YPS confirmed that they would normally be aware if a statement or other record of additional needs for a child existed, even if this was not recent. Such information for LA, with whom the YPS worked closely, was not known to the service.

The professional opinion of some Children's Social Care staff interviewed as part of the review was that LA presented as below their (LA's) actual age, but no formal assessment had been undertaken to determine this. The view of many of the involved professionals including those who knew and worked with LA the most was that LA was very vulnerable, whether due to a learning disability/difficulty, or circumstances, or both. LA's aunt was of the same opinion that LA was vulnerable. She also described LA as being "over-friendly" and not aware or able to understand friendship boundaries which made her (the Aunt) think LA did have a learning difficulty.

If Child LA did have a learning disability or learning difficulty this would mean that as well as sharing some of the same vulnerabilities linked to CSE as faced by all children and young people LA could face additional barriers to receiving protection and support to address CSE. The reasons for this are complex and appear to be connected to the way society perceives and treats young people with learning disabilities. *Addressing the sexual exploitation of young people with learning disabilities requires fundamental changes in societal attitudes and approaches to how this group of*
young people are treated and supported; Unprotected; Overprotected, Barnardo's for Comic Relief, September 2015

The overwhelming judgement of professionals was that LA did have additional needs but it appears that a request for a formal assessment was not considered within the timeframe of the review. Furthermore, despite much evidence of joint working between professionals throughout the case, there was a lack of communication and sharing of concerns between the professionals relating to LA's possible learning difficulties or disabilities. Recording of the professional judgement regarding Child LA's additional needs was also limited and this is explored later in the report.

Transition in mental health services

Child LA was referred to the Child and Adolescent Mental Health Service (CAMHS) prior to LA's sixteenth birthday meeting the CAMHS age criteria for the area where LA lived. CAMHS are specialist NHS services who offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. Most CAMHS see children up to age eighteen but if a child requires treatment and is over the age at which their local CAMHS stops seeing young people, they would need to be referred to the adult mental

health team, or to support services for older young people.

Different areas have different ways of organising their services and in the area where LA lived the upper age criteria is 16. Therefore when a referral was made to CAMHS after the false allegation at school, when LA was fifteen, this was dealt with by CAMHS as LA clearly fitted the age range for that service. When non attendance at CAMHS appointments became an issue in the spring of 2014, even though LA was still fifteen, CAMHS were already recognising that LA would need transferring to adult mental health services once reaching sixteen in the next few months. However, records suggest that in the last three months prior to LA being sixteen, although there was communication between Children's Social Care and CAMHS there was no evidence that a plan was in place for a safe exit strategy from CAMHS with part of this including plans for a safe entrance, or transition into adult mental health services.

It was at this point in the CAMHS intervention that LA had been failing to attend appointments but Children's Social Care referenced LA's access to CAMHS as a positive factor to influence the decision to close the case at LA's Child in Need review in 2014. In fact, LA had disengaged from the CAMHS input and ten days after the case closure by Children's Social Care, CAMHS informed LA by letter that the case was discharged back to the care of the GP, with no plan for future support or transition, or signposting to where other support might be accessed.

Within three months LA had self-referred to 'Mindsmatter', a service for over sixteens, with dedicated teams of Psychological Wellbeing Practitioners, Cognitive Behavioural Therapists and Counsellors who offer a range of support to help to reduce stress and anxiety and improve wellbeing. Unfortunately LA attended only two of the planned appointments and was therefore closed due to failure to engage.

Soon after, the retracted allegation of rape occurred resulting in LA's homelessness and the Social Worker's well intentioned, but misdirected request, due to confusion of the age criteria, for CAMHS support. This was quickly followed up by the Social Worker who had been advised to refer to Adult Mental Health Services as LA was now sixteen. A very prompt assessment appointment took place within days via the single point of access and it is positive that the Social Worker also attended to support LA. Further intervention was planned.

The Department of Health has continually highlighted the need for a *'coordinated multi-agency approach'* to transition planning. Whilst accepting that Child LA had been discharged from CAMHS for non engagement six weeks prior to being sixteen there was limited evidence in LA's case that any exit strategy or transition planning took place between the children's and adult mental health services once the new request for service had been made to adult services just two months after the sixteenth birthday. Successful transition depends on early and effective planning, which places the child or young person at the centre of the process to help them prepare for transfer to adult services.

Lancashire Care Foundation trust (LCFT) CAMHS transition to adult mental health services was the subject of a network priority audit on the organisation's 2015/16 audit programme. Several recommendations were made to improve this step in the patient journey. The two networks, children and adult services, have since worked together to review procedures and a new transition protocol has been agreed. A further audit is planned for this year, to measure how the new procedures are working and to identify any additional steps that may be necessary. Each CAMHS Team now has a Transition Champion; monthly meetings take place between the CAMHS Champion and identified Adult Mental Health Transition Practitioner.

Whilst acknowledging this positive step to improve transition between the two mental health services, there is a need to be more effective at recognising together that mental health support will be required by some children either side of sixteen years, even if those children don't realise that, and to be able to share information across the two services to assist planning how best to engage those who have been difficult to engage in the past.

An issue was raised at the learning event that CAMHS and Adult Mental Health Services have separate recording systems which can be a block to sharing information particularly on sixteen to eighteen year old children, or young adults who have accessed both services. If mental health practitioners or other professionals do not fully share all known previous treatment, the lack of an accessible electronic recording system adds to this being a barrier for an informed, holistic assessment. Other health professionals in the area with access to only 'one side' of the mental health system, such as the school nursing service could miss the opportunity to see important mental health information on children aged over sixteen who remain on school nursing caseloads but are being seen by adult mental health practitioners. In reverse the adult mental health service cannot access school health information on any of their 'older child' (sixteen and above) patients.

Professionals at the learning event provided some reassurance that they were generally aware and believed that most other colleagues also had a sound understanding of the age criteria for mental health services in the Lancashire area. However, misunderstanding the age referral criteria may lead to error for the direction of referrals, which may cause delay. The Lancashire Safeguarding Children Board may decide it is time to encourage relevant partners to reconsider the arrangements for mental health provision for sixteen to eighteen year olds, particularly as the majority of provision nationally is for CAMHS to see children until they are eighteen.

Decisions and outcomes regarding Children's Social Care intervention

In early 2014 LA was known as a Child in Need in terms of Children's Social Care involvement. This is the level of intervention below children requiring a Child Protection Plan, but a Child in Need plan is still in place with expected outcomes for the child, and involvement of a professional from Children's Social Care. After a recent inspection of Children's Social Care locally, the directive is that the professional involved will now be a Social Worker.
In the first six months of 2014 Child LA had moved schools due to a serious false allegation against a staff member, had been reported missing from home twice, was suspected to be self harming and was associating with friends involved in CSE. Furthermore there were concerns regarding Mother's parenting capacity, including no encouragement for LA to attend CAMHS, with CAMHS involvement ending due to the lack of engagement. LA was staying with Aunt around this time but not as a permanent arrangement. Records from the Child in Need review which was held in mid- 2014 show the review was attended by multi agency professionals but the concerns as detailed above do not appear to have been considered in full. With LA's position at the time including an unstable living arrangement, leaving school with no definite forward plan for education or training, and the recent events leading up to the review, there appears to have been an overly optimistic view of what had been achieved for LA and the issues which still remained. LA was fifteen at the point when Children's Social Care closed their involvement once LA had been removed from the Child in Need plan.

In the autumn of 2014 as a result of another serious retracted allegation, Mother said LA could no longer live at home. Children's Social Care records indicate that LA, who was then sixteen, was 'fragile and distressed' by the decision, and evidence of previous self harm was

noted. Home conditions were said to be poor. Coincidentally the next day Sibling 1's school made a referral to Children's Social Care regarding concerns of emotional abuse and neglect for Sibling 1. At this point a strategy discussion with multi agency input was held and a decision made to undertake a Section 47 investigation. A joint Police and Children's Social Care visit took place to the home where conditions were very poor. As part of the investigation both children were spoken to but both were considered as safeguarded as staying (separately) with relatives on a temporary basis. A planned Child and Family Assessment which determines further need, was the outcome of the investigation. Within weeks the family placement for LA had broken down and finding alternative accommodation was challenging. Records do indicate that *Section 20* voluntary care was considered for LA.

Section 20, Children Act 1989; the local authority has a duty to provide accommodation for 'children in need'. This accommodation– either in foster care, residential care or a family placement can be long or short-term, and does not involve the courts. The parent retains full parental responsibility.

However no appropriate family accommodation was available and attempts at other placements were unsuccessful. Foster care was not considered due to LA stating the wish to stay with Mother. Professionals at the learning event who worked closely with LA shared the view that whatever happened in LA's life, it was clear that LA did not want to live anywhere else other than with Mother at home and being over sixteen LA was entitled to refuse voluntary care.

A second strategy discussion is recorded as taking place a month after the original referrals on LA and Sibling 1, but this appears, only to consider Sibling 1. However, it was clear, at this time, that the Social Worker was trying hard to support and work with LA and subsequently LA returned to Mother's care, with some improvement noted to the home conditions.

A month after the second strategy discussion an Initial Child Protection Conference was held for both children. As detailed earlier, the outcomes for LA and Sibling 1 were not the same. Furthermore early recording from the conference is confusing as to whether LA was classed as a Child in Need under section 17, or not. Professionals who attended the conference, and who participated in the review's learning event, recalled that there was a significant difference in how the two children were considered in terms of risk, with LA's age (sixteen and 4 months at the time) being a major factor in LA being seen as at less risk of harm. There was also suggestion that some professionals did not agree with the conference decision for LA but felt unable to dissent from the majority view. One reason given for this was lack of experience and confidence in a conference setting.
The purpose of an Initial Child Protection Conference *is to bring together family members, the child (where appropriate), supporters/ advocates and those professionals most involved with the child and family to share information, assess risks and to formulate an agreed plan of management and services, with the child's safety and welfare as its paramount aim; Lancashire Safeguarding Children Board Child Protection Procedures 3.5.* Due to the outcome and views shared regarding this specific conference, management of conference processes generally and participation by some professionals may need review.

The conference minutes show that LA was described as "no longer a child but a school leaver, and able to consent to sex". Whilst this was partly true, the context and known circumstances for LA make this description, without consideration of other known facts, open to challenge. A sense of over optimism in terms of what LA and Mother were capable of is evident throughout the conference minutes and as circumstances did not appear to improve for LA over the following nine months until the death, this optimism was questionable.

A number of concerns were identified for Child LA in the following months including missing from home episodes, a relationship with a much older Partner, poor home conditions at Mother's and where LA stayed with the Partner, CSE indicators, mental health issues, and possible misuse of illegal substances. These issues, and responses, are considered in more detail throughout the report.

It is clear, and was acknowledged by professionals at the learning event that the professionals involved with LA through this period worked hard to support LA and Mother in many ways such as joint visits, creative use of disruption tactics for CSE, and a real attempt to build trust and rapport with LA. However, despite numerous concerns there appears never to have been consideration of thresholds in terms of whether LA was at risk of significant harm. The concerns, when considered collectively over the relatively short period of which they occurred, should have resulted in at least a discussion regarding thresholds and risk.

There is evidence that management oversight occurred within the months leading up to the death, with the case being stepped up to Child in Need, and a review taking place five weeks before LA died, leading to the decision that LA was to remain as a Child in Need. It is encouraging that many actions from this Child in Need review had been completed promptly, in particular to try to support LA's sexual health needs. Substance misuse had been raised as an issue for LA but professionals closely involved were sceptical that LA was using drugs based on professional judgement and lack of firm evidence. This view is shared by LA's Aunt. Nevertheless, a referral had been made for specialist support to explore the substance misuse. Unfortunately Child LA died of natural causes before the most current interventions could have an impact.

Children's Social Care and other professionals working jointly on complex cases should be reminded of the need to use formal processes such as the *Lancashire Continuum of Need and Threshold Guidance* and for this guidance to be regularly reconsidered during involvement with families with changing circumstances and needs.

Responses to child sexual exploitation (CSE)

As mentioned earlier Police within the area where LA lived have been commended for their sound response to CSE. Professionals attached to the Deter specialist team participated in the review. They are highly committed to supporting the children who are referred to Deter, and are also more widely engaged with the local Police and Crime Plan priority to work with agencies to ensure that vulnerable children are protected. In LA's case it is positive that joint visits took place, information was shared to inform the wider CSE context locally and disruption tactics were considered and used where possible.
A barrier to the use of legislation to tackle CSE for LA was home status and age (once sixteen). Abduction notices were considered but currently there are only two types of Child Abduction Warning Notices; one for a child under sixteen who is not in the care of the local authority, and one for a child under eighteen, who is in the care of the local authority under section 31, Children Act 1989. Once sixteen, LA did not meet either criteria. Lancashire Constabulary should be applauded for their creative use of a notice in this case on a child who was under sixteen and in company with LA. Both children were viewed as at risk from an older perpetrator and the application of an abduction notice regarding the younger associate of LA was seen to benefit both children, although legally did not apply to LA.

Submissions from some Police Forces to the *Parliamentary Inquiry into the Effectiveness of Legislation for Tackling CSE and Trafficking within the UK, page 19, April 2014,* proposed that the police should be able to issue a notice in relation to 16 and 17 year olds regardless of whether they are in care or not. While looked after children are seen as vulnerable and are disproportionately likely to be victims of CSE, the majority of victims are not in care. As

was the situation for LA.

Lancashire Safeguarding Children Board may consider making a formal request for an update regarding progress on the recommendation made from the Parliamentary Inquiry that *the Government amends legislation in order to place the notices on a statutory footing and create an offence of breaching the conditions of a notice. It is considered unacceptable that young people should not be afforded the same level of protection on the basis of whether they are living at home or are in the care of the State; there should be consistent provision for all children, regardless of their legal status. The Home Office should also work with the police to ensure they receive guidance and advice on their use, Parliamentary Inquiry into the Effectiveness of Legislation for Tackling CSE and Trafficking within the UK, page 11, April 2014.*

In the timeframe of events for Child LA Protecting Vulnerable People (PVP) forms were submitted by Police officers and other Police staff as a result of attendance at incidents, some of which related to CSE. The PVP submissions were completed by front line staff, as well as specialist officers, which is positive in terms of awareness of risk. Only one reported incident of LA being missing at the start of the timeframe was not followed up by a PVP submission and unfortunately this was one of the times when LA was associating with a child suspected as involved in CSE. This was an oversight as all other processes regarding the missing episode and an appropriate assessment of risk were completed. Furthermore the other episodes in the timeframe requiring a PVP submission were all identified with required action taken. Lancashire Constabulary may wish to reassure itself that all frontline staff, officers or civilians, coming into contact with vulnerable children and adults are aware and understand the requirements of the PVP process and the importance of sharing information about risk.

Managing allegations which are retracted

A theme in the timeframe was the serious allegations made by LA which were quickly retracted. On three occasions Police were required to commence investigations, the second and third of which had links to CSE. The first report involved an allegation against a professional which was proven to have been impossible to have occurred. In the latter two allegations initial action taken was appropriate which included the arrangement of specialist medical examinations. However, once LA had retracted the allegations, enquiries relating to the alleged suspects in each incident were stopped.

In both incidents the suspects (who were different adults) were identified by LA and were known to Police, and in one of the allegations the adult was already suspected to be involved in CSE activity. There was no evidence to suggest LA was pressured or coerced to make a withdrawal statement but LA's vulnerabilities which have been highlighted throughout the review, could have impacted on the decision to retract, or indeed to fabricate or embellish the allegation. It is of note that a strategy meeting was not considered for either allegation, even though Children's Social Care was actively involved at the time with LA and the family. A strategy discussion did take place soon after the (second) retracted allegation but this was due to separate concerns referred by a school for Sibling 1. For both allegations by LA a strategy discussion, focussed on LA, may have enabled multi agency professionals to share information to inform the course of any investigation, including assisting the Police in their decisions regarding enquiries with the suspects. Despite the true version of events in both allegations remaining unknown, by not speaking to the alleged suspects an opportunity may have been missed to try to gather wider intelligence, and information relating to risk posed to LA and other children. The Police do need to respond proportionately to allegations and particularly when circumstances in allegations change, as in LA's case. However, opportunities to gather information, where possible, must be used, including when serious offences are withdrawn by children. The Lancashire Constabulary Public Protection Lead

with senior investigators and partners should explore how serious allegations which are quickly retracted, and particularly those relating to CSE, are managed in terms of actions taken regarding the alleged 'suspects'.

Responses to children who go missing from home

Missing from home episodes were a feature throughout the review timeframe, and children going missing, or absent, is widely accepted as an indicator of CSE. LA was found on a number of times, after being reported missing, to be in circumstances where CSE was known or suspected. On all occasions, except the first missing episode in the timeframe as discussed above, appropriate action was taken to share information regarding LA.

In total Child LA was formally reported missing to authorities seven times during the review timeframe of April 2014 to September 2015, albeit the last reported missing episode was six months prior to the death. The *Association of Chief Police Officers (ACPO*) definition of a missing person is *"Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another."*

The *Pan Lancashire Joint Protocol: "Children and young people who run away or go missing from home or care", September 2014* (known from here as the Joint Protocol) categorises three levels of risk for people reported as missing; these are standard, medium and high and the levels of police response are dictated by the category applied. It is of note, after earlier observations in this report regarding ages of children, that the *Joint Protocol* states *'no child under sixteen'* will be placed into the *'standard'* category. The risk to children aged between sixteen and eighteen who go missing is therefore considered to be different. That said, responses to the reports of Child LA going missing, and the categories of risk and response applied, did meet the criteria as set out in the Joint Protocol. Police did conduct face to face safe and well checks when LA was found or returned after a missing report, and as per the Joint Protocol, intelligence was submitted and information shared across agencies, particularly Children's Social Care. This was overseen by the Missing from Home Coordinator from Lancashire Constabulary and the Multi Agency Safeguarding Hub (MASH) Duty Manager.

The return interviews for LA were less robust. The Joint Protocol states *return interviews is the term applied to the safety, needs and risk assessment carried out by an independent person (someone not involved in caring for the child). It should include and in depth exploration of the reason the child left their home (as well as what risks they were exposed to whilst missing) and helping the child plan how to prevent repeat missing episodes. The 'return interview' is different from the police 'safe and well' check.* The Joint Protocol states the *local authority will prioritise return interviews but these should occur within seventy two hours of the child returning home.*

During the review timeframe Children's Social Care were continually involved with LA and the family, including at all times when LA was reported missing. There are three occasions within Children's Social Care recording when a formal return interview process is documented but information in the record is brief and does not meet the requirements as expected in the Joint Protocol for returns. In 2013 an Ofsted report on the issue of missing highlighted *in nearly all (ten) local authorities the limited evidence of effective return interviews with children undermined the capacity of professionals to learn more about the reasons and risks attached to children-missing episodes, Ofsted; Missing; a report to explore the effectiveness of arrangements to safeguard children and young people, including those who are looked after by the local authority, who are at risk of going missing or running away, Page 6, February 2013.*

What is relevant in LA's case is the professionals involved were often working very hard to also manage another concern or allegation within LA's family at the time of trying to complete a return interview. Therefore the absolute focus may not reasonably be expected to have been the missing episode, although such circumstances would not be an unusual scenario for professionals working with families with complex needs in authorities across the country. If more attention and scrutiny could have been applied to the reasons why LA went missing, interventions which were ongoing may have been informed and adjusted by what LA may have shared as to why the missing episodes occurred. The home and family circumstances are explored below.

In Lancashire changes have been made to return interview processes for children who go missing but who are not in the care of the local authority or considered as an open case to Children's Social Care. The Children's Society since 1st July 2015 was commissioned to undertake these interviews but unfortunately as Child LA was an open case and was not reported as missing from July to September 2015 LA did not benefit from an independent return interview which is part of the Children's Society offer in the area. Enquiries were made with the Children's Society regarding the process now in place for some children in Lancashire compared to the return service which was available to LA, and possibly others in the same position The arrangement whereby independent and dedicated professionals are conducting return interviews, and are able to focus solely on the missing episode seems advantageous for children, families and other safeguarding professionals. The completion and recording of return interviews for what could be viewed as the most vulnerable children; those in care or open to services, should be reviewed.

Engaging parents and carers

There were many incidents in LA's case where professionals met with Mother and attempted to support her. This was positive, particularly in view of Mother's lifestyle as described in agency records and in the opinion of the Aunt of LA (Mother's sister). Professionals at the learning event shared the view that Mother was not consistently difficult to engage and this is evidenced in records of home visits and in her attendance at some meetings. However there were concerns about Mother's ability to support and protect her children, and for her general parenting capacity. Interventions with Mother were planned and did commence but were rarely completed due to what could be described as her disengagement. Minor improvements were made to the home conditions but were not sustained, as discussed above. There was a sense that Mother "did just enough" to satisfy professionals. This could be described as disguised compliance.

The NSPCC Information Service in its *Summary of Learning from Case Reviews* suggests *"disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Published case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance. Learning from reviews highlights that professionals need to gather evidence about what is actually happening in a family, rather than accepting a parent's presenting behaviour and assertions. By focusing on outcomes rather than processes professionals can keep the focus of their work on the child", March 2014.*

Disengagement and disguised compliance, by parents and carers must be a standard area for discussion in supervision of professionals. In referring to reflective practice and the role of social workers and managers *Lord Laming stated "supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children", The Protection of Children in England: A Progress Report, March 2009 3.15.* Supervision needs to challenge the beliefs of professionals about apparent changes in

families and to seek evidence of actual progress. For all professionals, disengagement, resistance and disguised compliance should be included as a key area of concern when assessing risk to a child, and therefore be included in supervision discussions about decisions and risk analysis.

A recommendation relating to engagement of parents and carers has been made in the *Lancashire Safeguarding Children Board Serious Case Review: Child LB, 2016.* This highlights the need for continued scrutiny by the Board regarding this issue.

Threshold for neglect

It is known that LA and the family lived with a number of concerns including mental health issues, suspected substance misuse, self harm, sexual exploitation, emotional abuse and neglect. The home conditions were noted as being very poor by a number of different professionals at different times. It was positive that Children's Social Care staff in particular, on more than occasion, physically checked bedrooms, washing facilities and cupboards to judge the living conditions for the children. Sibling 1 eventually moved to live with Aunt as a result of concerns relating to emotional abuse and neglect and was made subject to a child protection plan. The outcome for LA was different, and the assessment and decision making regarding referrals is discussed earlier. There were differences also in terms of other accommodation options for LA due to ongoing issues including missing episodes, sexual exploitation, retraction of false allegations, suspected substance misuse, and the overriding fact of LA being sixteen.

LA mostly lived at home and was clear with professionals who considered the voice of the child that home was where LA preferred to be. Unfortunately any small improvements to the home conditions were never sustained and the environment remained mostly poor. There was also hostility within the address due to adult visitors attending parties which were said to regularly take place. Aunt of LA has spoken of the needs of both children being second to those of Mother and evidence in agency records supports this view. There was a lack of parental encouragement to ensure attendance at appointments for LA and no clear boundaries or general parental support within the home, including when the relationship started between LA and the older Partner. For a period after meeting the Partner, the couple stayed at an address which was in a similar state of neglect and disrepair, a fact noted by professionals who visited.

The conditions wherever LA lived during the timeframe were poor, especially where LA stayed predominantly, which was with Mother at home. Professionals did visit and record their concerns and at times challenged Mother about what they saw. However a sense of acceptance on the behalf of professionals appears prevalent of the conditions that LA lived in, as no action was taken other than advice given to Mother to make improvements. The understanding of 'what is good enough' is very subjective in that what is good enough for one group of professionals or a family, is not for another, as is the type of area and housing where people live. In areas where there is known deprivation the threshold for intervention for neglect can be higher. Furthermore and relevant to LA's age, adolescent neglect *is a significant problem within child protection, but focus on* (younger) *child neglect and other forms of maltreatment means that it can often be overlooked*; *Adolescent Neglect: Research, policy and practice; Rees, G., Stein, M., Hicks, L. and Gorin, S., 2011.*

Much of LA's behaviour was viewed by Mother as adolescent risk taking by choice but the behaviour was more likely to have been as a result of longstanding adolescent neglect in the home environment. In *Barnardo's Guidance on CSE a Practitioner's resource pack, February 2014*, a disrupted family life, a history of abuse and disadvantage, problematic parenting, going missing, poor health and wellbeing, drugs and alcohol misuse are all

vulnerability factors for CSE. These were all concerns in LA's life.

The definition for neglect includes the phrase "persistent and severe failure to meet a child needs", this does not mean circumstances and the environment have to get progressively worse, the threshold can be met by the neglect concerns not getting any better, despite professional intervention. Due to the subjective nature in agreeing the severity of neglect in a family, it is suggested that Lancashire would benefit from the implementation of a formalised neglect assessment tool such as, or similar to *The Graded Care Profile (GCP)* with the commitment from all agencies to use it. This would allow the threshold for neglect and emotional abuse to be promoted and used consistently. *GCP helps professionals identify risks of child neglect and potential harm more effectively and promotes positive change for families, while encouraging professionals to focus on the child's experience rather than on the adults' needs, National evaluation of the Graded Care Profile: NSPCC, Johnson, R. and Cotmore, R. 2015.*

Recording of professional judgement

Throughout the timeframe of the review, as well as concerns relating to LA having a learning difficulty or learning disability, there were some concerns suggesting that LA was misusing substances, particularly in the last six months prior to the death. There was also reference to LA drinking alcohol at times with Mother. At the learning event professionals were unanimous in the view that there was little evidence to substantiate the claim of drugs misuse, despite LA and Mother both speaking about LA's experiences of using drugs. There was a professional view that this was fabricated by LA, for reasons unknown and no other evidence fully corroborated LA' admissions. The Aunt of LA in her contribution to the review also held the view that LA was not using drugs and believed Mother "wanted people to think LA was involved in using them". There was no trace of illegal substances in the toxicology findings (within the scope of testing) after LA's death.

Unfortunately recording of the concerns and in particular the professional judgement and opinions of those working closely with LA was limited. It is important to acknowledge the strong and consistent recollections of the professionals in contact with LA and the family at the time, due to the initial suspicion and focus on drugs and LA's use of them, leading up to the date of the death and immediately after. It is positive that the support worker for LA made a referral to a specialist drugs support service in the month before LA died. This was made in the hope that a specialist drugs worker would be better placed to judge LA's drug involvement, or not, as the support worker maintains that she did not suspect LA to be using drugs. The rationale regarding these decisions and actions is not recorded.

The issue of whether LA was using drugs has been explored in detail in the Police investigation into the death and this serious case review has enquired similarly where possible into that aspect of LA's life. What is apparent is that recording on the issue in some agency records could have been more comprehensive especially the valuable professional judgement of what was being said and observed.

This finding is relevant to other concerns for LA especially the issue of LA having additional needs, and related professional opinion not being documented. Accurate case recording is an absolute requirement of professional practice and all professionals should be expected to meet such standards.

Practice issues

Five practice issues were highlighted for individual organisations as a result of the review.

These issues are not subject to separate recommendations as practice improvement and/or action is already in place or planned, or the practice is already expected as part of the role of the organisation. The governance arrangements of the responsible organisations will need to monitor that issues have been or continue to be resolved:

- Processes within the Multi Agency Safeguarding Hub (MASH) regarding the sharing of information via Protecting Vulnerable People (PVP) submissions, including with Health partners, should continue. However, the onward sharing of information within Health for children post sixteen years and not in education, should be strengthened.

- GPs should continue to receive training on indicators of Child Sexual Exploitation, including reference to ages of children who can be affected.

- Decisions and actions from Child Protection Conferences should be recorded clearly and accurately with minutes agreed by all participants.

- Lancashire Constabulary should continue to raise the awareness of all operational non Child Protection trained staff, both Police and civilian, regarding the information sharing processes involving the use of Protecting Vulnerable People (PVP) reports to ensure incidents including vulnerable children or adults are appropriately identified, risk assessed and information shared with relevant partners. All police training programmes relating to safeguarding should include guidance and/or reminders on the use of PVPs.

- Case recording by professionals in all agencies must be accurate and timely, and must include details of professional judgements, evidence of information sharing, and rationale for key decisions.

Good Practice Identified

Good practice was identified during the review, by the panel, by professionals at the learning event and by the Aunt of LA. In particular:

- The main Social Worker allocated to LA's case, and to Sibling 1 was persistent in her attempts to engage and build rapport with LA, including accompanying LA on a college visit and to mental health service appointments. There was a sense that the Social Worker worked extra hard to hear the child's voice throughout her involvement;

- Joint visits to the family were planned and took place on a number of occasions particularly between Deter team members and Children's Social Care. This demonstrates the strong partnership working arrangements which exist in the area, and especially within the Deter team in response to CSE and other associated issues.

Conclusion

The findings of this serious case review do not indicate that inter-agency practice or the practice of any individual or organisation could have altered the outcome of this case or that the death of Child LA could have been predicted or prevented.
Areas of good practice were noted. Scrutiny of practice, however, always provides an

opportunity to consider ways in which services may be improved and therefore the following recommendations, based on the learning from this case, have been made:

Recommendations

In order to promote the learning from this case the review identified the following actions for Lancashire Safeguarding Children Board and its member agencies:

1. The Lancashire Safeguarding Children Board should seek assurance from all safeguarding agencies that staff have been reminded of the legal responsibilities of agencies for children up to the age of 18;

Intended outcome: Professionals from all agencies are reminded that children are children until aged eighteen and therefore should receive services and support which reflect that age.

2. Lancashire Safeguarding Children Board through its Quality Assurance and Performance Group should conduct a multi agency audit of cases where the subject child is aged sixteen to eighteen, to examine decisions, actions, and use of threshold guidance on different referral categories, including Section 17 and Section 47 referrals, and in Child Protection Conferences, with a focus on the age of the child and what impact this had on the service provided and the outcome;

Intended outcome: Assurance is provided that children aged over sixteen who are subject to referrals to Children's Social Care have holistic assessments according to their needs, and that age is not the overriding factor in thresholds applied, services delivered and the outcome for the case.

3. Lancashire Safeguarding Children Board should highlight the findings of this serious case review, specifically relating to mental health services, to relevant strategic Health partners in Lancashire. In particular, the Board should emphasise the need to explore the current arrangements within Adult Services for mental health provision for sixteen to eighteen year olds and for safe exit strategies to be developed where required;

Intended outcome: That consideration is given to children in Lancashire aged sixteen to eighteen being supported more appropriately through the Child and Adolescent Mental Health Service and that subsequent transition into the Adult Mental Health Service can be better planned to achieve improved outcomes for older children/young adults.

4. Lancashire Safeguarding Children Board should request assurance from the Lancashire Care Foundation trust (LCFT) that a second network priority audit has taken place relating to the CAMHS transition to adult mental health services, and the outcome of the audit is shared;

Intended outcome: To ensure the new LCFT procedures for transition are working effectively and children aged sixteen to eighteen are receiving appropriate mental health support.

5. Lancashire Safeguarding Children Board should make a formal request to the Government for an update on progress on the recommendations from the *Parliamentary Inquiry into the Effectiveness of Legislation for Tackling CSE and Trafficking within the UK, April 2014.* Specifically recommendations- (i) that legislation is amended in order to place Child Abduction Notices on a statutory footing and create an offence of breaching the conditions of a notice; and (ii) that there should be consistent provision under

Abduction Notices for all children, regardless of their legal status or age;

Intended outcome: To provide assurance that better protection for all children will be available through amendments to legislation relating to the use of Child Abduction Notices.

6. Lancashire Constabulary should explore options and issue guidance if necessary, regarding information and intelligence gathering from alleged 'suspects' when serious safeguarding allegations are made but retracted;

Intended outcome: Investigators consider that even when allegations are retracted, an attempt to gather information and intelligence from 'suspects' may inform other investigations and help to shape ongoing safeguarding processes. Information supplied by 'suspects' may also assist to identify why the allegation was retracted and prevent further retractions in the future.

7. Lancashire Safeguarding Children Board through its Missing From Home sub group should conduct an audit of missing from home episodes of children open to Children's Social Care (including children in care) to examine the quality of return interviews undertaken with those children, to identify any changes required to the current return interview process;

Intended outcome: The process for conducting return interviews for children open to Children's Social Care can be re-examined if necessary, as a result of the return interview audit, to provide an improved service for children who have been missing and to the professionals supporting them.

8. Lancashire Safeguarding Children Board should receive assurance from all partners with formal supervision arrangements that managing disguised compliance, dis-engagement and resistance in families is a standard agenda item for discussion in supervision meetings, with actions identified as necessary and outcomes recorded. Agencies without formal supervision processes should provide assurance and evidence to the Board that professionals in those organisations are similarly supported regarding issues of non compliance and resistance;

Intended outcome: To provide support to all practitioners in working with parents and carers who are dis-engaging from professionals or where disguised compliance is suspected, to explore strategies and risks when such challenges exist.

9. The Lancashire Safeguarding Children Board should explore the introduction of a formalised neglect assessment tool to enhance practice and provide consistency regarding thresholds for neglect and subsequent assessment of concerns and risk, and for the implementation of the tool to be supported by appropriate multi-agency training and awareness raising across all safeguarding partners;

Intended outcome: All professionals involved with families where neglect is suspected will utilise an agreed neglect assessment tool to help them to identify risks of child neglect more effectively and consistently, resulting in professionals focussing on the child's lived experience, with improved outcomes for children and their families.

References

- **The Children Act 1989**
- **Barnardo's Guidance on CSE: a Practitioner's Resource Pack, February 2014**
- **Mindroom.org**
- **Unprotected; Overprotected, Barnardo's for Comic Relief, September 2015**
- **Lancashire Safeguarding Children Board Child Protection Procedures, Child Protection Conferences, 3.5**
- **Parliamentary Inquiry into the Effectiveness of Legislation for Tackling CSE and Trafficking within the UK, April 2014**
- **Pan Lancashire Joint Protocol: "Children and young people who run away or go missing from home or care", September 2014**
- **Ofsted; Missing; a report to explore the effectiveness of arrangements to safeguard children and young people, including those who are looked after by the local authority, who are at risk of going missing or running away, Page 6, February 2013.**
- **The NSPCC Information Service: Summary of Learning from Case Reviews, March 2014**
- **The Protection of Children in England: A Progress Report, March 2009 3.15.**
- **Lancashire Safeguarding Children Board: Serious Case Review: Child LB, 2016**
- **Adolescent Neglect: Research, policy and practice; Rees, G., Stein, M., Hicks, L. and Gorin, S., 2011**
- **National evaluation of the Graded Care Profile: NSPCC, Johnson, R. and Cotmore, R. 2015.**

Statement by Reviewer

REVIEWER
Amanda Clarke (Independent)

Statement of independence from the case
Quality Assurance statement of qualification

I make the following statement that prior to my involvement with this learning review:-

- I have not been directly concerned with the child or family, or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.

Reviewer (Signature) **A.Clarke**

Name **Amanda Clarke**

Date 20 July 2016

Annex 1

Terms of Reference
Serious Case Review Child LA

Introduction
This Review is being commissioned by the Chair of Lancashire LSCB in accordance with the learning and improvement framework for LSCBs described in Working Together to Safeguard Children guidance (HM Government 2015). The Serious Case Review is undertaken as a concise Child Practice Review in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSCB will conduct the Serious Case Review and report progress to the Board through its Chair.

Membership will include an independent Lead Reviewing Officer and representatives from key agencies with involvement.

Organisation	Role
Independent	Lead Reviewer
Panel Chair Lancashire Safeguarding Business Unit	Manager, Lancashire Safeguarding Business Unit
Lancashire County Council	Director of Children's Services Panel Member
Lancashire County Council	Fostering and Adoption Performance Support Team Manager Panel Member
Lancashire County Council	Lancashire YOT Team Manager Panel Member
Lancashire Constabulary	Review Officer Panel Member
Lancashire Care Foundation Trust (LCFT)	Named Nurse CLA Panel Member
NHS Chorley and South Ribble CCG, NHS Greater Preston CCG and NHS West Lancashire CCG	Designated Lead Nurse Safeguarding Children. Panel Member
Lancashire Teaching Hospitals NHS Foundation Trust	Trust Lead Nurse for Safeguarding Children Panel Member
Lancashire Safeguarding Business Unit	Business Co-ordinator. Panel Member
Lancashire Safeguarding Business Unit	Business Support Officer Panel Member

Timeframe for the review
The SCR will cover the time period of 25/04/2014 to 14/09/2015. Any significant incident relevant to the case but prior to the start of the period 25/04/2014 may be included in the analysis completed by each agency.

Subject(s) of the review
Child LA: Aged 17 years

The purpose of the review is to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB;
- Examine inter-agency working and service provision, including quality of assessments, for the young person and the parenting capacity of the mother;
- Examine the effectiveness of information sharing/ working relationships between agencies and within agencies;
- Determine the extent to which decisions and actions were child focussed on the subject young person;
- Examine the involvement of other significant family members in the life of the young person, and family support provided to the subject family;
- Explore whether thresholds for neglect were appropriately considered;
- Explore whether the services being provided to the sibling (of the subject young person) took the needs of the subject young person into consideration;
- Examine whether responses to possible child sexual exploitation were effective;
- Consider if support offered and/ or provided to the subject young person relating to substance misuse was adequate
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify any actions required by the LSCB to promote learning to support and improve systems and practice.

Tasks specific to the review panel:

1. Agencies that have been involved with the child and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;
2. To set the time frame for the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. The case summary may include any relevant additional background information from significant events outside the timescale for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses;

6. A full and accurate genogram of the subject family will be prepared for the panel and to assist the learning event;

7. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

8. The Panel will plan with the Lead Reviewer a learning event for practitioners' to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

9. The learning event will explore hypotheses and draw out the key learning from the case including any recommendations for the development or improvement to systems or practice;

10. The Panel will receive and consider the draft serious case review report prepared by the Reviewer, to ensure that the terms of reference for the review have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report;

11. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead Reviewer for presentation to the LSCB for consideration and agreement;

12. The Panel will plan arrangements for feedback to the family and the practitioners attendance at the learning event and share the contents of the report following the conclusion of the review, and before publication;

13. The Panel will take account of any criminal investigations or proceedings related to the Case;

14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SCR report for publication.