Knowsley Safeguarding Children Partnership

Multi-Agency Learning Review

Ava

Final Draft

Family Composition

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| --- | --- | --- |
| Known in review as | Relationship | Age at time of incident leading to review |
| **Ava** | **Subject of review** | **12 years old** |
| Georgia | Sister | 11 years old |
| Jack | Brother | Not given |
| MA | Mother | 28 years old |
| FA | Father of Ava | Not known |
| FG | Father of Georgia? | 38 years old |
| FJ | Father of Jack | Not given |

Significant Others

|  |  |  |
| --- | --- | --- |
| Known in review as | Relationship | Significant dates |
| Marian | Previous short-term then long term foster carer | (unknown) – 16.10.12 14.12.12 – 29.08.17 |
| Prospective adopter | Prospective adopter | 16.10.12- 14.12.12 |
| Nicky and Joel | Temporary foster carers then possible long term carers | 29.08.17 – 10.12.17 29.11.17 – 09.03.18 |
| Jenny | Long term foster carer | 10.10.17- 15.11.17 |
| Children’s Home 1 | Residential Placement | March 2018 – February 2019 |
| Children’s Home 2 | Residential Placement | February 2019 – October 2019 |
| Children’s Home 3 | Residential Placement | October 2019 - present |

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## Background to the review

* 1. At the beginning of August 2019, Ava was seriously sexually assaulted by a group of teenage boys in an incident at which a number of girls were present. Ava was 12 years old at the time and was looked after by Knowsley Council. Ava was living in a children’s home close to the park and wooded area where the assaults took place. The children’s home was outside the borough.
  2. Ten days later 2019, Knowsley Safeguarding Children Partnership undertook a rapid review of the circumstances readily available to agencies, including organisations working with children in the area local to Ava’s placement. Information was provided by Knowsley Children’s Social Care; Knowsley Virtual School; Lancashire Constabulary; NSPCC (Child Line); Lancashire Care NHS; East Lancashire Hospitals NHS Trust; Lancashire CC, MASH; Pennine Safeguarding Team East Lancashire CCG; and, CAFCASS. Information was not directly sought, at that stage, from the children’s home where Ava lived or from her previous placement.
  3. The Rapid Review meeting agreed that the criteria were met for a multi-agency learning review and that an independent reviewer should be appointed. The purpose of the review would be to identify learning which could improve multi-agency arrangements to safeguard and promote the welfare of children, particularly for those children looked after at a distance from their home area. It was anticipated that the review would be conducted using a hybrid systems method.
  4. While the review was to be proportionate; it would take account of complexity of the circumstances in which professionals work and would seek to understand both what happened and why. It was anticipated that a learning event for practitioners and first line managers would provide the opportunity for learning for those working with Ava. Single agency analyses would promote learning from the case at an organisational level. The final review report would seek to reflect that learning in the context of lessons for multi-agency practice and recommendations for change.
  5. In December 2019, an initial scoping meeting took place between representatives of the Partnership and the independent reviewer. An independent reviewer ‘in training’ also attended; mainly in an observational capacity. The meeting discussed proposals by the independent reviewer to consider, essentially, four practice episodes over a three year period. The representatives of the Partnership were clear; however, that a more targeted review of practice was required with a focus on children looked out of area.
  6. The Partnership favoured a short review period of a single year. It was agreed, however, that the review period would be from June 2018 to October 2019. These slightly extended parameters would enable the review to include both the nature and impact of NSPCC (ChildLine)/ Local Authority Designated Officer (LADO) involvement with Ava in the early months of her first out of borough placement as well as the safeguarding response by partner agencies and organisations following the assault on Ava.
  7. The overall review process and timescales for completion of each element were established following that meeting and the early stages of review work were undertaken as planned. The Safeguarding Children Partnership business manager who had been absent due to ill health when the review process had been agreed returned to work during this time.
  8. Unfortunately, from Mid-March of 2020, as the coronavirus epidemic affected the whole population; it also had a significant impact on all areas of operations within local services, including Partnership case reviews. The specific effect on this review is described below.
  9. The learning event for practitioners and managers which had been due to take place on 26 March was cancelled immediately. Shortly afterwards, as duties and working arrangements for practitioners and managers were being re-prioritised, a decision was taken by senior officers within the local authority to bring the review to a conclusion. Learning was to be based on information which had already been gathered. There would be no opportunity to consult with senior managers of relevant organisations to consider the analysis or to work together to ensure that recommendations are designed in a way that best reflects the gaps in current multi-agency safeguarding practice. There would be no opportunity either to obtain Ava’s views.
  10. As a consequence, it was inevitable that there would be some gaps in terms of understanding what had happened during the review period. And, crucially, the review would necessarily be less able to identify *why* things happened as they did than would have otherwise been the case.
  11. At the beginning of May 2020, an initial draft of the review report was completed. This was based on information provided by agencies and organisations through the rapid review, the combined chronology and the learning summaries which had been completed using a bespoke template. In addition, information was included from a visit by the reviewer and observing reviewer which had already taken place to Ava’s first residential placement.
  12. The key lines of enquiry for learning summary authors were adapted by the independent reviewer to provide a framework to underpin the multi-agency review analysis. These revised key lines of enquiry were:
      + Insofar as it is possible to determine, how effective was the work of agencies and organisations with Ava prior to the review period?
      + At the point that the review begins, how well did agencies and organisations understand Ava’s needs and the risk of harm to her?
      + What were the particular challenges posed by Ava’s changing circumstances, needs, risks, wishes and feelings? How effectively did agencies and organisations respond to these challenges?
      + How effective were looked after child reviews?
      + How well were Ava’s lived experiences understood?
      + What were the factors which supported good safeguarding practice and what were the barriers?
  13. Then, at the end of May, discussion took place between the business manager and the independent reviewer as to whether any mitigating actions could be taken to compensate for the early closure of the review process. The question also arose as to whether it would be possible to extend the review period to take into account practice from 2017.
  14. As a result of that discussion; the independent reviewer completed two separate options for the Partnership to consider. Both options identified a number of actions; the ways in which they could lead to a more comprehensive review; the gaps which would remain; what would be required from agencies and organisations; and, an outline of the potential benefits/disadvantages.
  15. The Partnership chose Option 1 which was designed to build on the existing draft report by:
      + Providing a full history of the processes which underpinned the review;
      + Obtaining written information which was originally expected but had not been provided at the point that the review was suspended;
      + Identifying ways to obtain and include Ava’s views and her messages for professionals;
      + Seeking further written information from services where gaps were identified;
      + Meeting virtually with panel of Safeguarding Children Partnership members to discuss a revised draft report and to consider its recommendations; and,
      + Confirming recommendations through a virtual process.
  16. Under Option 1, the review period remained as had been previously agreed and the reviewer would not speak directly to practitioners and managers but would rely on written updates from services. A revised timetable for completion of the review was agreed at that point, working towards the end of July 2020.
  17. Discussion took place about how best to obtain Ava’s views. It was concluded that this should be facilitated by the local authority prioritising Ava’s needs and circumstances. The reviewer provided the local authority with examples of open questions which might prompt Ava to highlight, from her perspective, the important issues which have affected her over the last few years.
  18. The review report has been completed within the parameters of this revised process.

## Key lines of enquiry

* 1. Insofar as it is possible to determine, how effective was the work of agencies and organisations with Ava prior to the review period?
  2. Although the focus of the review is on learning about children placed away from Knowsley, particularly in residential care; Ava’s own experience can be best understood in the context of what went before. Each agency or organisation contributing to the review was asked to evaluate, where pertinent, its work with Ava prior to June 2018 either as part of the rapid review or through a learning summary. Inevitably, given Ava’s unfolding history; there are significant gaps in detail from agency accounts. Overall, however; the information has provided offers opportunities for learning which could otherwise have been missed. Most of the detail has been provided by children’s social care.
  3. MA was a very young parent when Ava was born, with difficulties of her own. Ava’s father is unnamed and he has never been an active part of Ava’s life. MA, who is white British, has described Ava’s father as being of ‘black Afro-Caribbean’ heritage. Ava has been in the care of the local authority since she was 9 months old. Care proceedings were initiated when her mother, MA, was pregnant with Ava’s sister, Georgia. At that point, MA and the father of the unborn (FG) were considered to pose a risk of significant harm to the children.
  4. Care proceedings were active for more than 2 years. During that time, it appears that the children were living primarily with MA, albeit in a variety of supervised circumstances. Efforts to allow the children to remain in their mother’s care, however, were unsuccessful. As a result, in July 2010; the local authority’s plan for adoption for the children was agreed by the court. At this point, Ava was three years old and Georgia was two.
  5. Although the local authority had a plan for adoption, no family finding efforts had been made prior to the granting of the final orders. This was not consistent with good practice in planning for permanence, as parallel planning was a well-established concept by that time.
  6. Ten months later, the local authority made a new application in respect of Ava’s third child, Jack. It is assumed that he was an infant at the time. Those care proceedings ended with a supervision order being granted in December 2011. Eighteen months later, however, Jack was made the subject of both care and placement orders. It is understood that he was subsequently adopted. Ava and Georgia’s knowledge of Jack’s past and present circumstances is not known to the review.
  7. In the meantime, the local authority’s search for an adoptive placement for Ava and Georgia had been continuing. The CSC learning summary describes the lengthy search which took place as being ‘*characterised by a need to achieve an ethnic match as opposed to (a consideration) of the holistic needs of two baby girls’*. As a result, it was not until October 2012, that the children moved to what was anticipated to be their permanent home. At that point, Ava was five years old and Georgia was four years old. Immediately before their move; the children had been living with short-term foster carer, Marian.
  8. The children’s adoptive placement came to an end within two months. The CSC learning summary indicates that the prospective adopter was unable to manage the children’s behaviours. She was ‘*not accepting of advice and support’* and had also ‘*admitted smacking the children*’. The children returned to Marian’s care.
  9. With hindsight, a number of factors associated with poor outcomes for adoptive placements appear to have been present. These included: the children’s ages at placement; Ava’s reported emotional and behavioural problems; and, what appears to have been the inflexibility of the children’s prospective adopter.
  10. It is notable that, in 2014, Ofsted inspectors found that adoption services in Knowsley were inadequate. The delay and drift which had characterised casework with Ava and Georgia were found more generally in permanency planning in the borough[[1]](#footnote-1).
  11. In May 2015, Ava’s and Georgia’s placement orders were revoked. The children’s last contact with their mother had been three years earlier. Two months later, Knowsley’s permanence panel recommended that Ava and Georgia’s placement with Marian be formally approved as long term. By that stage, Ava and Georgia were coming up to, respectively, their 8th and 7th birthdays. This recommendation was subsequently endorsed by the local authority Agency Decision Maker. At a Looked After Child Review in September 2016, it was noted that both Ava and Georgia were ‘doing well in all areas’.
  12. Some six months later, however, there were significant difficulties within the placement and, following a pre-disruption meeting; a placement support plan was put in place. But, despite initial positive indicators, difficulties continued to accumulate. Ava’s placement finally came to an end in August 2017, following an assault by Ava on Marian while on a plane on the way back from holiday.
  13. The CSC learning summary states: *The opportunity to place (the children) back with Marian was positive and this provided stability … for a five year period. It is clear that the girls were loved but the impact of Ava’s early childhood experience was not fully understood and the impact as she began to try and make sense of her life was not anticipated. The escalation of distress and associated behaviours was rapid’.*
  14. The next months were very tough for Ava. When her placement with Marian came to an end; Ava was placed temporarily with Nicky and Joel in West Lancashire. The children continued to attend the same school. A sibling assessment was completed the next month. This concluded that Georgia should remain with Marian and that a new long term placement should be sought for Ava on her own. This is a decision which Ava has struggled to accept.
  15. In October 2017, Ava went to live with Jenny and her nineteen-year-old daughter. This was intended to be a long-term placement. Within a month, however, two significant events had taken place: Ava had made an allegation that she and Georgia had been assaulted by Marian; and, Ava had assaulted Jenny. The placement with Jenny came to an end and Ava moved to another temporary placement.
  16. In respect of the allegations made against Marian: Ava was ABE interviewed and Marian was interviewed under caution. No further police action was required. It is recorded that Ava thought that by making this allegation, Georgia would have to move and the two sisters could be together. Since that time, however, Ava appears to have repeated the same allegation to different people on a number of occasions.
  17. Ava returned to Nicky and Joel’s care in West Lancashire where it was hoped she could remain long term. To support the placement, a referral was made to West Lancashire CAMHS and, in the middle of February 2018; a ‘full mental health assessment’ was undertaken. It was agreed that one-to-one sessions ‘around managing emotions’ would start two weeks later. In the meantime, however, Nicky and Joel had given notice that they were terminating Ava’s placement. As a consequence, Ava had moved before the planned appointment could take place. West Lancashire CAMHS ended their involvement.
  18. When this last placement broke down, CSC came to the conclusion that Ava ‘*would not invest in a foster placement*’ and that ‘*to keep trying to meet her needs in the same way would result in greater instability*’. Although a search was still initiated to find a suitably skilled foster carer; when this proved unsuccessful, ‘*residential care became the only alternative*’. A placement was identified in Sheffield. CSC has emphasised that the decision to place Ava in residential care was ‘*not taken lightly*’. This is acknowledged by the review.
  19. At the same time, the IRO learning summary asks whether there were missed opportunities to take a slightly different course. For example, whether earlier ‘triggering’ of therapeutic intervention for Ava and increased support to foster carers could have ‘*enabled a better match to be found*’.
  20. At the beginning of March 2018, Ava moved to Children’s Home 1: she was ten years and 8 months old. Children’s Home 1 provided care for up to four children with ‘emotional and/or behavioural difficulties’. It had been [rated as a good children’s home](https://files.ofsted.gov.uk/v1/file/2711891) by Ofsted in June 2017 and was noted to be in a position of ‘sustained effectiveness’. At the time, the other children living in the home were older than Ava. This proved to be significant, as issues in respect of age differences were a source of tension and, at times, conflict between Ava and the others. The IRO report also notes that the older children were not in full-time education, which Ava was expected to be.
  21. As part of the multi-agency case review process; the two independent reviewers visited Children’s Home 1 and spoke to the manager and a senior care worker. The manager and care worker described their first impressions of Ava. They commented on how small and pretty Ava was; but, also on how she appeared to be emotionally delicate. They remarked on Ava’s strong identification with Liverpool/ Merseyside and their awareness that that being surrounded by Yorkshire accents was another change for her. They were also conscious that the people in her immediate environment and wider surroundings were mainly white, although this was consistent with her previous experience. It seemed to them that her identity as a young person of colour had not been actively promoted.
  22. The staff in Children’s Home 1 had been anticipating that Ava would have a high level of emotional needs and that her behaviour was likely to be challenging: this proved to be the case. Before long, Ava’s placement was characterised by episodes of ‘*prolonged chaos’* during which Ava had to be prevented from harming herself or others, sometimes by restraining holds. The children’s home manager described how Ava ‘*struggled with relationships*’ and found the ‘*group dynamic’* difficult to manage.
  23. At the end of March 2018, the children’s home staff and CSC discussed Ava having CAMHS input for additional therapeutic support. This, however, proved to be less than straightforward to arrange. The difficulty in accessing additional therapeutic support became a continuing feature of Ava’s time in Children’s Home 1.
  24. In April 2018, CSC managers responded to an ‘IRO cause for concern’ about the lack of therapeutic support for Ava. The question was raised as to whether it would be possible to commission therapy directly from the placement provider ‘*until Ava’s therapy could be appropriately transferred over to the local CAMHS*’. Although not raised as an issue in learning summaries; the children’s home manager told the independent reviewers that the charge for this in-placement therapy would have been an additional £1000 per week.
  25. A referral to CAMHS was received by the service in mid-April. A few days later, the Named Nurse for Looked After Children contacted Sheffield CAMHS, confirming that Ava had recently been assessed by CAMHS in West Lancashire, but that due to her placement move, recommendations for therapy were not enacted. She also referred to the increased concerns that had arisen since Ava had moved to Sheffield and requested an appointment for her as a priority.
  26. Sheffield CAMHS, however, determined that Ava would remain on the routine waiting list as, Ava was ‘*not currently presenting as psychotic or displaying extreme self-harming behaviours*’. The timescale for CAMHS assessment following referral was within 18 weeks. This meant that the first appointment should have been by the end of August/ beginning of September 2018. It is not clear whether local practitioners took the advice given by Knowsley Clinical Commissioning Group to escalate concerns with services in Sheffield.
  27. Also during these early weeks of placement, Ava’s school attendance was poor. School attendance had not previously been an issue for Ava, although the Virtual School suggests that instability in her primary education, generally, ‘*will have impacted her attainment and achievement overall’.* Although frequent school moves can make it ‘*more difficult for teachers to identify any issues a child might have in accessing the curriculum’*; prior to the review period, Ava ‘*had not presented as having unmet educational needs’.*  Schools had reported that Ava had generally engaged well while in lessons but that unstructured times could be problematic. With hindsight, the VS recognises that frequent school moves may have had an impact on Ava’s ability ‘*to make and sustain positive relationships with* *her peers and adults’.*  The VS acknowledges that this aspect was ‘*perhaps not given enough consideration at the time by schools and Virtual School’.*
  28. Nevertheless, school absence at this point in Ava’s educations was particularly significant. As she was now in the middle of Year 6, Ava was missing not only standard education, but also activities designed to prepare her for a smooth transition to secondary school. At the same time, the distance from Knowsley meant that it was not possible to engage Ava in the usual transition support provided by the VS. In addition, children generally also accessed work in respect of sex and relationships as part of the Year 6 curriculum. Ava missed all but one of her SATs tests.
  29. The VS report describes how Ava’s difficulties in making friendships contributed to her poor attendance: ‘…, *she was described as being ‘controlling’ of those who she started making friendships with. She did not experience success in making friends and latterly was able to articulate that she needed help with this. Ava was looking to friendship and belonging’.*
  30. It is not entirely clear from information provided when the VS allocated the team’s attendance officer to be Ava’s key worker[[2]](#footnote-2). The chronology suggests that this was in October 2018. It appears, however, that the Virtual School took steps earlier to work with Children’s Home 1 and to develop an incentive scheme to encourage Ava to attend. As a result, Ava’s attendance showed some initial improvement during the last term of primary school but this was not sustained. The VS’s planned rewards could not be given. The children’s home manager also reported that home-based incentives became larger and Ava’s compliance became less.
  31. In the pre-review period, at Children’s Home 1; two referrals were made to the local authority designated officer in respect of professionals working with Ava. No action was required on either occasion, although the children’s home considered that one member of staff had responded ‘disproportionately’ during an incident. That individual resigned and did not return to the home.
  32. Overall, therefore, at the end of the pre-review period, Ava was unsettled and unhappy. She was living away from home and was separated from the people who were most important to her. She was having difficulties making relationships and was not attending school. Her behaviours indicated that she was unable to manage her emotions. Ava was, therefore, in a very vulnerable situation and professionals were, rightly, concerned about her immediate safety and well-being, as well as about her longer term prospects.
  33. At the same time, it must be recognised that Ava had been looked after since she was less than a year old, and so; her circumstances should have been much better. It is notable, for example, that Ava is recorded as having lived at 14 different addresses and had attended four different primary schools in the pre-review period. These are both generally indicators of a greater level of instability than would be expected for a looked after child. While there has been no in-depth analysis of the first 10 years of Ava’s life, therefore; the apparent impact of her earlier experiences in care cannot be disregarded.
  34. At the point that the review begins, how well did agencies and organisations understand Ava’s needs and the risk of harm to her?
  35. The review period begins in June 2018. At that point, Ava’s circumstances were well known to agencies and organisations which were providing or commissioning services for her. In particular, Ava was well known to CSC. The CSC summary indicates that, prior to Ava’s move into residential care; the local authority had been sensitive to the fact that the necessity of ending Ava’s long-term placement with Marian had caused Ava further harm; increased her level of unmet need; and had contributed to the difficulties which followed in securing a permanent placement for her. At that earlier point, therefore, while access to therapy was important for Ava; CSC concluded that her most significant need was to achieve a stable living arrangement.
  36. This was a reasonable position as, without stability in her everyday life; Ava would not be able to take advantage of therapeutic opportunities and the possibility of her developing positive self-esteem would be much reduced. At that time, the local authority had thought that the most likely means of achieving that stability would be for Ava to live in, essentially, a ‘non-family’ placement. The extent to which CSC believed this level of stability could be achieved by Children Home 1 at the point the review begins, however, is not entirely clear. There were certainly doubts.
  37. Unusually in times when frequent changes of social worker are relatively commonplace; Ava had had the same social worker during the previous five years. Information provided to the review indicates that Ava’s social worker is highly regarded both within the local authority and by other agencies. In conversation with the reviewers, for example, Children’s Home 1 made a particular point of stressing the commitment to Ava they observed on the part of the social worker and the quality of the working relationship she was able to forge with them. The social worker’s thorough knowledge of Ava’s life and circumstances provided an optimal basis for the decisions that needed to be made about her care. It is understood that Ava had a close relationship with her social worker.
  38. The local authority independent reviewing service also provided consistency for Ava by ensuring that Ava had the same IRO. In addition, in line with agency practice in respect of out of borough placements; the service increased oversight through 3-monthly reviews.
  39. By contrast, however, the move out of borough had lessened the extent to which some local services were involved in Ava’s life. For example, although Knowsley Looked After Children Health Team continued to coordinate Ava’s statutory health care; it was now the responsibility of another authority to provide it. Similarly, for the Virtual School; Ava now had a place in a school with which it was not familiar and with which it had no established relationships.
  40. Significantly, as noted within the previous line of enquiry; the West Lancashire CAMHS offer of therapy was not transferrable when she was placed in Sheffield. This had created a detrimental gap for Ava which was affecting her health and wellbeing. At the point the review period begins; Ava was on Sheffield CAMHS ‘routine’ waiting list for assessment.
  41. What were the particular challenges posed by Ava’s changing circumstances, needs, risks, wishes and feelings? How effectively did agencies and organisations respond to these challenges?
  42. At the beginning of June 2018, professionals were most concerned about Ava’s perceived inability both to regulate her emotions and to avoid putting herself at risk of harm. From May 2018, Ava had made frequent calls to the NHS 111 service and had attended ED with physical ailments and mental health issues. From June, examples of Ava’s increasingly concerning behaviours included: threatening to throw herself from a motorway bridge; putting a metal knife into a toaster when live; attempting to throw herself on the road; starting a small fire in her bedroom; and, being physically challenging both to other children in the home and to staff.
  43. At the ED, Ava was assessed by the CAMHS STAR team who undertook to ‘speed up’ the process for Ava. An initial assessment appointment was subsequently offered in July 2018, but when Ava ‘refused to attend’; a rearranged appointment was made for September 2018, approximately six weeks later. This was consistent with ‘routine appointments’ but, from the point of view of professionals working with Ava, it did not take account of Ava’s level of need. This issue was highlighted in the Looked After Child Review in July 2018.
  44. In the meantime, staff in the children’s home report that they had changed their approach to Ava and had incorporated the use of the Playfulness, Acceptance, Curiosity, Empathy (PACE) model of care to support Ava and were attempting to manage incidents by a number of agreed techniques which included removing Ava’s audience; engaging in a small person hold; and, rocking with her in a therapeutic manner.
  45. It is not known how the effectiveness or appropriateness of these interventions was being evaluated but the records from the children’s home refer to a ‘*significant reduction in the rate of incidents and the length of time that they lasted*’ with staff ‘*continuing to provide consistent boundaries and a consistent approach*’.
  46. Also from June 2018, Ava had begun to telephone NSPCC ChildLine. Initially, she talked about having been moved from foster care to her current home and described how this had affected her feelings and behaviours. She said that she had been stopped from harming herself by staff. She was also unhappy about having only limited telephone contact with Georgia. In the third call, in July 2018, however; Ava referred to ‘*years of physical abuse*’ in the past by Marian and, in the present, to physical and verbal abuse from children’s home staff and other young people living in the children’s home. The local authority and the respective LADOs were informed of Ava’s allegations.
  47. In August 2018, the combined chronologies indicate that the SW, staff at Children’s Home 1 and the Sheffield LADO reviewed a number of allegations that Ava had made. The record indicates that all had been either unfounded or unsubstantiated: none had led to child protection enquiries or had involved the police. The types of occasions when Ava was likely to make allegations were identified and a risk management plan agreed. Any future allegations, however, would follow due process. Both CSC and the children’s home report that this plan worked satisfactorily.
  48. Information subsequently obtained from LADO Sheffield is brief and does not contain detailed accounts of allegations made. It states that ‘*there are no references to allegations … that would be within the scope of LADO guidance within Working Together to Safeguard Children’*. It concludes: ‘*Summary of all decisions made in respect of Ava; no role for Sheffield Children’s Social Care. Outcome: No further action’.*
  49. At the beginning of September 2018, Ava started secondary school. She had, by that stage, attended five primary schools in total. Initially, Ava travelled to and from school independently and she appears to have managed this successfully. Within two weeks, however, Ava left school early and ‘went missing’ with a school friend. She was later located in a city shopping centre and returned by police. Arrangements were made to collect Ava from school from then on.
  50. The record suggests that Ava had her first assessment session with CAMHS on the same day that she started her new school. The outcome, however, was not immediately known to professionals working with her. CSC notes reflect the SW’s frustration that, despite her efforts, she was unable to achieve clarity from CAHMS about their assessment; their intentions; and, timescales for action. Ava’s second CAMHS appointment appears to have taken place on the same day as the next looked after child review in October 2018. The poor timing of these appointments is noted.
  51. The looked after child review in October noted that Ava had been living in Sheffield for 7 months and that she had consistently said that she did not want to be there. She continued to struggle being apart from Georgia. More positively, she appeared to be making relationships with a number of members of staff. And, the fact that incidents within the home were reducing in frequency and intensity was also encouraging. At the same time, however, there were worries about her behaviours in other areas. For example, it was noted that Ava had run off from school or home on four occasions in the previous month.
  52. Ava had been in secondary school for just less than six weeks. Already, her poor school attendance and refusal to go to lessons were causes of concern. Ava was identified as ‘a priority’ for the Virtual School; the VS trigger for non-attendance (75%) had been hit and she was refusing to attend lessons. Since then, her attendance had continued to decline and she was yet to complete a full week.
  53. At Ava’s personal education plan (PEP) review, the school was asked to consider ‘My Plan’ for Ava which would provide her with additional support. This could have been the first step towards instigating an Education Health and Care Plan (EHCP), although that would not happen until a third review of progress had taken place under My Plan. The school, however, was of the view that it would be more beneficial to get to know Ava better and to discuss the possibility of My Plan at the next care planning meeting.
  54. The VS attendance officer was either allocated or confirmed as Ava’s key worker from the VS[[3]](#footnote-3). The officer established regular contact the school and the children’s home. It was agreed that the school attendance officer would visit the children’s home to follow up non-attendance. The VS report confirms that school were clear about what was expected from them and they were challenged if actions agreed in meetings were not carried out. There was, however, limited evaluation or assessment of the impact of the monitoring work and other activities carried out by the key worker.
  55. The VS emphasises that schools have day to day responsibility for keeping children safe and supporting their welfare and that, in this case, the VS was able to contribute through its monitoring service. At the same time, its learning summary notes that the VS and other professionals did not look for opportunities to build on what schools were saying about what was and what was not working for Ava.
  56. The VS is primarily focussed on the school placement that a looked after child has at that time, with involvement if school moves are being planned. It does not formally review cases across multiple school placements. In this case, however, the VS suggests that *‘it might have been useful to review learning from schools’ perspectives,* *given the number of school placements and the lack of Ava’s engagement’.*
  57. Discussion between the independent reviewers and the children’s home manager suggested that the manager was not entirely convinced that the significant efforts designed to improve Ava’s school attendance were always helpful to their overall therapeutic aims, as they frequently resulted in increased conflict and confrontation between Ava and carers[[4]](#footnote-4). It is not known whether this implied tension was articulated at the time[[5]](#footnote-5).
  58. Three days after her looked after child and PEP reviews, Ava had her annual health review. That states that Ava was very mixed up with attachment difficulties and trust issues. She was recorded as having a history of physical and verbal abuse towards her carers and to have ‘emotionally challenged dysregulation and anger outbursts’. In the month before her health review, Ava had made 5 calls to the NHS 111 service. At the end of September, Ava had attended the ED with abdominal pains. Ava said that she was scared she might be pregnant, although she denied being in a sexual relationship. A pregnancy test was negative. This is not explored in information provided to the review. Again, it is an issue that is likely to have been picked up in a practitioners learning event. On the day of the health review, Ava was noted to have ‘no suicidal or self-harm thoughts’. She was described as being ‘*under the care of CAMHS’*.
  59. In mid-October 2018, Ava’s GP received a letter from CAMHS following ‘the completion of their initial assessment’. The letter reports concerns about verbal and physical aggression and challenging behaviours. Ava was reported to be having difficulty with loss and rejection. The planned intervention was to be ‘an MDT and further support’. It is also noted that, in her meetings with CAMHS; Ava had alleged that she had been hit by a member of staff in the children’s home and also by a former foster carer. It was stated that the local authority had been informed.
  60. It is not clear whether a copy of the letter to Ava’s GP was received by Knowsley CSC/ Looked After Children’s Health Team. It is clear, however, that within CSC, the lack of clarity about CAMHS intentions continued to exasperate. CAMHS’ next step was noted to be an intention to meet with children’s home staff on 8 November. CSC records indicate that Ava’s attendances at ED and suicidal presentations were considered by CAMHS to be ‘more behavioural’ and ‘rooted in her wanting to leave her placement and get back to Liverpool’.
  61. In the face of this slow progress, therefore, Ava’s circumstances were discussed at the Complex Mental Health Panel in Knowsley. All members agreed that the therapeutic package offered by the residential care provider should be accessed. A funding request was to be made to the CCG.
  62. Two days later, CAMHS cancelled the proposed meeting at the children’s home and a new arrangement was made for December 2018: it is not clear from the chronologies whether that meeting took place. By this stage, the children’s home was caring for Ava 2:1 due to her behaviours and continuing allegations against staff.
  63. Between September and December 2018, Children’s Home 1 continued to record incidents of Ava’s physically and verbally challenging/ aggressive behaviours with staff or other young people. An intervention meeting to consider Ava’s ‘missing’ episodes concluded that there were no obvious ‘pull factors’ for Ava and there was no evidence of sexual exploitation. Staffing continued at 2:1 ratio.
  64. Incidents continued into the New Year and, while some were ‘de-escalated’; on one occasion, police were called by staff as Ava was threatening ‘to stab (a member of staff) with a broken mug’ and to hurt herself. On a more positive note, however, a therapist had been identified for Ava and she had met with Ava’s social worker to consider the next steps.
  65. Then, in the middle of January 2019; Children’s Home 1 served 28 days’ notice on Ava’s placement. The placement chronology refers to frustration on the part of the children’s home that Knowsley had not provided an adequate response to the issues that they had brought to the local authority’s attention. In conversation with the reviewers, the children’s home manager re-stated that this was not a criticism of Ava’s social worker who was described as ‘fantastic’ but rather of the manager’s frustration that a decision was not made earlier to access in-house therapy. As a result, staff reported feeling that the children’s home was simply trying to contain Ava rather than helping her build a secure base to grow from.
  66. The CSC’s view of the end of placement is, on the other hand, that ‘… *the placement was not skilled enough to be able to stick with Ava through the manifestation of (her) trauma’*. The CSC learning summary acknowledges, however, the local authority ‘had not appreciated the level of distress that Ava would exhibit’ when placed in residential care.
  67. It is not clear whether the local authority would have served notice on the placement had Children’s Home 1 been prepared to continue to look after Ava. The CSC learning summary states, however, that, with hindsight, it should have considered ending the placement sooner but that ‘*there were always concerns about the lack of Availability of suitable placement and the impact on health and education of a placement move’*.
  68. Towards the end of January, the Whole Life Commissioning Team – Access to Resources Team (ART) received a referral from the SW for a new placement for Ava. A care planning meeting, chaired by CSC team manager, discussed the type of placement that Ava needed and how to ensure that she could access therapy as soon as she moved.
  69. By the middle of February, the identification of a new placement for Ava was beginning to take shape. The VS began to look for a suitable school nearby. The match was agreed by the Head of Service and the CSC team manager applied to Knowsley CCG for funding for therapeutic support in Ava’s proposed new placement.
  70. On 20 February, Ava moved to Children’s Home 2. At that point, Ava was 11 years and 7 months old.

* 1. Children’s Home 2 learning summary indicates that, from the start, Ava was physically and verbally challenging so that there was ‘*a greater need for physical intervention as adults proved they could care for her’*. Ava is described as needing lots of reassurance and as demonstrating ‘*an ambivalent attachment style’*. It appeared to Children’s Home 2 that ‘Ava was intent on ending or breaking down the placement from moving in until she started to settle about 3 months later’.
  2. At the beginning of March 2019, Ava started at her new high school. She was also registered with a GP. Her GP records contained an alert that she was a looked after child and that she had ‘*suffered from a depressive disorder since May 2018’*[[6]](#footnote-6).

* 1. From a CSC perspective, Ava’s placement move had proved to be generally positive. At the first looked after child review at Children’s Home 2 a month later; the IRO noted that Ava ‘seemed to be adjusting to the changes in her life’. Although Ava continued to look for more contact with Georgia; it was agreed that the current arrangements were meeting the needs of both children.
  2. It was recorded that Children’s Home 2 would be undertaking a 12 week assessment to inform the nature of the therapeutic support that Ava would need. In the meantime, the IRO also recommended that ‘*life story work should be revisited at some point*’ and should be discussed as part of care planning.
  3. Ava’s PEP was completed on the same day as the looked after child review took place. It was noted that Ava was struggling to get into school on time. She was coping well in class, however, although demonstrating difficult behaviours in unstructured times. She had ‘left the school site’ on a number of occasions.
  4. In April, the GP received a letter from CAMHS in Sheffield stating that Ava had been discharged due to her transfer out of area. CAMHS indicated that the service had been about to start sessions re: emotional regulation. This was not what had been understood by professionals working with Ava at the time. It is notable, however, that CAMHS proposed focus for therapeutic work was the same as had been recommended in the CAMHS mental health assessment in West Lancashire 14 months earlier.
  5. At the end of the month, it was agreed that Ava’s therapy at Children’s Home 2 would not start yet as she did not have an attachment figure in placement. In the meantime, there would be some group therapy to support Ava and ‘the other young people[[7]](#footnote-7)’ who lived together. It is not clear whether this happened but in the middle of May; Children’s Home 2 requested 2:1 staffing in the short term for Ava who been displaying extreme bullying behaviours towards a fellow resident. That young person had made a formal complaint against Ava.
  6. At the end of May 2019, the SW found Ava to be ‘*the happiest she had seen her in a long time*’. Although Ava’s relationship with the other young person in the house continued to be problematic, Ava was more settled overall than she had been in her previous placement. She appeared to be forming a good relationship with her key worker. For the first time in a year, Ava did not ask the social worker to move her.
  7. In mid-June 2019, Ava went missing from placement for the first time. She had gone to meet three of her friends from school and went to ‘a local park’. She was found by the police and returned to placement just before midnight; two hours after she had left the premises. This is the first time that she had gone missing in 6 months. Ava was ‘de-briefed’ by her key worker. It is possible that this is the same park where Ava was later assaulted.
  8. Just before the end of June, a second looked after child review took place and Ava’s PEP was reviewed. Ava continued to have difficulty regulating her emotions which, at times, escalated into aggressive outbursts but the review reflected the positive progress that Ava had been making. Although she had not been in a position to date to access therapy; it was hoped that this would begin during the forthcoming review period. The IRO noted that Ava spoke positively of her named therapist and that she was able to identify how she was going to help her.
  9. In the meantime, Ava had become aware that that her mother, MA, had been in touch with the social worker and she had ‘lots of questions about that’. A plan was made for SW to meet with Ava to answer those questions. This information reinforced the IRO’s view that ‘Ava needed life story work carrying out with her’. It is not known what, if any, life story work had already been undertaken with her.
  10. The PEP recorded that Ava’s school attendance was 78%. Ava was making expected progress in some subjects but her attendance in some lessons was still poor. Ava was said to be accessing emotional support frequently through the school pastoral system. She had asked for help in keeping friends. It is not known what actions followed, but the VS acknowledges that ‘*if* *she continues to struggle with establishing effective and lasting relationships particularly with her peers then we may see a repeat of this pattern …’*
  11. By the beginning of July 2019, Ava had started her 1:1 sessions with her therapist who planned to undertake life history work with her, based on information from the SW.
  12. In the middle of the month, Ava went missing from placement for the second time. There were concerns that Ava and a friend had been planning to meet up with a man whom they had asked for cigarettes and money. Ava’s friend’s father brought Ava back to placement, after the girls had arrived at the friend’s house.
  13. As the result of this incident, a referral was made to Knowsley’s child sexual exploitation team (Shield). It was considered, however, that the incident had been a one-off and that there were no signs that Ava was being sexually exploited. It was agreed that Shield would consult with the placement and give them work to complete with Ava.
  14. A week later, Ava was taken by one of her carers to see the GP with low mood. During the consultation, Ava reported frequent thoughts of self-harm with previous harm by cutting. She denied any previous contact with mental health services. The GP made a referral to East Lancashire Child and Adolescent Services (ECLAS), marking it urgent.
  15. This referral was considered by ECLAS at MDT and the risks of harm were noted to be: looked after child; frequent moves of placement; and, thoughts of self-harm. ECLAS planned to close the referral and to discharge Ava back to the care of the GP. In the closure letter, the service indicated that for looked after children, referrals would only be accepted if they came from social workers. The GP did not follow this up with CSC at that point.
  16. In its submission to the Rapid Review, ELCAS reported that the reason for accepting referrals only from CSC for children who are looked after is ‘… *to ensure that all referrals are appropriate and contain all the relevant information that we require. In this case we would also want to know what the plan was for (Ava in the (East Lancs) are, given that she had only moved there a few months ago. Because she is a looked after child placed out of area, we would also want services … to agree funding for any intervention she may require’*.
  17. At the beginning of August 2019, the incident that gave rise to this multi-agency review took place. Ava had been allowed free time, with staff checking on her regularly, and had been in a park at the end of her road. She returned to Children’s Home 2 just after 10pm with two other girls. She was very upset and crying. Ava gave a clear description of having been led by a girl that she did not know to a wooded area where she was raped by three teenage boys. A number of other boys and girls were present in the vicinity ‘having sex’. Ava had had her 12th birthday the week before.
  18. The police were informed and a criminal investigation began immediately. Specialist officers de-briefed Ava and, after addressing forensic issues, arranged for her to be interviewed (ABE). Lancashire child sexual exploitation team (Engage) was informed of the incident. It was noted that ‘other females named by Ava were open to the Engage team; however, Ava’s case was ‘being managed as rape by CID’. Engage health workers requested emotional support for Ava from Virgin Care, which provided health visiting and school nursing services in the area. This was followed up by the Knowsley Looked After Child specialist nurse to ensure that, where possible, a school nurse would attend any further meetings for Ava.
  19. A strategy meeting took place two days later in Knowsley and it was agreed that Ava would remain in her current placement. At that point, it was considered that staff at the children’s home were best placed to care for Ava and to support her through her experience. It was agreed that Ava would not be allowed unsupervised or free time and no phone access. Ava was recorded as ‘a high risk when missing’ on the police system.
  20. The strategy meeting was followed a few days later by a multi-agency meeting with Lancashire Police and Lancashire Engage. That meeting included 31 members of the Engage Team, specialist social workers for Lancashire and the police. Although it was the incident with Ava which triggered the meeting; there were a number of girls involved about whom there had been concerns of sexual exploitation for some months. Ava had now become connected to that. Significantly, it is recorded that police had identified that the park in which Ava met the girls was a ‘child sexual exploitation hotspot’; Children’s Home 2, however, had not been aware of this.
  21. In the middle of August, the two girls who had led Ava to the wooded area were charged with arranging or facilitating sexual offences against children and perverting the course of justice. They were released on bail with a condition not to contact Ava. Staff at Children’s Home 2 were advised that there might be repercussions and a vulnerable persons' marker was put on the address.
  22. In the meantime, Ava’s SW found her to be confused and unsettled. Ava reported feeling unsafe but did not know whether she wanted to move or stay. Ava’s key worker had also left the organisation. As Ava had been close to her key worker, this was another loss for her.
  23. Around this same time, Ava went missing. She had gone to a shop close to her placement with a member of staff. On the way home, she asked to go to the park. When she was told no, she ran off. A 999 call was made and police responded immediately. Ava was located within 20 minutes; she was with one of the girls who had been charged with offences against her the day before.
  24. A week later, Ava was taken to the GP who prescribed treatment for pain associated with the sexual assault. The GP was aware of the circumstances and of the current investigation. Later that evening, Ava attended the OOH service supported by a carer. She had been prescribed antibiotics for a urinary tract infection. STI (sexually transmitted infection) screening had still not been carried out, as the ‘Safe Centre’ in Preston were ‘still trying to find a paediatrician in the local area to help with this’. The East Lancashire CCG report to the Rapid Review noted that the East Lancashire deputy designated nurse for children was to link with the Safe Centre to ensure that STI screening took place. Although there is no specific confirmation that STI screening has taken place; it has not been identified, through additional questions to agencies, as an outstanding issue.
  25. Locally, children who may have been subjects of sexual abuse or victims of sexual offences are referred to the Paediatric Sexual Assault Referral Centre (SARC) at Alder Hey Hospital. Arrangements are governed by pan-Merseyside child sexual assault multi-agency care pathway. Those arrangements include referrals for ‘in-house psychologist’ for child and to Independent Sexual Violence Advisor (ISVA) for child/ parent within 2 days. STI screening, pregnancy test, and mental health screening are addressed at follow up appointment within 2-3 weeks. Information from the local authority indicates that in Ava’s case, that she is still supported by the Safe Centre and it is intended that a referral will be made for an ISVA for Ava ‘when / if there is trial’.
  26. At the end of August, ART received a referral from CSC, seeking an alternative placement for Ava. Notice had not yet been served on the placement. The overview of the request, matching priorities and the young person’s characteristics appear to have been as before. There is no reference in the commissioning chronology to suggest that risk of sexual exploitation was an identified issue.
  27. In the context of care planning, however, the risk of sexual exploitation was one of the key issues being considered. Risk management plans were agreed for placement and school. It was agreed that sexual exploitation work could begin with Ava ‘to ensure that she was able to develop skills to keep herself safe’. This work was to be undertaken by Ava’s therapist, with Shield providing information and consultation. At his request, copies of risk assessments were sent to Knowsley’s Assistant Executive Director of Children's Social Care.
  28. When the social worker visited her in placement at the beginning of September; Ava was angry and upset, asking to be moved. She was said to be struggling with the fact that no-one was talking to her about what had happened, ‘although it had been explained that this was because of the police investigation’. The SW noted that Ava’s therapist had undertaken some ‘non-verbal symbolic work’ with Ava to ‘help her process what had happened subconsciously’. Ava had started back at school.
  29. Over the course of the next three weeks, Ava went missing from placement on one occasion and missing from school on five times. On the first time that she went missing from school, she is thought to have travelled by train with a 15 year old friend, Child X, to Burnley where Child X’s parents lived. Police information suggests that Child X got cannabis from contacts in Burnley and that she shared this with Ava. On the four subsequent occasions, staff from Children’s Home 2 or police intercepted Ava, in her friend’s company, at Accrington railway station and she was returned to placement.
  30. At the end of September, the third looked after child review took place. Prior to the meeting, the SW found Ava to be quiet and nervous about the meeting. She asked if there would be a decision about whether she would move or stay. Ava said that she did not feel safe anymore and that she wanted to move.
  31. The looked after child review acknowledged that this had been an incredibly difficult time for Ava. Prior to the incident, she had been settling well and had a positive package of support around her. Since then, it appeared that Ava had been putting herself at risk by running off frequently: she no longer seemed to be investing in the placement and talked about wanting to return to Liverpool. It was acknowledged that, if Ava were to move again; the local authority would consider the possibility of Ava’s current therapist continuing to work with her.
  32. On the last day of September, the decision was made by CSC to move Ava. CSC describes this decision as having been based on ‘*careful consideration of the risks to Ava in the community and professionals expressing the view that she should not be considered safe unsupervised*’.
  33. In its learning summary, however, Children’s Home 2 describes this decision ‘*very disappointing*’. From its perspective, the decision to move Ava four days later, ‘*left (the home) with a move that felt like a crisis, when it needn’t have been*’.
  34. At the beginning of October 2019, therefore, Ava moved to Children’s Home 3 in Heysham, Lancashire. At that point, Ava was the only child in the home and it was understood that matching would be ‘*done around her’*, when decisions were being made about placing children in the other 2 rooms. The rapid move is noted to have had an impact on planning in respect both of Ava’s education/ schooling and of her health review which had not yet been completed.
  35. A member of the Shield team met with Ava’s therapist shortly after her move to discuss the work that had already been undertaken with Ava and to plan further work in respect of child sexual exploitation. This work has subsequently been picked up by care staff. The children’s home has been supplied with various resources, in addition to having had access to direct consultation from Shield on a regular basis.
  36. The local authority’s commissioning team has provided a comprehensive learning summary to the review, describing the general process of placement searches and the detail of those which took place within the review period. The report identifies both factors which support good practice in commissioning and challenges or barriers to effective work.
  37. In general, the learning summary emphasises the positive impact of experience, good knowledge and relationships with children’s homes providers; evaluation of placement options by due diligence; and co-working with colleagues from Liverpool and across the 23 north west local authorities with, among other aims, a view to ‘*raising the bar on quality and best practice by providers*’. In this particular case, effective commissioning was supported by good communication and working relationships with the social worker and team manager and attendance at a multi-agency planning meeting at Children’s Home 1.
  38. Nevertheless, the task of matching placement to a child’s need is consistently limited by factors outside the commissioning team’s control. These include: the increase in the number of children being looked after coupled with a reduction in the number of Available foster placements; the impact on local sufficiency of distant local authorities placing children in an area; the complexity of children’s needs militating against placement in multi-bed homes; and, the limited Availability of dual and solo bedded homes.
  39. For Ava in particular, complicating factors included: the complexity of Ava’s needs and the risks to which she was vulnerable; the timescales for decision-making; the local arrangements for quality monitoring; and, the resource available to manage the volume of other referrals.
  40. The learning summary suggests that, with hindsight, it would have been helpful if a member of the team or quality improvement service could have attended the strategy meeting that took place following the precipitating incident. It acknowledges, however, that resources to attend key meeting for children would be an issue.
  41. Information provided by Lancashire Police suggests that a suspect has been identified and interviewed with regards to the allegation of rape against Ava. He is noted to have been released under investigation while further enquiries are being conducted.
  42. How effective were looked after child reviews?
  43. As already noted; reviews took place every three months, which is a local requirement for children placed out of borough. The IRO was consistent in highlighting the lack of therapy for Ava and in intervening on her behalf with the local authority. The CSC learning summary indicates that an IRO challenge about the delay in accessing therapy for Ava while she was living in Sheffield contributed to the decision to pay for in-house services. The IRO learning summary acknowledges, however, that ‘*the escalation process by the local authority and the IRO service to CAMHS could have been more robust’.*
  44. The IRO maintained good contact with Ava during the review period and was confident that she understood Ava’s views in respect of her care plan. The IRO notes that during the review period, meetings were generally well attended. Children’s Home 2 learning summary refers to looked after reviews being ‘thorough’ and ‘comprehensive’, with the IRO always taking time to meet Ava and to ascertain her views prior to the meeting.
  45. Participation in looked after child review for partner agencies for children placed out of borough is through the attendance of, or through written reports by, local practitioners involved in Ava’s day-to-day care, health, education and wellbeing. The IRO learning summary indicates that physical attendance by professionals is more frequent when children are living in residential rather than in foster care. When the child is living out of borough, however; from the perspective of the IRO, it can be more difficult to challenge agencies about their contribution to a child’s care plan. This is partly as a consequence of unfamiliarity with different organisations but also of not being fully cognisant of local commissioning offers for looked after children.
  46. Within Knowsley, there has been no expectation that a member of Knowsley looked after children health team would attend or contribute to the reviews of individual children placed out of borough. Virtual School officers can attend care planning reviews on request, although it does not appear that they attended any of Ava’s looked after child reviews. The review of Ava’s PEP, however, generally coincided with Looked After Child reviews.
  47. The IRO learning summary indicates that while there was good attendance by agencies and organisations in this case; it would be generally beneficial if the VS, Looked After Children Health Team and, possibly, the local child sexual exploitation team could be ‘*included from the beginning*’. The IRO learning summary envisages that their involvement could provide a link with the relevant out of borough partner agencies to identify any pertinent issues with local services.
  48. The IRO is reported to have promoted the sibling assessment which took place in the pre-review period and to have been instrumental in securing an independent advocate for Ava.
  49. How well were Ava’s lived experiences understood?
  50. Much of Ava’s everyday life was recorded, reported on, and discussed. By its nature and purpose, however, a large proportion of that information centred on her problems and behaviours. As a result, it has been very difficult through this review to develop a picture of Ava through, for example; her favourite activities; her likes and dislikes; and, the things that make her laugh. These are details that are more easily provided through a learning event with practitioners and managers.
  51. Professionals have consistently acknowledged the cumulative harm that Ava has experienced throughout her life. Specifically, she suffered neglect, instability and loss during her early years. She has subsequently been separated from her sister who, at the same time, continues to enjoy the family life she has lost. Ava has had repeated exposure to short-term relationships with carers. She is also living with the impact of the most serious of sexual assaults.
  52. Ava has been described as being ‘without an anchor’ which, for anyone, is a very frightening and lonely experience. The impression gained of Ava during the review period is of a child whose behaviours have been driven by confusing and red-hot emotions but whose inner world was not accessible to adults around her. Outward demonstrations of Ava’s emotions were often through anger and aggression. Concern about Ava’s emotional wellbeing appears to have underpinned practitioners’ consistent efforts to secure therapy for Ava.
  53. It is already apparent that Ava has found it difficult to make and sustain friendships. Some of the reasons for this are evident. Some of the consequences are also clear. For example, not being able to make friends appears to have affected her experience of school life. And, not being able to judge ‘who would make a good friend’ is likely to have made her susceptible to exploitative relationships with other young people.
  54. The importance of friendships for young people is not always given appropriate weight by professionals working with them. Friendships can be a source of pleasure and support. They can increase a person’s sense of belonging and purpose and can improve self-confidence and feelings of self-worth. Having friends can also make it easier to cope with traumas and difficult life events. For Ava; not having friends is likely to have reinforced her negative feelings about her place in the world and of her value to others.
  55. The IRO learning summary acknowledges that ‘*Ava’s ability to manage her friendships and her free time in the community’* were not fully considered. An opportunity to support Ava to learn and practise ‘friendship skills’ in a safe environment appears not to have been taken[[8]](#footnote-8) [[9]](#footnote-9).
  56. There is limited evidence that professionals understood the full extent of Ava’s experience as a child of mixed heritage living in environments which were not ethnically diverse. The local authority reports that it was satisfied that IC, in particular, had been providing Ava with ‘lots of support’ in terms of her dual heritage. It acknowledges, however, that it was not until Ava went to Sheffield that attempts were made to identify positive role models for her. Since then, it is understood that Ava has been placed, and has attended school, in more diverse and multi-cultural environments.
  57. It is highly likely that Ava will have been exposed to racism which exists across British society. Black and minority ethnic children need to be protected from, as well as prepared for, the various forms of racism and discrimination they may encounter in their lives. As described in [‘Caring for a child of a different ethnicity’](https://www.nottinghamshire.gov.uk/media/127866/caring-for-a-child-of-a-different-ethnicity-web-version.pdf) (Bristol Council); a series of moves in early childhood can mean that a child will have had varying experiences of how families perceive or have dealt with racism. This is likely to have been Ava’s experience but the extent to which this was recognised by practitioners and managers has not been articulated.
  58. In addition, for Ava; being cared for by white foster carers will have made her status as a foster child more visible. Ava herself drew attention to this when she said to one of her carers in Sheffield that, unlike Georgia, she ‘couldn’t be Marian’s daughter’ as she did not look like her. There was also a suggestion that, at some level, Ava believed that her ethnicity was a factor in the decision to move her and not her sister.
  59. On a practical level, caring appropriately for a child’s skin and hair makes an important contribution to their wellbeing, self-esteem and identity. For children of mixed European and Afro-Caribbean heritage, this is likely to mean having a different hair and skin care regime from children with a white ethnic background. It has been reported, however, that it was not until Ava moved to Sheffield (where one of her carers was the mother of mixed heritage child) that Ava was given the support she required to manage and style her hair. It is not known what help Ava is currently receiving in respect of her personal grooming.
  60. What were the factors which supported good safeguarding practice and what were the barriers?
  61. Despite the circumstances which gave rise to this review; there is evidence throughout the review period of factors which support good safeguarding practice. Most particularly, there has been the consistent involvement of a committed social worker who has been reliable for Ava and who has able to form good working relationships with other adults around Ava. In addition, Ava has had an advocate and an independent visitor, as well as key workers in placement and regular contact with the Independent Reviewing Officer.
  62. Shortly after the beginning of the review period, Ofsted inspectors described Children’s Home 1 as providing ‘highly effective services that consistently exceeded the standards of good’. The children’s risks and vulnerabilities (including Ava’s) were ‘unquestionably understood’ and risk management strategies were ‘individualised and of the highest quality’. The effectiveness of leaders and manager was found to be outstanding.
  63. The local authority and Children’s Home 1 both referred to the risk management plan which was put in place with the Sheffield LADO as an example of good safeguarding practice as it ensured that Ava was heard and supported while, at the same time, reassured staff who had considerable anxieties about the number of allegations which Ava was making. It is acknowledged that taking this action helped keep Ava’s placement from disrupting at that time.
  64. In the circumstances at the time; that intended balance would have been a particularly difficult to strike as there were high levels of physical contact between Ava and members of staff in the context of heightened emotion, both in the form of assaults by Ava and of physical interventions by staff.
  65. It is reassuring, therefore; that Ofsted also noted that physical restraints were ‘used on safety grounds when there was no alternative’. The registered manager described as being ‘a highly skilled trainer in managing actual and physical aggression’ and she was said to have ‘disseminated this learning across her staff team’.
  66. The issue of the high number of restraints recorded in respect was discussed in Panel, both in terms of ensuring that the looked after health team is able both to capture the data and to use the data to make a difference. The fact that an individual child’s health reviews takes place only annually was identified as a barrier to ensuring, in real time, that a child’s mental health was being supported by holding rather than being compromised. Nevertheless, the group was of the view that the possibilities should be explored in more detail.
  67. In terms of additional safeguards, it has been noted that there were regular visits to the placement in accordance with Regulation 44 of the Children's Homes Regulations 2015 and that the independent visitor spoke to CSC every month.
  68. Early indicators that Ava could be at risk of sexual exploitation either online or in the community appear to have been identified and dealt with promptly and proportionately.
  69. The circumstances in which Ava moved from Children’s Home 1 to Children’s Home 2 have been described above. It is clear that, at that point, it was becoming increasingly difficult for Children’s Home 1 to keep her safe. Seven months before Ava moved placement, Ofsted had described Children’s Home 2 as providing a good standard of help and protection for children.
  70. In particular it was noted that young people ‘rarely’ went missing from home and that, when they did; staff were ‘active in their response to locate young people and to liaise with other agencies to reduce any recurrence’. Moreover, the need for staff to use physical intervention was said to be infrequent, as ‘staff employed individualised de-escalation techniques effectively’. As a result, it was reported, ‘young people, over time, begin to manage their emotions in more socially acceptable ways’.
  71. These were positive indicators in terms of planning for Ava.
  72. Prior to the incident which gave rise to this review, Ava was considered to be making good progress in a safe environment in Children’s Home 2. The response to the incident by all relevant agencies and organisations appears to have been as would be expected and has been described in the previous section.
  73. In terms of safeguarding practice immediately before the incident; it appears that, on the evening in question, Ava had been in the park close to her placement and was being checked staff every half hour, but at her at her curfew time of 8pm; she asked for an extra half hour. This was agreed, but then were 15 minutes late going to check on her. When they arrived at the park, she was missing. It is not clear what action followed then between 9.45 (approx.) and 10.15 when Ava came home.
  74. The rationale for half-hour checks has not been given. It is not known either whether Ava’s susceptibility to influence by others was taken into account in assessing risk of harm when she was unsupervised by an adult.
  75. Children’s Home 2 learning summary refers to the internal investigation/s and to the Ofsted inspections which took place following the event. While the learning summary refers to the error of a particular member of staff who was expected to check on Ava; it acknowledges a number of systemic issues including the absence of a separate risk assessment for free-time/ unsupervised arrangements for Ava. Instead, the existing risk management plan was found to contain insufficient detail to direct staff. For example, there were no details on the exact checks that staff were to follow when Ava was out unsupervised from the children’s home. The risk assessment had not been shared with CSC.
  76. CSC acknowledges that it had not considered the relevant risk assessment prior to the incident as it should have. With hindsight, it has recognised the shortcomings described above.
  77. Crucially, Children’s Home 2 was not aware that that police had concerns about the park and so, did not appreciate that the location of the children’s home itself might have increased Ava’s vulnerability. Children’s Home 2 now includes comments from police and the local child sexual exploitation team in its ‘safe location assessment’. It is also noted that meetings which had previously taken place quarterly with the Missing from Home coordinator have since been reinstated.
  78. Following its inspection after the incident, Ofsted rated the home inadequate, noting that arrangements for the supervision and protection of children were not clear and that ‘*this was particularly true when children are outside of the home*.’ The report refers to (Ava’s) free time risk assessment as ‘*lacking clear strategies’* which allowed staff to ‘use their discretion’. It concluded that there had been a lack of management oversight and failure by staff to protect a child[[10]](#footnote-10).
  79. Since September 2019, work has been undertaken with Ava to raise her awareness of child sexual exploitation and to help provide her with the knowledge and skills to reduce the risk of harm to her. The sexual exploitation team learning summary acknowledges that the full assessment of Ava’s knowledge and risk of sexual exploitation has taken longer than would normally be the case, ‘*mainly due to the fact that the work is being done by a third party… and the assessment will be informed by reports received by her therapist and now placement staff*’.
  80. The rationale for the decision to move Ava to Children’s Home 3 has been given. From partner agencies’ perspectives, the safeguarding risks of Ava remaining in Children’s Home 2 were greater than the risks inherent in a further placement move.
  81. The circumstances of Ava’s move to Children’s Home 3 have also been described above. Coincidently, Children’s Home 3 was also inspected by Ofsted while Ava was living there: she had been in placement for almost two months. That inspection found that the overall experiences and progress of the children and young people were outstanding, taking into account similarly outstanding help and protection. Staff were reported to have a very thorough safeguarding knowledge and to be highly skilled in responding to children’s needs. Children’s Home 3 also impressed inspectors with its emphasis on education while, at the same time, ensuring that ‘there is a healthy balance between study and leisure activities’.

## Ava’s views

* 1. The independent reviewer provided a general framework for conversation with Ava. This was designed to support her to provide her perspective on the issues that had most affected her over the last few years and to help her articulate what lessons she might have for professionals. It was anticipated that any questions would be framed in the most open way possible in the course of the conversation.
  2. The short document suggested that main areas for conversation with Ava should be:
     + How safe and supported does she feel now?
     + What are the things that are best in her everyday life?
     + Who are the people (professionals) that she feels closest to?
     + What is it that they do that helps her?
     + What have been the things that have affected her most over the last couple of years?
     + How did professionals help in those situations?
     + What does she think professionals could have done better?
     + If she could speak to professionals working with young people in her situation; what would her messages be?
  3. In the event, Ava has provided written answers to the questions contained in the document provided. A copy in Ava’s own handwriting is provided at Appendix 1.
  4. These are Ava’s answers:
     + I am very safe and I am supported very well
     + I used to go out on activities with XXXX and ZZZZ. Would have contact with my sister.
     + YYY AAA and Social Worker)
     + When ~~am~~ I want to talk they will sit down ~~and~~ with me while I talk
     + My assult
     + Move me to help get a fresh start or to help me feel safe
     + Nothing
     + ~~Give them~~ paitent with them be

## Analysis

* 1. Both the incident which gave rise to this review and its immediate impact on Ava have been described and discussed in detail within the Key Lines of Enquiry. It has been identified that a number of systemic weaknesses contributed to increasing Ava’s vulnerability on that evening and so increased the risk of harm to which she was exposed. These included: the absence of a discrete and agreed free-time risk management plan; a failure to implement the risk management plan which was in place; and, a lack of knowledge about the potential dangers present in the location.
  2. The relationship between these accumulative risks of harm to Ava and to the events which followed is, however, neither simple nor directly causative. In other words, the same risk factors could have existed on other occasions when Ava was unsupervised by staff and no harm might have come to her. While, at the same time, there is no guarantee that improved risk management would have prevented these crimes being committed against Ava. This position does not diminish, however, the importance of learning lessons from events.
  3. Analysis of the key lines of enquiry suggests that the lessons for Knowsley’s Safeguarding Children Partnership relate to:
     + Children’s free time risk assessments in the context of location risk assessments for children’s homes;
     + Supporting young people who have been the victims of sexual crimes;
     + Reducing the likelihood of foster placement breakdown leading to a child being placed in residential care;
     + Meeting the needs of minority ethnic looked after children; and,
     + Mitigating the known hazards for looked after children living out of borough.
  4. Children’s free time risk assessments in the context of location risk assessments for children’s homes
  5. In 2014, [Children’s Homes Regulations Amendment](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/339545/Children_s_homes_regulations_amendments_2014.pdf) required children’s home to assess a home’s location with the aim of strengthening safeguards for children. The local authority commissioning team describes the Location Risk Assessment as a standard document completed by each children’s home and provided to the local authority prior to any placement being made. This document helps inform placing decisions by social work teams.
  6. Children’s Home 2 is located within Lancashire police area. Additional written questions were sent to both Merseyside and Lancashire Police in May 2020. Both forces subsequently provided details of both their strategies for ensuring that children’s homes are aware of general information about the incidence and locations of relevant criminal activity as well as of their processes for providing updated local information to care providers.
  7. Lancashire Police report that it is the responsibility of Neighbourhood Teams and the relevant Missing from Home Co-ordinator to make relationships with individual homes. The force expects that ‘*relevant information will be shared, subject to ongoing operations, and the multi-agency child sexual exploitation teams would work closely with all parties involvement to safeguarding children and young people’.* Additional actions can also be considered in specific circumstances. It remains unclear, however, why previously routine meetings between the children’s home and the Missing from Home team had not taken place while Ava was in placement. Although the meetings are reported to have been reinstated since then; their unexplained absence for a period could represent a gap in safeguarding practice.
  8. Locally, Merseyside Police report that ‘*it is not clear that any feedback (from monthly Multi-Agency Child Exploitation meetings) is given to care homes in the area’.* They have, therefore, suggested potential remedial action. Their written response to the review states: *‘In Merseyside, there are PCSO[[11]](#footnote-11)care home SPOCs[[12]](#footnote-12) who are aligned to each of the care homes. It has been identified that they are not necessarily kept in the loop with environmental issues/ crimes and they are in an ideal position to be able to update the care home staff’.*  Their response goes on to identify how police processes could/ will be improved as a result of the issues raised by this review.
  9. Two recommendations arise from this learning:
     + Recommendation 1

Lancashire Safeguarding Children Partnership should be provided with a copy of this review report so that they can consider any outstanding safeguarding issues which are raised for them.

* + - Recommendation 2

Knowsley Safeguarding Children Partnership should seek reassurance from Merseyside Police, by December 2020, of the steps taken to improve safeguarding information-sharing arrangements with children’s home and the effect of these measures.

* 1. Learning from this review reinforces, therefore, that existing and future ‘free time risk assessments’ for individual looked after children must take into account all relevant about known hazards and risks in the community, including information from the police or local child sexual and criminal exploitation teams.
  2. At the same time, ‘free time’ risk assessments must take account of all relevant child factors including their age; stage of development; and, particular vulnerabilities. In this case, as in many other instances; Ava was ‘befriended’ by another girl who is alleged to have led her into the situation in which Ava was sexually assaulted. This highlights that free time risk assessments should also consider the child’s particular vulnerability to being caught up in exploitative peer relationships[[13]](#footnote-13).
  3. The CSC learning summary suggests that the local authority is of the same view. The third and fourth recommendations of this review is, therefore:
     + Recommendation 3

The Safeguarding Children Partnership should, by December 2020, obtain evidence from the local authority that all children living in children’s homes have satisfactory ‘free time risk assessments’ which accord with the findings of this review.

* Recommendation 4

The Safeguarding Children Partnership should seek reassurances from the local authority commissioning service that there are robust governance processes to ensure that location risk assessments are completed effectively and efficiently and are focused on the needs of the child.

* 1. Supporting young people who have been the victims of sexual crimes
  2. [The Survivors’ Trust](https://www.thesurvivorstrust.org/the-effects-of-sexual-violence-how-to-support-a-survivor) describes the devastating effects that the experience of sexual violence can have on every aspect of a person’s being and life. Although it is not inevitable that all victims will suffer from all effects, each individual is likely to experience a unique mix of symptoms of varying severity and degree of complexity. Before she was raped; Ava was already struggling to manage her emotions, to make and sustain relationships, and to navigate social situations. As a result, much effort has been made to ensure that Ava has had continuing access to a consistent therapeutic relationship, now focussing on her life story. In addition, Ava is involved in direct work in relation to sexual exploitation.
  3. Soon after she was raped, however, it was noted that Ava expressed frustration that no-one wanted to talk to her about what had happened. Information provided to the review suggested that professionals working with Ava, at the time, had referred to the perceived constraints of the criminal process. Additional information from CSC states, however, that *‘Practitioners were very open with Ava regarding the rape. It was very important that she knew that she could talk openly about this and get the support she needed. Her therapist was also available to discuss this with her when she wanted to’.* As already noted, Ava has additionally been supported by the Safe Centre (Preston) and by the Child Sexual Exploitation teams in Lancashire and Knowsley.
  4. In 2019, the Criminal Prosecution Service (CPS) published [legal guidance for safeguarding children who are witnesses or victims](https://www.cps.gov.uk/legal-guidance/safeguarding-children-victims-and-witnesses) which states that ‘it is a fundamental aspect of CPS policy that the best interests of the child are paramount when deciding whether, when and in what form, therapeutic help is given’. At the same time, it is acknowledged that this is a complex area of decision-making and professional practice. For that reason, the guidance refers to its previously published multi-agency practice guidance, ‘[Provision of Therapy for Child Witnesses Prior to a Criminal Trial’](https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-child-witnesses-prior-criminal-trial).
  5. That multi-agency practice guidance recommends discussions at a local level between the agencies concerned to explore practical ways to facilitate good practice with child witnesses and victims, with a view to setting out a local protocol setting out the approach to be followed. It is not clear that considerations in the CPS multi-agency guidance informed professional thinking in this case. The reviewer has been unable to find a local protocol. This gives rise to the fifth recommendation:
     + Recommendation 5

The Safeguarding Children Partnership should:

1. ensure that relevant practitioners and managers are aware of the CPS legal guidance in respect for safeguarding children who are witnesses and victims; and,
2. determine how multi-agency guidance relating to the provision of therapy for child witnesses prior to a criminal trial can best be embedded into local practice.

*Note: These actions should be consistent with the Pan-Merseyside multi-agency* *child sexual assault multi-agency care pathway.*

* 1. Reducing the likelihood of foster placement breakdown leading to a child being placed in residential care
  2. In terms of the ways in which the review of Ava’s story provides a ‘window on the system’; two particular elements of Ava’s circumstances and history are considered with a view to making recommendations for action.
  3. The first of those relates to Ava’s history of being looked after. As already described, Ava’s levels of emotional distress and consequent challenging behaviours were key factors in decisions that were made about her care. They led to the breakdown of placements intended to be permanent and were fundamental to the decision to place her in residential care. Then, when living in Children’s Home 1; while safer and more contained in some ways, her emotional difficulties continued as she struggled to adapt to group living. Two subsequent placement moves, while justifiable, will certainly have contributed to a sense of ‘not belonging’.
  4. A lesson from this review must be, therefore, about the importance of reducing the likelihood of a similar outcome for another child. Ava’s history reinforces the need for agencies and organisations to work together to ensure that children who are looked after can live in permanent homes where they are suitably supported.
  5. [Knowsley’s Sufficiency Position Statement and Action Plan 2018-2021](https://www.knowsley.gov.uk/knowsleycouncil/media/Knowsley-Media/Knowsley-Sufficiency-Position-Statement-2018-2021-min.pdf) indicates that the Council has a higher than national rate of children looked after in the age group 5-10 years old. The Council acknowledges that this has implications for planning, with ‘the potential for long term demand coming from this age group as they grow older’.
  6. At the end of March 2019, 22% of Knowsley’s looked after population were between the ages of 5 and 9 years old (66 children). It is not known to the review what proportion of those children (and 10 year olds) are in permanent placements, although the local authority will be familiar both with the children in this group and with their carers.
  7. The sufficiency report recognises the benefits of long term stable placements and that ‘improving placements and placement stability should underpin improved outcomes for children’. At the same time, it acknowledges that ‘children looked after are presenting with increasingly complex and challenging needs’ and that ‘there is a gap in the number of foster carers with higher levels of skills’, particularly in in-house provision[[14]](#footnote-14).
  8. It is possible, therefore, that by targeting children aged 5-10 and carers living together permanently, action taken now could increase the likelihood of them staying together as a family unit while the children pass through their teenage years.
  9. This would require a process of identifying accurately those permanent families where the gap is most evident between a child’s needs and their carers’ capacity to adapt to changes over time and then, determining how best that gap can be closed. Such an approach would be consistent with the commitments which the local authority has already made in respect of support to children and carers and ‘upskilling’ of foster carers in the Council’s Sufficiency Action Plan 2018/19.
  10. The sixth recommendation, therefore, is:
      + Recommendation 6

The Safeguarding Children Partnership should:

1. work with the local authority to agree a method of identifying those children aged 5-10 in permanent placements where there may be the most significant threats to long term stability;
2. commission a multi-agency audit of practice; and,
3. consider what actions partners should take on the basis of those findings, both immediately and at a strategic level.
   1. Meeting the needs of minority ethnic looked after children
   2. The second area of learning is in respect of Ava’s identity needs as a child of mixed ethnicity. It is important that social care and health practitioners, teaching staff and carers are able to recognise and respond purposefully to the potential needs of looked after children of mixed ethnicity, particularly those living and attending school in an area, such as Knowsley where the vast majority of residents identify as White British[[15]](#footnote-15). In 2017, Ofsted noted that ‘in the small number of cases in which children looked after are not White British, assessment and planning generally omit what it is like to be that child in a local environment that is not ethnically diverse’.
   3. Subsequent information provided by CSC and by the IRO service acknowledges that there has been limited exploration of Ava’s experience as a child of colour. The CSC report states that‘… *the majority of the focus has been on her being a looked after child and not residing in Liverpool where she is from’.* Both services have described activities which have been designed to support her developing a positive self-image but, in general, the IRO report notes that ‘*this is an area for development and, on reflection, needs to be strengthened’.*
   4. In addition to ensuring that the local authority and partners is able to address the identity needs of a child of colour; the Partnership needs to be confident that individual carers, professionals and settings openly acknowledge racism when it occurs and make clear that they will not tolerate it.
      * Recommendation 7

The Safeguarding Children Partnership should:

1. require all agencies to provide evidence, and evaluation, of all actions they have taken to improve the extent to which ‘assessments and planning for looked after children take into account what it is like to be a child of minority or mixed ethnicity in a local environment that is not ethnically diverse’ ; and,
2. identify what further action should be taken to suitably equip carers, professionals and children’s settings to identify and respond to racism when they encounter it.
   1. Mitigating the known hazards for looked after children living out of borough
   2. In terms of professional and safeguarding practice with Ava during the review period; the details are contained in the Key Lines of Enquiry. There is no doubt that this has been an extremely harrowing time for Ava and that she has suffered significant harm. There are, however, examples of good planning and decision-making with Ava’s needs and welfare being placed at the centre of professional concern.
   3. For the most part, learning summaries provided by agencies and organisations have been comprehensive and have demonstrated a good level of critical reflection. In particular, key partners have recognised the challenges for agencies, services and individual professionals when children who are looked after are placed out of borough. These include: the lack of professional knowledge about resources in the area; not having established multi-agency working relationships with local providers; and, more specifically for CSC, that distance can at times prevent rapid response by practitioners and reduce familiarity with contextual risks.
   4. The VS, in its learning summary, describes the range of activities that it carries out to support looked after children in education. For Ava; when she was relatively settled in foster care, the VS’s role was mainly to track her educational progress. Since then, the input from the service has increased ‘as required’. For example, there have been discussions between the VS and Ava’s social worker when school moves were being considered or planned, as well as discussion and collaboration with professionals/ schools inside and outside of Knowsley. Ava’s school attendance was also monitored and communicated to key professionals and carers.
   5. In addition to the actions by the VS attendance officer earlier; the service notes that it attended PEP and looked after child reviews where possible; liaised with admissions services in various local authorities; and, contributed to discussions about education with professionals involved. has took place between the limited influence it has had at times in terms of care planning, particularly where rapid placement moves are required and where there are a restricted number of suitable placements Available.
   6. At the same time, the learning summary acknowledges that while the service responded to changes in Ava’s placement; there were a number of gaps. For example, it had not been in a position to ask Ava about her wishes and feelings when schools were changing and, as previously noted; when Ava reported that she need help in keeping friends, no specific plans for this were recorded in her PEP.
   7. The review has highlighted for the VS that it needs to better understand the impact on individual children of repeated school transitions; to identify what is important to the young person; and, what can be put in place to support transition and to maximise the chances of achieving successful and stable education.
   8. From a health perspective; the most significant issue which affected Ava while she was living out of borough was her difficulty in accessing CAMHS. The frustrations both professionally, and on Ava’s behalf, in engaging CAMHS services locally to placement are strongly felt. Significant in those frustrations was that Ava had been assessed and therapy had been agreed before she moved to Children’s Home 1; but that neither her assessment nor her care plan was transferable. While the Looked After Children Health Team attempted to intervene, their efforts were unsuccessful.
   9. The review has until now concentrated on Ava’s unique experiences. Yet, it is known that many of the factors which affected Ava’s experience can also be features of the lives of children and young people who are placed more than 20 miles from home. In Knowsley, this is a relatively small number of looked after children (37).
   10. The [Children’s Commissioner’s report: Pass the Parcel (2019)](https://www.childrenscommissioner.gov.uk/publication/pass-the-parcel-children-posted-around-the-care-system/) suggests that many children who are in this situation struggle to settle; to attend school; to stay safe; to build trust with adults; and, to receive from local mental health services the help that they need. It is also likely that many of these children, like Ava, will have moved from one children’s home outside the area to another home which is both outside Knowsley and distant from their last placement.
   11. ‘Waiting for therapy’ was a common complaint made by children and young people who contributed to the Children’s Commissioner’s report. The commissioner notes that the pressure on children’s mental health services has been exacerbated by high numbers of looked after children being placed in a ‘cluster of homes’ in areas of relative deprivation from different areas of the country. Because of the insufficiency of resource, the commissioner found that children were left ‘*not only to suffer alone but …to develop their own coping mechanisms*’. Such ‘s*etbacks*’ in providing mental health services can also lead to ‘*needless months that children waste in places that they do not want to be’.*
   12. The review understands that there have been two innovations in Knowsley that are operating to support looked after children who need therapy. The first of these is the work of the multi-agency children’s complex mental health panel. The second has been the commissioning of a bespoke mental health service (Core Assets)[[16]](#footnote-16) for all looked after children.
   13. The multi-agency children’s complex mental health panel is attended by a representative from Knowsley CAMHS and is chaired by children’s social care. Social workers present difficult cases for consideration by the panel and potential solutions. It includes any Knowsley child who is looked after; regardless of the borough in which they are placed.
   14. The panel is attended by representatives of Core Assets and by the CCG (Designated Nurse) who can also support social workers to access funding if services cannot be secured within the core offer. The review has been advised that this forum has been very successful in securing services for children who did not meet the criteria for mental health services in the community.
   15. The review has been advised that Knowsley CAMHS continue to provide a service to those children that meet their criteria and this may be picked up through the complex mental health panel or via a routine referral.
   16. It is positive that Knowsley has been using its best endeavours to mitigate the risks for looked after children who are struggling to access CAMHS but the systemic factors, which underlie placements at a distance, are likely to need national solutions. As part of her recommendations for government, government departments and the NHS, the children’s commissioner recommends the publication of a protocol focusing on the mental health needs of children in care, specifically to include measures to ensure that moving to a new home address does not affect access to support. This situation underpins recommendation 8.

* Recommendation 8

The Safeguarding Children Partnership should determine how it might work collaboratively with other local Partnerships to support this national imperative.

* 1. In the meantime, as noted above, preventing the disruption of permanent placements for younger children might help the local authority might, at least in part, reduce the need to place some children and young people in children’s homes out of borough at a later date. Earlier, bespoke mental health services in that context could make a significant contribution to placement stability for this younger group of children.
  2. Two final recommendations relate to single and multi-agency learning which has been identified and where actions have been agreed.
     + Recommendation 9

Agencies providing services for looked after children should identify how they can collectively put into place suggested improvements in practice relating to promoting social/ friendship-building and scrutinising the impact of the use of restraint.

* Recommendation 10

The Safeguarding Children Partnership should require, with 12 months, evidence that single agency learning from this review reflects the overall findings and that, along with the their initial learning, this has been translated into effective action.

## Recommendations

* 1. Learning summaries provided by agencies have already identified some changes to practice which have taken place or are planned. These include:
     + Improved arrangements for information sharing between agencies before placements are procured;
     + More explicit quality assurance arrangements in relation to commissioned placements;
     + Obtaining feedback from key stakeholders in respect of such placements, including those out of borough;
     + Review and updating of the ‘new into care and school changes process’ with particular regard to those being placed outside the borough; and,
     + As part of its PEP quality assurance process, ensuring that identified social and emotional issues are followed up at subsequent PEPs.
  2. Six recommendations for additional actions derive from the analysis set out in the previous section. They are:
  3. Recommendation 1

Lancashire Safeguarding Children Partnership should be provided with a copy of this review report so that they can consider any outstanding safeguarding issues which are raised for them.

* 1. Recommendation 2

Knowsley Safeguarding Children Partnership should seek reassurance from Merseyside Police, by December 2020, of the steps taken to improve safeguarding information-sharing arrangements with children’s home and the effect of these measures.

* 1. Recommendation 3

The Safeguarding Children Partnership should, by December 2020, obtain evidence from the local authority that all children living in children’s homes have satisfactory ‘free time risk assessments’ which accord with the findings of this review.

* 1. Recommendation 4

The Safeguarding Children Partnership should seek reassurances from the local authority commissioning service that there are robust governance processes to ensure that location risk assessments are completed effectively and efficiently and are focused on the needs of the child.

* 1. Recommendation 5

The Safeguarding Children Partnership should:

1. ensure that relevant practitioners and managers are aware of the CPS legal guidance in respect for safeguarding children who are witnesses and victims; and,
2. determine how multi-agency guidance relating to the provision of therapy for child witnesses prior to a criminal trial can best be embedded into local practice.

*Note: These actions should be consistent with the Pan-Merseyside multi-agency child sexual assault multi-agency care pathway.*

* 1. Recommendation 6

The Safeguarding Children Partnership should:

1. work with the local authority to agree a method of identifying those children aged 5-10 in permanent placements where there may be the most significant threats to long term stability;
2. commission a multi-agency audit of practice; and,
3. consider what actions partners should take on the basis of those findings, both immediately and at a strategic level.
   1. Recommendation 7

The Safeguarding Children Partnership should:

* 1. require all agencies to provide evidence, and evaluation, of all actions they have taken to improve the extent to which ‘assessments and planning for looked after children take into account what it is like to be a child of minority or mixed ethnicity in a local environment that is not ethnically diverse’ ; and,
  2. identify what further action should be taken to suitably equip carers, professionals and children’s settings to identify and respond to racism when they encounter it.
  3. Recommendation 8

The Safeguarding Children Partnership should determine how it might work collaboratively with other local Partnerships to support this national imperative.

* 1. Recommendation

Agencies providing services for looked after children should identify how they can collectively put into place suggested improvements in practice relating to promoting social/ friendship-building and scrutinising the impact of the use of restraint.

* 1. Recommendation 10

The Safeguarding Children Partnership should require, with 12 months, evidence that single agency learning from this review reflects the overall findings and that, along with the their initial learning, this has been translated into effective action.

Isobel Colquhoun

Independent Reviewer

11/08/2020

1. In 2017, Ofsted found that the local authority had made ‘significant improvement in placing children for adoption’. Inspectors highlighted that Knowsley was ‘very successful in ensuring that brothers and sisters remain together when it is right for them to do so’. They also noted that ‘rigour in matching children with their new parents’ minimised the risk of disruption. [↑](#footnote-ref-1)
2. This is an example of the kind of ‘timeline detail’ that a learning event with practitioners and managers would have resolved; enabling a better understanding of both ‘what happened’ and ‘why’ in terms of actions and outcomes. [↑](#footnote-ref-2)
3. See previous note about the uncertainty as to when the VS allocated the attendance officer as key worker. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. This would normally have been explored in the practitioner learning event, which the children’s home was anticipating attending. The additional information provided by CSC indicates that Ava’s poor school attendance was one of the reasons that her placement ended. [↑](#footnote-ref-5)
6. This is the only reference, within the documents provided to the review, to Ava having a depressive disorder: it is not known who made this diagnosis or in what circumstances it was made. The implications for treatment are not given. [↑](#footnote-ref-6)
7. The report refers to the ‘other young people’ as described, but it is the reviewer’s understanding that there was only one other young person in the children’s home at that point. [↑](#footnote-ref-7)
8. See paragraph 2.82 [↑](#footnote-ref-8)
9. In Panel discussion, it was reported that high schools in Knowsley have established ‘nurture groups’, offering support and opportunities to develop social skills for vulnerable young people, including those who are looked after. [↑](#footnote-ref-9)
10. The most recent Ofsted inspection in respect of Children’s Home 2 (October 2019) noted that managers and staff had put a great deal of effort into addressing the shortfalls in child protection identified at the previous inspection and that ‘the children at the home are now protected and safe’. [↑](#footnote-ref-10)
11. Police Community Support Officers [↑](#footnote-ref-11)
12. Single Points of Contact [↑](#footnote-ref-12)
13. **Note:** 28% of perpetrators identified to the Office of the Children’s Commissioner’s Inquiry into Sexual Exploitation in Gangs and Groups were under 19 years of age. Reported in [Children’s Society information relating to child sexual exploitation](https://www.childrenssociety.org.uk/what-is-child-sexual-exploitation) [↑](#footnote-ref-13)
14. The sufficiency report highlights that the three year trend to 2017/18 indicated that placements for children in KMBC mainstream and kinship placements were significantly less stable than placements for children through independent fostering agencies. This is attributed to a more robust matching process in the latter case.

    In 2018-19 overall, Knowsley was less successful in achieving placement stability than its statistical neighbours, northwest authorities and England overall. The extent to which disruption of permanent placements contributed to overall levels of placement instability, however, will be known to the local authority. [↑](#footnote-ref-14)
15. https://knowsleyknowledge.org.uk/facts-and-figures/ [↑](#footnote-ref-15)
16. Core Assets is a service which has been commissioned by the local authority since April 2020. The service supports Knowley’s looked after children in relation to their emotional health and wellbeing. This includes support to foster carers. It covers a 40-mile radius. [↑](#footnote-ref-16)