Local Child Safeguarding Practice Review (LCSPR) Child F

Michael Botham, Integrated Service Manager, Children's Services – Dudley MBC

Local Child Safeguarding Practice Review (LCSPR)

Learning identified from considering Child F

Contents

Introduction

1.1 The Dudley Safeguarding People Partnership (DSPP) agreed to undertake a Local Child Safeguarding Practice Review (LCSPR) by considering a case to be referred to as Child F. Child F is a child at risk of criminal exploitation and is supported by Dudley MBC's Children's Services Exploitation Team. During the period of focus, Child F was open to Children's Services twice on a child protection plan before becoming a Child Looked After on a Section 20 basis. Child F has significant Police and Youth Justice involvement, including criminal convictions during the scoping period. Child F's mother also had involvement from services for mental health, and substance misuse.

1.2 Following a Rapid Review it was recognised that lessons could be learned from reviewing the practice in the case, with the aim of better safeguarding the children of Dudley. The LCSPR focused primarily on the period February 2020 to December 2022 although some themes are drawn from the family's overall reflections on working with agencies which are relevant context to their interaction with agencies in more recent times.

1.3 Child F left his residential placement and stayed at his mother's house on the Friday night. He did not return to his address on Saturday evening and sustained potentially life changing injuries during an assault. Initial reports suggested Child F was assaulted by a group of males who used motorbikes to knock him to the ground. His belongings were stolen, and he was left with injuries to both his ankles/feet.

1.4 Child F sustained a fractured fibula and tibia, and lacerations to his right foot. Surgery was carried out and part of his right toe was amputated. It is believed Child F knows his attackers but has not revealed their identity or given much by way of further detail. It is believed that this was a targeted assault, possibly linked to criminal exploitation.

1.5 Learning was identified in the following areas:

- Information sharing and communication
- Relationship building and professional curiosity around potential safeguarding concerns
- Recognising exploitation risks
- The potential relevance of 'adultification' in safeguarding teenagers
- Think family approach in relation to safeguarding, contextual risk and lived experience of a child.
- Identifying young carers

Process

2.1 The LCSPR was initiated following a Rapid Review process.

2.2 As part of the LCSPR professionals involved at the time were invited to an in person meeting to discuss Child F's case and learning for the wider system.

2.3 The lead reviewer met with Child F's mother in order to identify any learning from her perspective. Child F's father was approached to inform the review but did not reply.

2.4 Regarding Child F's views, these were sought by a mentor with an existing relationship with him. This followed feedback from Child F's mother that he does not tend to talk openly with many people and was unlikely to engage with a new professional.

2.5 Covid-19.

It is acknowledged that the Covid-19 pandemic was a significant context for the vast majority of the time period that this LCSPR is focused on. The particular nature of that time and the pressure this applied on public services cannot be overstated. In writing this review I have tried to be sensitive to that context and focused on learning that can be applied in 'normal' operating conditions (rather than Covid-19 specific).

Learning

Communication; including specifically how complex decision making and rationale is explained to families.

3.1 The mother of Child F said to me that her 'number one message' to all services was to think more meaningfully about communication. She explained a long history of working with agencies and how in her experience, decision making is consistently not well communicated. In her view, this is particularly the case at the most critical times in terms of the potential impact of decisions on her family; 'Tell me face to face

not in a letter', and 'give me the reasons' was her clear message, explaining that without this, confusion follows and decisions which may have been made with sound reasoning, appear arbitrary. This was not aimed at any particular agency but was her general comment on the lack of perceived effort made to help people experiencing services understand what is happening and why. The reason I have chosen to commence this report with this piece of learning is because it appears to underpin Child F's mother's view of agencies and her relationships with them over the longer term.

Relationship building and professional curiosity around potential safeguarding concerns

3.2 Related to the above, Child F's mother relays that relationship building should be key to all practice but is not applied consistently in her experience. She describes some excellent practitioners who have 'really tried' to support her but that unfortunately they leave their organisations and then she ends up starting again. She feels that she can quickly establish those who are not really interested. This inconsistency in 'genuine interest' was something that Child F also mentioned in his limited feedback.

3.3 The reason this is important for Child F is that in the practitioner's meeting some agencies described a sense of resistance to change from Child F's mother at times in their involvement with her. From my conversation with her it appears that she is feeling jaded with services and therefore resorts to short-hand accounts of complex experiences to avoid repetition. It also perhaps goes some way to explaining why in some practitioner's views, Child F's mother seeks diagnoses or labels in order to access support and explain behaviours; these labels arguably giving her a solid grounding for conversing with professionals rather than trying to convince each new practitioner of the presence of certain behaviours from Child F. When I asked her about what she thinks a diagnosis brings with it for Child F, she said 'it means he gets the right support' thereby suggesting that without the 'label' she feels he would not get that.

3.3 Child F's mother said the starting point for most professionals is not to believe her version of events or the extent to which she has struggled with Child F's behaviour from a very early age. 'When I'm being open, I want to be believed'. She described her motivation to engage fluctuating over time, which, when combined with what she sees as a series of arbitrary decisions (see 3.1) leads to a lack of disclosure. When I asked her how she thinks services perceive her, her answer was 'as a single mum who is trying to claim all the money I can and who uses domestic violence as an excuse to make people feel sorry for me'. She states she has lost count of the amount of times professionals have started talking to her about the welfare benefits she can claim (without her mentioning it), which whilst perhaps well meaning, in her view shows that their underlying view of her is that she is trying to maximise the income she can access from that system.

3.4 A particular example which relates to the importance of relationships in gaining disclosure is that Child F's mother stated that in the period of time just before the focus of this review period (2019) she was using crack cocaine and 'went from a dress size 16 to size 6'. She explained that despite being visited regularly by various professionals, people seemed to assume the weight loss was stress, rather than asking her in a meaningful way what was happening. On reflection she feels that she was waiting for someone to explore her weight loss with her so that she could share the information about the drug misuse. In her view, it was only when she got to the point of proactively seeking support for this issue (which continued in to the LCSPR review period and records note her being proud of her abstinence by 2021) that professionals sought to help, something which could have been started earlier through a stronger relationship. This would have been an important context for understanding Child F and his siblings lived experience during that time.

3.5 In the practitioner's meeting, generally all present agreed that the family were pleasant to work with albeit that there were different experiences of meaningful engagement by professionals. There is evidence of agencies trying consistently to support the family, trying different approaches and there are some periods of progress noted.

3.6 Regarding Child F, it appears from records and from his mother, that he does not disclose anything meaningful to services. This makes it very hard to have an accurate and nuanced understanding of his thoughts and feelings, or his lived experience. Various methods of engagement have been tried including culturally competent mentors and bespoke interventions via placements as a Child In Care with little sustained success in terms of his willingness to open up to professionals. Child F's mother did identify one youth justice professional who Child F had respect for and would listen to, but even in that relationship he will not disclose very meaningfully. There could be a plethora of reasons for this reluctance to disclose, but the consequence of this is that even six months after the assault took place, professionals are not exactly clear on what went on or why. The limited feedback from Child F is included in this report.

Recognising exploitation risks and the potential relevance of 'adultification' in safeguarding teenagers

3.7 Child F's mother described his behaviour as beginning to escalate at age 13 (slightly earlier than the focus of this LCSPR) when he began to mix with other groups, smoke cannabis and probably, in her view, started low level street dealing of cannabis. Whilst not having a sophisticated understanding of exploitation herself, she did know the concept of county lines and gave an example of this via Child F catching a train to go 'OT' (out of town) but explained that he got scared and she had to get him a taxi

back. She is unsure if he still is approached for this but suggests he probably is known locally as someone who can get drugs for people.

3.8 The family have been known to children's social care since 2013. Child F was subject to child protection plans under emotional abuse between February and March 2021, and again from October 2021 to February 2022 at which point he became a Child In Care under Section 20 (with agreement from the parent). Child F had five moves of address since coming into the care of the LA with a focus of rehabilitation and reunification home to mother. A variety of interventions and activities were offered. He accessed discussions/education around exploitation and grooming, in addition to mentoring, Youth Justice Service work and psychological assessment. The National Referral Mechanism was completed and updated as incidents occurred. Agencies did coordinate information to try and map and understand his lived experience, but analysis in the rapid review highlights the complexity of mapping and planning when there is a risk of exploitation and absence of firm information from the family as to what is happening.

3.9 For a period of time within the focus of this LCSPR, Child F was residing out of borough. Professionals and his mother identify this time as a significant period of positivity for Child F, with movement on education/training and a more positive attitude. This period of time came to an end following a Position of Trust incident at the address and was dealt with via the appropriate LADO intervention in the area it occurred; however it appears that ultimately the move back to Dudley and resuming previous relationships did undermine the progress being made. Children's Social Care and Youth Justice professionals offered support to explain the incident to Child F and to explore his understanding of what had happened. However he did not wish to access this, and based on his mother's account of that time, appears to have seen the incident as something to show off to his friends about, rather than understanding it as inappropriate behaviour by a member of staff within a context of sexual abuse. Relating this to the theme of exploitation, it is perhaps indicative of Child F not really understanding what is safe behaviour by adults towards him.

3.10 In the practitioner's event, no one in the partnership felt they had a critical piece of information that would have prevented the specific assault from taking place, but that it could have perhaps been predicted that something might happen at some point. Rapid Review notes show some inconsistencies in understanding the family's situation and little evidence of exploring the contextual risk Child F has faced or how to support him.

3.11 In the practitioner's event, it was explored why professionals working with either Child F or his family may not have always demonstrated the professional curiosity about the potential for exploitation that could have been expected. There is DSPP activity around exploitation and aside from considering the impact of the training, the ongoing awareness raising of exploitation and contextual safeguarding is in place.

However, the concept of 'adultification' was introduced to the partnership and appears to be new terminology that is worthy of further consideration and integration into the existing exploitation training.

Adultification

3.12 An HMIP academic insight into adultification was circulated to practitioners prior to the event and services were asked to consider whether there had been any evidence of this topic in their working with the family.

3.13 Adultification can impact more negatively on children from ethnic minorities. Davis and Marsh (2020) define adultification as:
'The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias.
Reference: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf

3.14 Although this did seem to be a new concept to the partnership, certain emerging themes could be identified in terms of:

- Language (sofa surfing as opposed to homeless, did not attend as opposed to was not brought, making unhealthy choices, choosing to drug deal or 'street-wise', as oppose to potentially being exploited, inappropriate relationship rather than abuse of power).
- Consideration of trauma experienced by Child F and whether he was being expected to cope.
- Exposure to adult conversation at an inappropriate age.
- Not sharing information as proactively as if this was a younger child, and not proactively considering support for transitions when transferring to other services.
- The 'was not brought' policy was seen as a positive policy from health which other agencies have highlighted as useful; unfortunately, it does not appear that this was actioned as intended or escalated for Child F when he did miss appointments. In addition, a particular scenario in health led to consideration for adult rather than children's services. This was rationalised in terms of overall capacity in those services but it is unlikely that adult services would have a child centred approach in the same way that children's health services would.
- Children's Services' feedback indicates that the first Child Protection Plan was more holistic in its focus than the second and may be a further indication of adultification.

3.15 In youth justice, the service identified that the national drive towards 'child first, offender second' would have positively impacted on the types of interventions Child F

received if entered the YJS now. When Child F was previously open to the YJS, interventions focused heavily on offending behaviour and were punitive in nature. Under a child first lens, a more therapeutic, strengths based plan would be developed.

3.16 The tension between child centred youth justice practice which seeks to divert children from the formal youth justice system, and a sense of 'letting someone off' was apparent in the professional conversations and the youth justice service should perhaps make effort to explain the rationale for the child first approach.

A note on culture:

3.17 Child F is of mixed heritage, White and black Caribbean. This review found little conscious consideration of culture and ethnicity in the provision of services or the understanding of experiences (the exception being e.g. attempts to introduce a mentor to Child F). Child F felt his cultural needs were met by services but said it would be useful to know more about his culture and heritage.

3.18 Child F's mother explained one negative experience with a worker but aside from that did not see the family's culture as particularly relevant to this review. Perhaps the partnership agencies nor the family appreciate intersectionality in this regard. Given that evidence suggests adultification does negatively impact on children from minority ethnic backgrounds, this may be more relevant than she perceives.

Think family approach in relation to safeguarding, contextual risk and lived experience of a child.

3.19 One of the DSPP's priorities is 'Think Family' and this concept was something that was highlighted in the Rapid Review as a learning point. This theme was explored further in the practitioner's event and agencies were asked to consider what 'Think Family' means to their organisation. Perhaps inevitably, this concept means different things to organisations but there may be value in seeking to clarify key messages or arrive at a collective partnership understanding of what 'Think Family' means in practice and what impact it is making. Within the review it seemed apparent that unless there was a specific direct safeguarding risk (e.g. father being allowed to see the children when on licence, mother's suicidal ideation), services working with either mother or father focused on the person in their service, rather than the potential implications or experiences on the children. Child F felt that the best thing about the last couple of years were living with his mum and siblings, but said that only some people try to see and respond to the family's issues as a whole picture.

Some specific examples are as follows:

Mental Health:

3.20 Child F's mother has experienced trauma herself and has diagnosed mental health conditions for which she has received support. However I have not seen strong evidence of agencies helping her to understand the impact of her mental health on the children's lived experience. Child F has his own diagnosis of Oppositional Defiance Disorder (ODD) conduct disorder and severe anxiety (an additional ADHD diagnosis was later withdrawn in 2019). I cannot see evidence of those two conversations (mother's and Child F's diagnoses) being brought together to understand how their conditions impact on their behaviour, what that mean for their interactions, how to understand each other's conditions, or the impact of both their conditions on the lived experience of the other siblings etc. Given that some of the period of focus was during the worst of Covid-19, it may have been very beneficial for them to have received advice on coping in lockdown when there are people in the same household likely to be experiencing things differently. Child F's mother says that she doesn't remember ever receiving practical advice on what it means to be a mother with her conditions parenting a teenager with different conditions. Professionals suggest that his mother has at times insisted that Child F has more severe mental health conditions 'like his father', and this may have been said to him repeatedly through his life.

3.21 A particular sticking point seems to be the ADHD diagnosis. CAMHS are confident in the defensibility of their assessment and are able to articulate processes for parents who disagree with their position/diagnosis; however related to the first learning point in this review (see 1.3), Child F's mother doesn't recall ever having the rationale for the ADHD diagnosis being withdrawn explained to her in a way she understands. Her takeaway on this seems to be that 'everyone thinks his behaviour is all my fault'.

3.22 Regarding ADHD, CAMHS report being asked numerous times for medication for Child F by Children's services or other professionals after the diagnosis was withdrawn, when there was no diagnosis which would warrant this. It would suggest there has been some lack of clarity in communication about his mental health or that agencies tended to rely on Child F's mother's summary of the situation rather than seeking clarity from CAMHS (as an example, mother told the GP in 2021 that he cannot wait in Accident and Emergency 'because of his ADHD'). The exact nature of father's mental health diagnosis seems unclear and reliant on Child F's presumptions/narrative rather than proof of actual diagnosis.

Substance misuse:

3.22 In a similar point to the above, substance misuse services also appear to have focused on the individual they were working with rather than pulling together conversations about multiple elements of substance misuse in the same family, and how those things interact. When Child F's mother was not attending appointments, little consideration was given to exploring the barriers to attendance as it related to her being a single parent of three children. When she disclosed drug dealers going to the

property to deliver her drugs, the implication of children being exposed to this is not explored. The understanding about Child F's mother's drug misuse seems to be inconsistent between organisations.

3.23 Substance misuse services working with Child F's mother do record having sent her worksheets which encourage her to think about her substance misuse and her children, but these were not completed and arguably would have been more impactful if completed with her as part of an overarching joint plan which incorporated all the family's needs.

3.24 For Child F it seems unlikely that any plan around substance misuse would be effective if it does not consider the lived experience in terms of attitudes to substances and their availability at home.

3.25 I note as a positive step that since the focus of the review, the Family Safeguarding Model has been launched in Dudley.

Identifying young carers

3.26 Child F's mother said that when she has been struggling to cope, responsibilities have generally fallen on her daughter in terms helping around the house and looking after the younger sibling. I wasn't able to see evidence of professionals working with the family actively considering whether any of the children might be considered young carers. Given Child F's mother's mental health and substance misuse issues over protracted length of time it is perhaps highly likely that they would have been eligible for support from the young carer's team. Given that referral rates for the young carer's service remain lower than might be expected, and are particularly low for ethnic minorities it may be worthwhile the partnership helping to raise awareness of this service.

Recommendations

4.1 There has been self-identified single agency learning and practice improvements since the review. The following recommendations are made which may help consolidate changes across the partnership:

Recommendation 1:

Agencies working with adults and/or children to provide assurance to DSPP that they have effective joint working practices when working with members of the same family. Within their practice there is a need to recognise how the needs of each person in the family affect each other and to respond appropriately to this need.

Recommendation 2:

DSPP to revisit the multi-agency training content to incorporate 'adultification' into appropriate courses to raise awareness of this concept. This may assist in helping practitioners to understand how this can relate to practice and professional curiosity.

Recommendation 3:

The Partnership should strengthen communications to ensure that Professionals in Dudley are aware of their responsibilities in identifying and ensuring that there is assessment of young carers. The impact of this communication campaign should be monitored.