Knowsley Safeguarding Children Partnership

Child Safeguarding Practice Review

Child Paul

Executive Summary

Lead Reviewer: Stephen Ashley

Introduction

What this review is about

This review concerns a child known for the purpose of this review as Child Paul. Child Paul lived in a complex family environment with 4 siblings and his parents. Agencies had been engaged with the family since 2002; and with Child Paul since birth. Child Paul and his brother and half-brother engaged in, or were subject to, a large number of adverse childhood experiences throughout their childhood. Child Paul was subject to child in need planning from birth and was the subject of a child protection plan when he was 3 years and again when 15 years old.

When Child Paul became an adolescent, his behaviour deteriorated, and he was violent and uncooperative with professionals. Child Paul's mother requested that he be accommodated under Section 20 of the Children Act when he was fifteen years old.

When Child Paul was 17 years old, he was arrested for a series of sexual offences against family members and was convicted of 10 sexual offences, including 2 counts of rape. In April 2020 he was sentenced to 11 years imprisonment with a further 6 year licence extension.

The Rapid Review Panel

Child Paul was arrested in June 2019 and a Rapid Review Panel was held in November 2019. The Panel agreed that there would initially be a review of children's services records and a strategic review of commissioning capacity and market strategy relating to placements for children looked after by the local authority.

Following discussion with the national Child Safeguarding Practice Review Panel it was agreed to conduct a child safeguarding practice review. The Panel appointed Stephen Ashley to conduct the review.

The Terms of Reference

The terms of reference provided 4 objectives:

1. Establish whether placements, commissioning capacity and market strategy were effective, efficient and child focused.
2. Establish how effective multi-agency arrangements in the management of risk were for Child Paul.
3. Understand whether the arrangements through MAPPA were effective and child focused.
4. Establish the effectiveness of support services (e.g. CAMHS) in providing therapeutic support to vulnerable adolescents.

It was agreed the review period would cover the period from April 2017 to July 2019, which covers the period prior to the child being placed in care and the date of the referred incident. Where relevant there is analysis of issues outside of that time scale.

Parallel investigations

A reflective review was carried out examining the contact that agencies in Knowsley had had with Child Paul and his family. This review provides detailed information that is reflected in both the content of this review and the recommendations it contains. The reflective review was conducted by Catriona Sreenan and included a reflective discussion with those front-line professionals who had been directly engaged with Child Paul.

The review process was initiated following Child D's arrest in July 2019 for serious sexual offences. A police investigation was in place from that time until Child Paul's conviction in April 2020.

A MAPPA serious case review has been commissioned and should be read in conjunction with this review. However, this review does touch on issues relating to MAPPA in order to understand the case holistically.

Family engagement

At the time this review was being conducted it was not possible for the reviewer to make contact with Child Paul, who had been convicted and was in custody, due to restrictions on prison visiting in place as a result of the Covid-19 pandemic. Child Paul's mother was contacted but has not engaged with the review team.

Significant Issues

Significant Issue One

Child Paul had been subjected to traumatic childhood experiences which are likely to have impacted on his behaviour as an adolescent. A trauma informed approach and the use of contextual safeguarding may have provided a more effective response in supporting Child Paul through his childhood and adolescence.

- Child Paul suffered from a very high number of adverse childhood experiences. As he moved through adolescence, he was being influenced by people from outside the family unit and was almost certainly being exploited in terms of his involvement with drugs and violence.
- The approaches that safeguarding professionals now understand as effective, taking a trauma informed approach and understanding contextual safeguarding, may well have proved effective in Child Paul's early childhood. However, in the early years of Child Paul's childhood these concepts were not common practice.
- By the time Child Paul reached 15 years old, and particularly by April 2017 (the start of the review period), the damage to Child Paul had been done. Whilst this part of analysis falls outside the review period, it places into context the problems faced by professionals when dealing with this child as a 15 year old with severe behavioural problems and a history of abuse and neglect.
- Knowsley Safeguarding Partnership has recognised the importance of contextual safeguarding and is taking a trauma informed approach, which is at the forefront of national work in this area. The case of Child Paul is an extreme example of how valuable these approaches might be.

Significant Issue Two

Child protection procedures were extensively used in this case but appear to have had little impact on outcomes for Child Paul and his family.

- Child Paul had engaged with social care practitioners over the entirety of his life.
- The way in which statutory agencies worked together to meet Child Paul's needs when he was younger was not sufficiently robust. For example, there were several assessments undertaken by children's social care which did not adequately identify the risks inherent within this family. As a result, there was drift in the planning and the delivery of safeguarding interventions.
- A section 20 was in place for Child Paul at the request of Mother. Care proceedings were not initiated in respect of Child Paul at this time. Formal care proceedings could have enabled specialist assessments to be commissioned and created the opportunity for court scrutiny of efforts to care for Child Paul; this should have taken place. Care proceedings in themselves should not be used as a means to find further information, which should have been obtained by professionals.
- Despite considerable intervention with Child Paul and his family by children's services and attempts to support and help him, it is clear that child protection procedures could and should have been more vigorously applied. In particular, legal planning meetings should have taken place at a far earlier stage to consider care proceedings. It is difficult to understand why Child Paul had not been placed on a child protection plan at a far earlier point in his teen years. The risks posed by Father were not properly considered, nor were the poor parenting skills of Mother.
- In the review period (April 2017 to July 2019) providing support to Child Paul was an extraordinarily difficult task for safeguarding professionals; in particular children's social care. There is evidence of good multi-agency working, but this failed to protect Child Paul and in particular his sisters, from further significant harm.
- Mother and Father have stated they did not feel agencies were transparent in dealing with them and describing the risks posed by Child Paul.
- Safeguarding arrangements have been significantly strengthened over the last two years with escalation provisions, threshold guidance and the implementation of the Signs of Safety model of child safeguarding.

3.3 Significant Issue Three

Child Paul had suffered significant childhood trauma and required effective support to deal with his mental health issues.

- Child Paul had received support throughout his childhood, but this had not been a structured therapeutic intervention to address his experience of sexual abuse. As he got older the potential for him to become a perpetrator of sexual abuse was never really considered.
- Child and Adolescent Mental Health Services should have been more engaged with Child Paul in his formative years.
- Once Child Paul reached 15 years old the level of support he needed was at a very high level. At this point, there is clear evidence of services working together to develop a plan of support. Unfortunately, despite this multi-agency approach, Child Paul remained a very high risk to others and his mental health issues were never effectively dealt with.

3.4 Significant Issue Four

Child Paul was placed in accommodation by the local authority under section 20 of the Children Act 1989. Child Paul's behaviour resulted in numerous changes in accommodation over a relatively short period.

- Child Paul was moved through a number of accommodation settings as a result of his aggressive and criminal behaviour.
- The options for accommodation were extremely limited both locally and nationally.
- Child Paul was never placed in accommodation that suited his needs.
- A legal planning meeting made a decision that Child Paul should not be placed in secure accommodation but did not consider what alternative solutions were available.
- The local authority appreciated that Child Paul needed specialist support, but the lack of suitable options resulted in Child Paul being placed in unsuitable accommodation as the only available option.
- Child Paul required accommodation that included a high degree of support for his complex mental health needs and his highly challenging behaviour. This was not available. As a result, Child Paul continued to harm himself and others.

3.5 Significant Issue Five

Child Paul was made subject of MAPPA arrangements and was engaged with Knowsley Youth Offending Service. Whilst under these arrangements Child Paul committed serious sexual offences.

- Knowsley Youth Offending Service put in place a multi-agency risk management plan which was comprehensive and child centered.
- The YOS plan was used in conjunction with MAPPA.
- The MAPPA referral and Panel correctly identified that Child Paul should be managed under MAPPA.
- There is evidence that support was put in place for Child Paul at this time.
- The MAPPA arrangements did not significantly reduce the risk to Child D or protect those to whom he came in to contact. Following work with the YOS, and referral to the MAPPA, Child Paul, start to engage with support services.
- A serious case review of the MAPPA process will provide a detailed analysis of MAPPA engagement and identify areas for learning.
- MAPPA planning appears to have lacked a significantly child focussed approach however this was counter balanced by the engagement with YOS.
- Professionals on the MAPPA Panel clearly understood the problems that Child D had faced and the level of support he required.

3.6 Significant Issue Six

Child Paul had become violent and uncooperative and would often threaten professionals. This had a significant effect on professional's ability to support Child Paul

- Child Paul exhibited high levels of aggression and violence towards professionals.
- Professionals were frightened of Child Paul and avoided engaging with him.
- There appears to have been no risk management plan in place for professionals or Child Paul until YOS engagement in August 2018.

Good Practice

Youth Offending Service

In this case the youth offending service held high quality multi-agency meetings and developed effective child friendly plans that were closely monitored. There is evidence that for the first time in his life Child Paul was engaging with professionals.

Merseyside Paediatric SARC

This recent innovation was unfortunately created after Child Paul had reached adolescence. The service has had great results and is a unique addition to the services available to children in Merseyside. There is close liaison with CAMHS service with the SARC psychologist advising on cases already engaged with CAMHS and other services. This means that services to support children are coordinated and child centered.

The contextual safeguarding project

This review highlights the work that Knowsley is currently engaged in with Bedford university. This is a piece of work that looks to develop the skillset of front line professionals to understand and work in a trauma informed way. This should ensure that in future there are clear early intervention plans that were lacking in Child Paul's case.

Key Findings

Contextual safeguarding and a trauma informed approach

The evidence of this review is that the Child Paul was the subject of multiple adverse childhood experiences and criminal exploitation throughout his life. This almost certainly impacted on his later violent and abusive behaviour. Professionals engaged with Child Paul throughout his childhood but lacked the understanding and strategies to deal with these issues. Early intervention strategies were not sufficiently developed in Knowsley which, as government research has shown, was a national rather than a local issue.

Multi-Agency Public Protection Arrangements

Child Paul was correctly assessed for MAPPA, but the arrangements were not sufficiently child focussed. There was improvement in Child Paul's engagement with professionals and signs that he was progressing under MAPPA. A serious case review will determine the effectiveness of MAPPA in this case and make separate recommendations.

Child protection processes

Child Paul and his family were engaged with child protection professionals throughout his life. The interventions and support provided was insufficient to protect Child Paul from harm and the use of child protection procedures lacked rigour. Child protection interventions were not robust or timely prior to the review period, and as a result professional found Child Paul virtually impossible to manage by April 2017.

Mental Health support

Child Paul did not receive the mental health support he required through his childhood. By April 2017 the level of support and professional intervention Child Paul needed to deal with the multiple issues he suffered from was at a high level. At that point FCAMHS, children's social care, the youth offending team and CAMHS worked well together to assess Child Paul and develop a plan to support him. Unfortunately, this work was too late to reduce the risk he presented to himself and others.

This review has found that safeguarding professionals failed to find suitable accommodation for Child Paul. The accommodation he was placed in lacked the right levels of support and there was little control over his activities. There is a lack of suitable accommodation for children with these types of needs and options for professionals are extremely limited both locally and nationally.

Dealing with violent children and engaging in specialist high level work

Child Paul was violent, carried weapons and abused and assaulted those trying to help him. Some professionals were frightened of him. In cases where children exhibit these levels of anti-social and criminal behaviour, professionals need specialist support and training. Risk assessments should be in place to protect both the child and the professionals trying to work with them.

Overall Finding

Child Paul had been abused and neglected since birth. The lack of an early intervention strategy resulted in those adverse childhood experiences never being effectively resolved. By April 2017 Child Paul was beyond the control of professionals, who he abused and assaulted. Child Paul was placed in unsuitable accommodation without appropriate support. This occurred because accommodation options for violent children are limited; both locally and nationally.

Child Paul caused significant harm to himself and his victims over the course of his childhood. Despite evidence of good partnership working during the review period, professionals were never able to find effective strategies to deal with a child suffering from such severe and deep-rooted childhood trauma.

Recommendations

Recommendation one

The recommendations contained in the reflective review conducted by Catriona Sreenan should be considered by the safeguarding partners

Recommendation two

A serious case review to the effectiveness of the Multi-Agency Public Protection Arrangements is to be undertaken and any recommendations it makes should be considered at the appropriate time by the safeguarding partnership.

Recommendation three

The safeguarding partnership should undertake a strategic review of available accommodation for children who are looked after. This should include current commissioning arrangements and the levels of support available within placements. A quarterly report on accommodation of children looked after should be submitted to partners including those children in unregulated accommodation.

Recommendation four

The safeguarding partnership should undertake an audit of those children who are the subject accommodation under section 20 of the Children Act and satisfy themselves that the local authority is putting in place the appropriate safeguards to protect those children who become looked after in that way.

Recommendation five

The safeguarding partners should seek assurance from all partners that those staff that are dealing with violent young people are properly protected through training and effective risk assessments. A review of staff training should be conducted to ensure there are sufficient specialists available to support high risk individuals.

Recommendation six

The clinical commissioning group in Knowsley should provide a report to the safeguarding partners detailing the commissioned services that are in place to support young people with a wide range of mental health issues. The partners should seek similar assurances from Public Health for those mental health support services provided and commissioned by them. This work should be conducted within the context of the work already being undertaken in Knowsley to assess the needs of children, taking in to account the trauma they have suffered. Safeguarding partners should consider a learning event to discuss how a trauma informed approach can be fully considered by all partners when making child protection decisions.