Knowsley Safeguarding Children Partnership

Child Paul

Final Report

Lead Reviewer: Stephen Ashley

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Section One – Introduction

1.1 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 2 older, and 2 younger, 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 were the subject of a number of adverse childhood experiences throughout their childhood. Child Paul was subject to child in need planning[1] from birth and was the subject of a child protection plan[2] when he was 3 years and 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[3] 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.

1.2 How this review was conducted

1.2.1 The review process

Section 17 of the Children and Social Work Act 2017 amended the Children Act 2004 to include a section regarding child safeguarding practice reviews (CSPRs). This section requires the safeguarding partners to make arrangements to identify serious child safeguarding cases that raise issues of importance, and for those cases to be reviewed where appropriate. Details of this section of the Act can be found at appendix one.

Working Together to Safeguard Children 2018 (Working Together) provides statutory guidance to safeguarding partners on the conducting of reviews. The guidance provides clarity on the criteria to be considered and provides a process, using a rapid review system, to oversee the review on behalf of the safeguarding partners[4]. In Knowsley, there is a system in place to identify serious cases and oversee the review. The Working Together guidance can be viewed at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[1] **Child in need -** Under Section 17 of the Children Act 1989, Local Authorities have a duty to safeguard and promote the welfare of children within their area if they are in need. A child is in need when they are disabled, or they are unlikely to achieve a reasonable standard of health or development or if a child's health or development is likely to be significantly impaired if services are not offered to him or her.

[2] **Child protection plan -** For all those children who have been identified at a Child Protection Conference as being at a continuing risk of significant harm, a Child Protection Plan will be created. This is a plan setting out what steps and provisions are needed to safeguard a child's welfare and minimize all risks of harm to a child.

[3] **Section 20 Children Act 1989** - provides the local authority with the power to provide accommodation for **children** without a court order when they do not have somewhere suitable to live. It is widely known as voluntary accommodation because the parents must agree to the child being accommodated.

[4] **Safeguarding partners -** A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as: the local authority; a clinical commissioning group for an area any part of which falls within the local authority area; the chief officer of police for an area any part of which falls within the local authority area.

1.2.2 The Rapid Review Panel

Child Paul was arrested in June 2019 and a Rapid Review Panel was held in November 2019. At this meeting the Panel agreed that whilst the threshold had been reached for a child safeguarding practice review (CSPR) this should comprise of an alternative method of review that would include:

- A multi-agency themed audit with the context of adolescents, violence, contextual safeguarding/county lines (linking to the work that the borough is currently conducting with the University of Bedfordshire).
- A review of the children social care records in relation to sexual abuse.
- A strategic review of placement / commissioning capacity and market strategy.

The Panel informed the national Child Safeguarding Practice Review Panel[5] (National Panel) of their decision. The National Panel responded in February 2020 and following further discussion the Rapid Review Panel made a decision to conduct a child safeguarding practice review.

The Panel appointed Stephen Ashley to conduct the review. The reviewer is independent of agencies in Knowsley and is an experienced reviewer of serious child safeguarding cases.

1.2.3 The Terms of Reference

Following interaction with the National Panel the Rapid Review Panel reconsidered the case and agreed that a CSPR would be undertaken with the aim of: *"identifying learning regarding the way in which local professionals and agencies worked together to safeguard and protect Child Paul from harm".*

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 it provides context and is of relevance issues outside of this period are considered.

1.3 Methodology

1.3.1 Chronologies

All agencies that had been involved with Child Paul and his family were asked to complete a chronology detailing any contact that they had had with Child Paul and his family. These

[5] **The National Panel -** The Child Safeguarding Practice Review Panel is responsible for overseeing the review of serious child protection cases in England. Established under the Children and Social Care Act 2017.

chronologies have formed the basis of this review. Additional information and reports have been provided by agencies at the request of the reviewer.

1.3.2 Reflective review

The first Rapid Review Panel meeting agreed that a reflective review should be carried out examining the contact that agencies in Knowsley had had with Child Paul and his family. This review focussed on the interactions with Knowsley Children and Families Service (children's services).

This comprehensive review of those contacts is widely referenced in this review and has provided the reviewer with significant and detailed information that is reflected in both the content of this review and the recommendations it contains. The reviewer would like to acknowledge the work of the author Catriona Sreenan; the reviewer who conducted the reflective review.

1.3.3 Parallel investigations

The review process was initiated following Child Paul'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. Whilst preliminary work was being undertaken by agencies, it was not possible to complete the review process until Child Paul's court proceedings had taken place.

At the time Child Paul was arrested and subsequently charged, Child Paul was a registered offender whose case was being managed through the Multi-Agency Public Protection Arrangements (MAPPA) at MAPPA level 2. The national MAPPA guidance requires the MAPPA Strategic Management Board to commission a serious case review in any case where an offender registered at level 2 commits certain offences, which include offences of violence, serious sexual offences and rape. The requirement for a serious case review in these cases is mandatory. The full criteria for MAPPA case reviews can be found at: https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/reviews/.

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.

1.3.4 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 family were able to review a draft copy of this report and provide comment and input to it.

1.4 How this report has been structured

The review begins with a description of Child Paul's life and his contact with a number of agencies. This background provides the context in which Child Paul and his family lived. The second part of this section focusses on the review period from April 2017 to July 2019. This section provides details of the engagement that Child Paul had with agencies and where significant issues are identified they are highlighted in boxes. These significant issues are then analysed in section 3.

In section 4 there is a description of areas of good practice and in section 5 key findings are summarised based on the analysis. There are a number of recommendations contained in section 6.

The report has been written in a style that should ensure it is able to be published without redaction. As a result, those involved are identified in the table below. The ages are not strictly accurate but reflect the family structure in 2019.

Referenced as	Age
Child Paul	17 years
Mother	
Father	
HB1	older sibling
B1	older sibling
S1	younger sibling
S2	younger sibling

Dates used in the review are not specific, although the timescales referred to reflect the real circumstances. In this document, a child is defined as anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout.

Section Two – The Story of Child Paul

2.1 Introduction

This section first provides the background to Child Paul and his family. This puts some context around the events that followed. It enables the reader to understand that this case is rooted in a family history of abusive relationships that influenced Child Paul's behaviour as he entered adolescence.

The second section concentrates on the review period agreed by the Rapid Review Panel. Throughout this section any significant issues are identified and analysed in section three.

2.2 The background

Child Paul was born in 2001 and at that time had an older half brother and an older brother. The family lived as a single unit. Both of Child Paul's parents had been engaged with children's services as children and been the subject of sexual abuse by their respective fathers.

The family were already engaged with safeguarding services at the time of Child Paul's birth and there had been a significant history of referrals regarding HB1 and B1.

HB1 had been on a child protection plan from the age of four to seven years due to concerns about physical abuse, a non-accidental injury and poor parenting. HB1 continued to cause concern and was thought to be beyond parental control. When HB1 was twelve years old, he made allegations of physical and emotional abuse against his stepfather (Father), which were unsubstantiated.

When Child Paul was three years old, B1 witnessed HB1 sexually abusing Child Paul and he also alleged HB1 had sexually abused him. The children were placed on child protection plans for a period of thirteen months. Thereafter the children were supported through children in

need planning and by universal services[6] through the common assessment framework[7]. There was a further period of child protection planning in 2017, due to concerns about Father's violence and mental ill health, and the impact on the children's emotional wellbeing.

It is clear that all of the family to this point had been engaged in a traumatic childhood and had suffered a number of adverse childhood experiences; including sexual abuse. This early history and family background raise two significant issues for learning.

Significant Issue One

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

Significant Issue Two

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

2.3 The review period April 2017 to July 2019

Child Paul's behaviour during adolescence became increasingly violent, he was using cannabis regularly and he had disengaged from education. Child Paul was placed on a child protection plan at the beginning of 2017. As part of his assessment, consideration was given to his mental health status and the support he might require. In fact, Child Paul had suffered from mental health issues all of his life and this had included an attempted suicide. At the time of his child protection assessment in January 2017 Child and Adolescent Mental Health Services (CAMHS) had stated that it was not possible to engage in therapeutic work at that point. Child Paul had clearly suffered from mental health issues for some time and it is a significant issue in Child Paul's life.

Significant Issue Three

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

Child Paul was difficult to engage with and Mother was struggling to manage Child Paul at home. In April 2017 Mother requested that Child Paul be accommodated under Section 20 of the Children Act 1989; he was fifteen years old.

[6] **Universal services -** Universal services are those services (sometimes also referred to as mainstream services) that are provided to, or are routinely available to, all children and their families. Universal services are designed to meet the sorts of needs that all children have; they include early years provision, mainstream schools and Connexions, for example, as well as health services provided by GPs, midwives, and health visitors.

[7] **Common Assessment Framework -** The Common Assessment Framework (CAF) is a national multi-agency assessment tool for all professionals involved with a child and their family, irrespective of their discipline.

Following his accommodation in local authority care, Child Paul's behaviour was challenging, and at times violent, which led to the disruption of several placements and the local authority, in partnership with other agencies, struggled to meet his needs. The Youth Offending Service (YOS) was involved from June 2018 with Child Paul as his offending behaviour escalated. Child Paul was regularly going missing and there was evidence that he was being exploited to sell drugs. Following convictions for assault, weapon and drug offences Child Paul was referred for a multi-agency risk management meeting[8] (MARMM) and was assessed as being at high risk. As such he was subject of a multi-agency risk management plan.

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.

In May 2019 Child Paul was referred to a Multi-Agency Public Protection Arrangements (MAPPA) Panel. The reason for referral was focused on his risks of violence; carrying and using weapons; association with older offenders; involvement in county lines exploitation; and his relationship with another child (a 13 year old girl). The referral also focussed on aggression used towards staff and his behaviour that was becoming more unmanageable.

The risk of harm to others included: staff; other children (in the context of violence); and concerns regarding his relationship with a 13 year old girl. This resulted in Child Paul being managed as an offender under Multi-Agency Public Protection Arrangements (MAPPA) that judged him to be: "*a very high risk"*.

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.

In June 2019, Mother is reported to have witnessed Child Paul sexually abusing S2. Child Paul was arrested, and a police investigation commenced. During the police investigation that followed, S1 and S2 disclosed that Child Paul had been sexually abusing them for about twelve months.

Child Paul 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 Child Paul was sentenced to 11 years imprisonment with a further 6-year licence extension.

Child Paul had an horrific family history of abuse and had himself become an abuser. There is no doubt that Child Paul's reputation for violence and the fact that he carried a weapon was of great and understandable concern to professionals. This clearly affected the opportunities to support him.

[8] Children assessed as a high risk in any of the 3 domains will be referred to the YOS Multi Agency Risk Management Meeting (MARMM) which is chaired by a YOS Manager. The Youth Offending Service is responsible for identifying and inviting the relevant agencies including where appropriate, representatives from Children's Social Care.

Significant Issue Six

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

Section Three – Analysis

3.1 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.

Over recent years there has been considerable development of safeguarding practice in two key areas. Firstly, understanding the effect of adverse childhood experiences (ACEs) on children as they grow up and become adults. This involves those engaged in safeguarding to take a trauma informed approach to dealing with children and families.

The second area of development is contextual safeguarding which involves professionals understanding the context in which a child is living and the external influences that are affecting their lives and shaping their behaviour.

In this section there is analysis of whether these approaches may have been useful in this case.

Adverse Childhood Experiences

The term adverse childhood experiences (ACEs) first came to notice following an American study that took place between 1995 and 1997. In 1998, CDC-Kaiser Permanente published the results of this study, that investigated the impact of ACEs on physical and mental health problems in over 17,000 adults. During the study, the adults were given a survey asking about 10 different types of ACEs and if they had experienced them prior to the age of 18. The study showed a direct correlation between ACEs and future health complications.

The 10 ACEs refer to stressful or traumatic events that children and young people can be exposed to as they are growing up. ACEs range from experiences that directly harm a child, such as physical, verbal or sexual abuse, and physical or emotional neglect, to those that affect the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment. There is however a distinction between 'normal' stressful life events, such as parental divorce or illness of a loved one, and adverse childhood experiences, very traumatic life events, such as being or seeing someone else physically or sexually abused. These are experiences that will often be associated with post-traumatic stress disorder.

The Knowsley Safeguarding Partnership have identified that understanding the impact of adverse childhood experiences is essential to frontline professionals and have produced both a 7-minute briefing for front line professionals and a section on their website:

https://www.knowsleyscp.org.uk/professionals/aces-adverse-childhood-experiences/.

An analysis of Child Paul's life highlights a number of adverse childhood experiences.

Whilst it falls outside the period of the review, an analysis of the known experiences of Child Paul provides significant context to the events that occurred in his later teenage years. Listed below are the significant events and the referrals that dominated his childhood.

Child Paul has a long history of engagement with services. These have often been triggered by events of sexual abuse by HB1 and other family members. Child Paul's parents have documented that they were themselves subject to sexual abuse by their own fathers.

Specific incidents that were known to safeguarding services were:

- Child Paul was 3 years old when a referral was made regarding an incident of Child Paul being sexually abused by HB1.
- Child Paul was 5 years old when another referral was made regarding Child Paul demonstrating highly sexualised behaviour.
- At 8 years old an educational psychologist expressed concerns regarding Child Paul's emotional health, his self-harming and deteriorating behaviour, both at home and school.
- At 9 years old a special educational need **(**SEN) statement was initiated for emotional and behavioural difficulties.
- At 9 years old Child Paul attempted to kill himself.
- At 10 years old in a referral from Merseyside Police they commented: *"The officers stated the premises was one of the most disgusting houses they had been into"*.
- At 12 years old a domestic abuse incident was reported by the police from the household.
- At 13 years old Child Paul witnessed a domestic violence incident where Father threatened to slit mother's throat. A Domestic Violence Protection Order was put in place for 28 days.
- At 15 years old the professionals supporting Child Paul described escalating concerns and deterioration in Child Paul's relationships: Mother and Father had separated; Father had threatened to kill himself; Father had assaulted Mother; and, Child Paul had assaulted Mother and Father and had been charged with those assaults.

Based on the research undertaken around adverse childhood experiences it is clear that Child Paul and his family had suffered huge trauma throughout their childhoods. It can never be known the true extent of the damage done to Child Paul through these experiences or the impact his childhood had on his behaviour as he approached adulthood.

In November 2018 the Government Select Committee on Science and Technology published a paper setting out their findings on the issue of ***"Evidence-based early years intervention".*** The Committee concluded that: *"There is now a body of evidence that clearly demonstrates a correlation between adversity suffered during childhood and an increased prevalence of health and social problems in later life."*

However, the Committee went on to establish that: *"Whilst there is evidence of good practice in some local authority areas in England, there is no clear, overarching national strategy from the UK Government targeting childhood adversity and early intervention as an effective approach to address it. Nor does there seem to be effective oversight mechanisms for the Government or others to monitor what local authorities are doing. This has led to a fragmented and highly variable approach to early intervention across England, with evidence of a*

significant gap between what the latest evidence suggests constitutes best practice and what is actually delivered by many authorities. Where local authorities are not providing early intervention based on the best available evidence, vulnerable children are being failed". The full details of these findings can be found at:

https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/50602.htm

Contextual Safeguarding

Contextual Safeguarding is an approach and a term developed by Dr Carlene Firmin and colleagues at University of Bedfordshire. The term was first used in 2015 to describe an ambition for how to advance practice and policy responses to extra-familial harm.

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.

Details of Dr Firmin's work can be found at:

https://www.csnetwork.org.uk/assets/documents/Contextual-Safeguarding-Briefing.pdf

In January 2019 Knowsley was selected from 50 local authority areas to work with the University of Bedford to embed contextual safeguarding into partnership working.

Child Paul suffered significant childhood trauma and an analysis of his adolescent years provides further detail on suspected involvement with influences from outside the family unit, that have impacted on his behaviour.

Child Paul was discussed at the Knowsley Child at Risk of Exploitation meeting in 2016. Child Paul had been referred by professionals over 5 incidents of potential exploitation. Concerns were raised that he was involved in County Lines[9] exploitation and was dealing in drugs. Child Paul was known to carry a knife. Child Paul had been reported missing on 47 occasions between June 2016 and November 2019.

There is no doubt that early intervention is key to effectively safeguarding children who have been the subject of childhood trauma. Work in Knowsley is underway to improve agency response in this area. Partners in Knowsley need to ensure that they are working together in this important area and that there is an understanding of what early intervention looks like. In particular, education is a key partner in identifying issues that a child is facing and helping to shape the response.

[9] **County Lines -** is the term used to describe a form of organised crime where criminals based in urban areas pressurise vulnerable people and children to transport, store and sell drugs in smaller **county** towns. It takes its name from the phone **lines** used by organised crime gangs to communicate between towns.

Summary

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.

Partners need to ensure that taking these approaches to early intervention and contextual safeguarding are understood by all those that engage in safeguarding and are also that they are clear about the role their agency plays in that approach.

3.2 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.

Prior to this review being commenced a reflective review analysing the engagement of safeguarding professionals had been conducted by Catriona Sreenan. This provides a comprehensive analysis of children's services records and provides significant detail of the engagement that Child Paul and his family had with safeguarding agencies; predominantly children's services. As part of this work a reflective discussion was undertaken with front line staff who had engaged with Child Paul and his family.

The reflective review provides a history and analysis of very significant engagement with the family over the entire period of Child Paul's life. The analysis below is lifted from that report with suitable redactions to protect Child Paul and the family.

The section below deals specifically with the engagement with Child Paul over the review period (April 2017 to July 2019).

At the beginning of 2017 a single assessment[10] had been completed on Child Paul and the family. It indicated that the children needed: *"a coordinated and multi-agency response to increase the level of protection".* This assessment addressed the historical intrafamilial sexual abuse in more detail than had been evident in any previous assessment. The risk analysis was well outlined and concluded that a child protection conference[11] was needed to safeguard the children.

An initial child protection conference was convened in January 2017 where it was agreed that Child Paul, S1 and S2 should be made the subject of child protection plans under the category of 'emotional abuse'.[12] Because B1 was nearly eighteen, it was agreed he was to remain on a child in need plan. It is difficult to understand why it had taken so long for Child Paul and his siblings to be placed on child protection plans given the high levels of risk they faced.

Further concerns had also emerged about Father who allegedly informed Child Paul and B1 that he had raped Mother. S1 alleged that Father had sent her an explicit video of Mother. This had resulted in Father's arrest. During this period, Mother was finding it more difficult to manage Child Paul's behaviour at home. Following a short period of him being looked after by a family friend, Child Paul became accommodated by the local authority in April 2017, under section 20 of the Children Act 1989 (section 20).

When Child Paul became a looked after child, case responsibility for him moved from the child in need service to the children in care service in children's services. Yet case responsibility for S1 and S2 remained with the child in need service. Therefore, there were two parts of children's services continuing to support this family, which created additional challenges. In the reflective discussion, conducted with front line staff who had been involved in the case, it emerged that not all staff in the children in care service were fully aware of the extent of the historical sexual abuse concerns within this family. This raises a question about how case responsibility is transferred and how information is shared in this process. This is an area in which the service has improved in recent years, with complex case discussions now taking place where families have long histories of social care involvement and where more than one social worker is working with the family. This is good practice and will promote more effective joint working.

During the reflective discussion concern was expressed about why care proceedings were not initiated in respect of Child Paul at this time, given it would have enabled specialist assessments to be commissioned and created the opportunity for court scrutiny of efforts to care for Child Paul. The social worker at that time advised that care proceedings were considered however, as Mother was cooperating with the section 20, it was not thought to be necessary and could have been emotionally harmful. Mother and Father have stated during the review that they felt that agencies were not transparent in their dealings with them about the risks that Dylan posed to their family. This is clearly their perception, but it should be acknowledged that Mother had approached Children's Services and asked for him to be cared for under section 20.

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[10] **Single assessment -** Assessments are undertaken of the needs of individual children to determine what services to provide and action to take.

[11] **Child protection conference -** The Child Protection Conference is designed to look at all the relevant information and circumstances to determine how best to safeguard the child and promote their welfare. A Child Protection Conference may be held following an investigation under **section 47 Children Act 1989** (a child protection investigation).

[12] **Emotional abuse –** The chair of a child protection conference must make a decision about the category of abuse or neglect based on the views of all agencies represented at the conference and any written contributions that may have been made. Emotional abuse is a form of significant harm which involves the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

Following Child Paul's accommodation with the local authority concerns escalated about his mental health and his challenging behaviour in placement towards staff. This led to the disruption of several placements and regular monthly multi-agency meetings were held to consider the management of risks in respect of Child Paul. There is evidence of good practice in how agencies sought to work together during this period, but given Child Paul's difficulties were so long-standing, agencies struggled to effectively meet his needs.

The child protection plans for S1 and S2 ended in September 2017 after nine months. The family had been re-housed, the girls had settled well in new schools and Mother was in a new relationship with a man who was thought to be a positive influence.

After twelve months in local authority care, secure accommodation was being explored for Child Paul, given concerns about his involvement in criminal activity in the community and drug dealing. It was agreed that Child Paul did not meet the criteria for secure accommodation and concern was expressed about what this would have achieved.

An assessment in April 2018 highlighted growing concern for Child Paul's safety due to his drug use, drug dealing and access to weapons. This assessment references Child Paul having no knowledge of the sexual abuse perpetrated on him by his brother HB1 and Mother acknowledged she had never openly discussed it with him. The assessment concluded that Child Paul's placement was just *"containing"* him, so it was recommended that a single small residential placement be sought for Child Paul, where his support needs and need for direct work could be provided.

Between February and June 2018, three pre-proceedings meetings were held however it was agreed to continue to support all of the children on child in need plans. During this period children's services were trying to engage with Child Paul but his continued abusive behaviour and failure to engage made this particularly difficult.

The independent review officers service was tracking Child Paul's progress throughout his time in care and escalated concern for his safety to senior management in May 2018, following which it was agreed an alternative care placement would be sought for him.

A single assessment in July 2018 concluded that Child Paul was beyond parental and professional control but due to his non engagement, it was difficult to understand exactly what support he required. Child Paul was regularly going missing for long periods, so his safety could not be guaranteed by those responsible for his care. Child Paul's violent and threatening behaviour meant that he was being cared for by two members of staff at a time and his contact with social workers had to be carefully managed, due to threats and assaults on staff.
Whilst social workers worked with partners to develop plans Child Paul's particularly in relation to mental health support there is little evidence of any change to Child Paul's circumstances. Child Paul was referred MAPPA Panel by the youth Offending Service in April 2019 having been subject to the YOS MARMM process prior to that. Social workers reported into those Panels and supported plans developed through the youth justice system.

In June 2019, Mother is reported to have witnessed Child Paul sexually abusing S2 which led to an investigation during which S1 and S2 disclosed that Child Paul had been sexually abusing them for about twelve months. Child Paul was remanded at a youth offending institute charged with offences of rape and other offences relating to assaults on staff.

Whilst the reflective review focussed almost entirely on children's services, Child Paul was subject to an Education and Health Care Plan and he had several changes of school linked to the difficulties his behaviour created in the school setting. There were clearly difficulties in securing Child Paul's engagement in education particularly during adolescence when he was

using drugs and going missing for long periods. At the reflective discussion, it was reported that when assessed in March 2018 by an educational psychologist, Child Paul was six years behind his chronological age for reading and spelling. Therefore, despite the efforts made by the pastoral lead at his school and having an Education and Health Care Plan in place from the age of nine years, Child Paul's educational needs were not met, and his educational development was significantly impaired.

It should be acknowledged that much of the work carried out by children's services was some time ago and multi-agency working has since developed in Knowsley. There is now clear threshold of need guidance (2018) which sets out the levels of needs for children and appropriate service interventions. There are step up and step-down procedures in place. Where there is a disagreement about a case between professionals, particularly around step up or step-down arrangements, there are regular weekly management meetings where this can be referred for consideration. In addition, there is a multi-agency escalation policy in place which enables differences of professional opinion to be resolved within tight timescales. The quality of assessment work has also been underpinned with the implementation of the Signs of Safety[13] framework, which is promoting the requirement of clearer analysis of risk, which will inform more effective decision-making about what level of service intervention is required by families.

Summary

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 would 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.

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.

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.

scale.

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 been abused and neglected throughout his life and both he and the other members of his family required considerable support with their mental health issues.

It would be expected that the support at this level would predominantly be provided by the Children and Adolescent Mental Health Services. How Child Paul's mental health needs, up until the age of 15 years old, were addressed by the Child and Adolescent Mental Health Service (CAMHS) is unclear.

There are references to Child Paul having attention deficit hyperactivity disorder (ADHD), but it is not clear if this was formally diagnosed and if so, whether he received any form of treatment for this. There is reference to Child Paul being referred to CAMHS for play therapy following further concerns about sexualised behaviour between Child Paul and B1 when he was five years old, but this was not pursued by the family. The school referred Child Paul to CAMHS in April 2010 due to concerns about his aggression and inappropriate behaviour but were advised that he did not meet their criteria. The family general practitioner referred Child Paul six months later and it would appear Mother attended one session with CAMHS, but nothing further was offered.

There is a reference to Child Paul having six play therapy sessions with CAMHS in March 2011, which followed Child Paul's attempt to kill himself in December 2010. At this point there does not appear to have been an assessment of his mental health issues which may have been an opportunity to establish the level of trauma he had already suffered. At the child protection conference held in January 2017, there is a reference to CAMHS not accepting Child Paul as there was too much going on in his life to concentrate on therapeutic work. Therefore, CAMHS, until the beginning of the review period (April 2017), appear to have been on the periphery at critical times in Child Paul's life.

During the review period mental health services had 12 interactions with Child Paul. Mother and Father stated to reviewers that they felt they had raised concerns around Child Paul's mental health with professionals, but they had not been listened to.

In July 2017 Child Paul was referred to CAMHS by Sefton Criminal Justice Community Liaison Service. The reason for referral was in relation to concerns that Child Paul was experiencing low mood and was self-harming. The referral to CAMHS was accepted and arrangements were made through children's services for initial contact. For some reason this referral did not result in Child Paul being seen by a CAMHS professional.

In February 2018 Child Paul was arrested. Whilst in custody Child Paul was seen by a nurse from the CJL Service which is based in police custody suites. The CJL nurse team reviewed the North West Boroughs Healthcare NHS Foundation Trust (NWBH) records and ascertained that Child Paul was already known to the CAMHS. The team approached Child Paul during his custody stay to advise him that they are available for mental health support in custody but also could coordinate support with the community CAMHS Team. Child Paul became angered by the offer of mental health support and refused any such involvement with services.

Later that month Child Paul was discharged from CAMHS without any work having been carried out with him, or any baseline assessments completed. Child Paul's consistent refusal to engage with CAMHS and the recognised risks of abuse and violence to staff, limited the option for the ad-hoc home visits. Child Paul refused to engage and despite liaison with children's services, Child Paul missed planned appointments including appointments in September, October, 2 appointments in November and 2 appointments in January 2018.
In April 2018 Child Paul was again seen by a CJL service nurse whilst in custody. Child Paul refused to be involved with any mental health services.

In September 2018 a referral was made to CAMHS as part of Child Paul's Youth Justice Plan. The referral was allocated to a CAMHS Youth Offending Service (YOS) worker, who attended a multi-agency care planning meeting to explore whether there was a role for CAMHS as part of the YOS offer to Child Paul. That meeting took place the following month. The care team discussed the difficulties of engaging Child Paul with therapeutic services and how it would be helpful to include such as part of existing interventions which Child D was engaging with. It was recognised that there was a lack of provision for psychological therapy within the existing care team, and that this would have to be provided by an additional service which Child Paul was unwilling to engage with. It was agreed that this barrier would be discussed with CAMHS for support in developing solutions and feedback would be provided.

In November 2018 the multi-disciplinary discussion that had been agreed by partners took place and this included CAMHS. The discussion included managers and a consultant psychiatrist. The group recognised the need for psychological therapy to help Child Paul resolve some of the emotional obstacles in his past that were negatively influencing his future. It was agreed that the complexity of Child Paul's risk profile and vulnerability would be best managed through assessment, intervention and professional consultation from Forensic CAMHS (FCAMHS). The outcome of this meeting was that referral would be initiated to FCAMHS in order for Child Paul to receive a service tailored to his individual and complex needs. The group of professionals around him were to be guided by a team that specialised in the forensic risks connected to child and adolescent mental health. This approach was the first coordinated attempt by professionals to put in place a holistic mental health support plan. This coordinated approach appears to have been a direct result of the Youth Justice Plan formulated by the YOS.

Later that month a further meeting was held attended by Child Paul's allocated social worker, Forensic CAMHS, Knowsley Youth Offending Team's health and wellbeing coordinator and Knowsley CAMHS. This meeting formulated a support plan for Child Paul. The group discussed Child Paul's history of trauma and the journey of his life that had resulted in the concerns with his presentation. It was noted that the current placement was ineffective in containing Child Paul's behaviours, and that the lack of skills in staff were actually increasing Child Paul's distress and risk of aggression; leading to further criminality. FCAMHS recommendation was that a therapeutic placement should include skilled and consistent staff. Children's services agreed to search for a more suitable placement and FCAMHS would assist them by providing consultation to the care team going forward. Assessment and intervention with Child Paul would be offered but required Child Paul's acceptance. Professional management plans and guidance on therapeutic interventions were offered by FCAMHS

In February 2019 a care review took place and whilst concerns were still present in terms of Child Paul's aggressive behaviour there were positive reports that Child Paul had engaged with the FCAMHS assessment process and the care team were being guided on the most appropriate interventions to support Child Paul's needs. It was agreed that there was no further role for CAMHS and as a result Child Paul was discharged by that service.

In May 2019 a record was created on the NWBH shared system to notify staff of the level of risk and vulnerabilities with which Child Paul presented. This allowed vital risk information to be recorded and be available for staff that may come into contact with Child Paul in the future. This demonstrated proactive multi-agency information sharing and effective case recording around risk and risk management.

In September 2019 a further record was made by Knowsley CJL Team following a MAPPA review. This record detailed the transitional arrangements for Child Paul's care, treatment and risk management post 18 years of age.

In November 2019 Knowsley CAMHS were represented at a local complex mental health meeting, where Child Paul's case was heard. An action for CAMHS was to clarify some confusion around continuation of mental health services and whether FCAMHS would remain involved as Child Paul transitioned to adulthood. This clarity was reached and recorded, and it was also noted that Child Paul had been remanded into custody.

FCAMHS completed a detailed forensic assessment of Child Paul's needs, called a Structured Assessment of Violence in Youth Assessment (SAVRY), in November 2019. The assessment considered Child Paul's aggressive, threatening and violent behaviour. This was largely a desktop exercise but incorporated the contacts Child Paul had with all agencies. The aim was to get a clearer understanding of Child Paul's needs and secure agreement about how best to meet his needs in the future and into adulthood. This was further evidence of good multi-agency working.

Child Paul did receive support from other support agencies. When accommodated by the local authority support was provided by Listening Ear service that provided boxing lessons and also by the Breathing Space project. It is unclear what positive help or support these services provided to a child with such deep-rooted psychological issues.

Child Paul also engaged with the Knowsley Multisystemic Therapy (MST) team which is an intensive family and community based intervention for children and young people aged 11-17, where young people are at risk of out of home placement in either care or custody and families have not engaged with other services.

The MST team continued to work with the family to try to secure Child Paul's rehabilitation back home, however this was unsuccessful. The MST reflected that this family presented with numerous complexities including intrafamilial sexual abuse, poor parental mental health, trauma and drug use which led to so much chaos that the therapeutic intervention was never established with this family.

Child Paul had no structured therapeutic intervention to address his experience of sexual abuse through his childhood and in the absence of that, the potential for him to become a perpetrator of sexual abuse was never really considered. This was borne out in the reflective discussion where those working directly with the family said that they had never thought about the possibility of Child Paul perpetrating sexual abuse, instead he was seen very much as a victim of sexual abuse.

However, at the end of 2018, when Child Paul was 16 years old, agencies began to work together to find an effective plan to support Child Paul. Whilst Child Paul continued to avoid contact with services and he remained engaged in serious criminality, there were clear signs that the multi-agency planning was beginning to have some effect. For the first time in his life Child Paul appeared to have an effective plan in place to support him.

Merseyside has, over recent years, developed a paediatric sexual xxx (SARC) which provides a dedicated SARC psychology service that has been commissioned for all children attending

the paediatric SARC. The SARC has a senior clinical psychologist in post to triage all children who are referred to SARC. The service has no lower age limit and each child receives a bespoke therapeutic package according to individual needs. This work has been highly successful and a recent successful bid for Home Office funding has resulted in an increase in the service with a second psychologist and development of additional resources including psychometric testing. This recent innovative work would potentially have seen an intervention in Child Paul's life at an early stage and importantly seen the coordination of support services.

Summary

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.

The development of the Merseyside SARC has meant that there is now a dedicated specialist service capable of coordinating support for children in Child Paul's circumstances.

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.

In April 2017 Mother informed children's social care that she could no longer deal with Child Paul or control his behaviour. Mother had separated from Father and been the subject of an assault by Child Paul that had resulted in criminal charges against him.

The local authority did not seek to enter in to care proceedings over Child Paul. At the reflective learning event one front line professional expressed the view that this should have been considered. There is little doubt that formal care proceedings would have resulted in more scrutiny from the courts and may have led to more specialist assessments and support. However, care proceedings should not just be used as a means to obtain further information which professionals should have obtained through a single assessment.

There was a delay in finding a suitable placement for Child Paul due to his complex emotional needs. As such Child Paul was residing with the family of his friend from March to April 2017. During this period Child Paul has been linked to three street robberies involving two older males. The police also executed a warrant at the address at which he was living and arrested the father of Child Paul's friend who was charged with five drug related offences. This again raised concerns that Child Paul was being criminally exploited.

Child Paul was first placed in accommodation commissioned by the local authority in April 2017. It was clear that Child Paul needed considerable support and work around his issues with violence and in dealing with adverse childhood experiences. The accommodation consisted of a house in an area away from his immediate family. It was felt by professionals Child Paul would benefit from being away from the area in which had previously lived with his parents, to provide an opportunity to engage Child Paul in positive diversionary activities.

The staff team reported that they had experience of supporting children at risk of exploitation and emotional and behavioural difficulties. Referral was made for Listening Ear service for Child Paul. 1-1 boxing lessons were provided to encourage Child Paul to engage in positive activity. It had been agreed that his friend could attend to encourage engagement.

Child Paul was also was working with Everton within the community – Breathing Space project. However, Child Paul was violent and aggressive towards staff and the commissioned service gave him notice to leave.

In May Child Paul moved into new accommodation. On this occasion Child Paul was placed in a smaller unit with only one other young person residing within the home. It was felt that Child Paul would benefit from a smaller setting as he had previously responded well in that environment. This accommodation was also close to family and friends who could have provided a degree of emotional support. This again highlighted the issue that professionals did not understood the affect that Child Paul's family had previously had on him and the potential risk he posed to members of that family.

The staff at this accommodation were experienced in working with young people and had been trained in taking a trauma informed approach. Child Paul engaged in an educational placement at Progressive Sport and continued with the Listening Ear service. This was Child Paul's longest placement and it lasted for 7 months.

In January 2018 Child Paul's behaviour had deteriorated and staff had been subjected to physical assault, and also racial and verbal abuse. There were concerns for his own safety given the unknown nature of his activities and involvements when missing from care; which he regularly was. It was felt that as a result of Child Paul's escalating poor behaviour his placement had become untenable. Child Paul was regarded as being at high risk of criminal exploitation and harm to himself and to others. Child Paul required a staffing regime of 2:1 which was financially unsustainable. It was identified that Child Paul would need greater therapeutic support. As a result of the risk he posed to himself and others, Child Paul was moved to an emergency placement at short notice.

At this point there were a very limited number of providers who were able to supply accommodation to Child Paul as a result of his violent and aggressive behaviour. Child Paul moved into a semi-independent accommodation setting in an area that he wanted to live in.

In May 2018 a legal planning meeting took place to consider secure accommodation due to escalation of threats to harm. The referral was not accepted as Child Paul was considered too high risk to mix with other children. Child Paul had attempted suicide and had stated that he felt he was: *"being passed around like a toy".*

Child Paul was placed in 4 different homes in 2018. Finding suitable accommodation became increasingly difficult during the year because providers did not come forward owing to Child Paul's aggressive and violent behaviour and the requirement for 2:1 staff support.

In June 2019 Child Paul was placed in a young offender's institute for 3 months having been remanded in custody charged with 4 assaults. In September 2019 he was released and was

again placed in a semi-independent living home with the only provider who was willing to accept him.

In November 2019 he was again remanded in custody where he has remained.

Finding suitable accommodation for Child Paul had proven to be a difficult and at times impossible task. There was a chronic lack of accommodation for high risk children both locally and nationally. Child Paul was placed in the accommodation that was available rather than accommodation that met his needs. This meant that he was often in accommodation where he was able to continue mixing with criminal associates and engage in criminal activity. 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.

Summary

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.

In August 2018 an initial multi-agency risk management meeting took place under the auspices of the Knowsley Youth Offending Service. Child Paul had a number of convictions including 5 offences of assault, possession of weapons, drugs offence, affray and criminal damage.

The meeting agreed a risk management plan that was comprehensive and dealt with a wide range of issues. There is clarity within the plan around who is responsible for each action. Many of these actions were specifically aged at Child Paul as a child, which would be expected. The plan was regularly updated and monitored by the Youth Offending Service

These plans for Child Paul continued when he became subject to MAPPA. As noted earlier in the report there is no doubt that the plan resulted in a more targeted approach than had previously been seen.

By April 2019 it was agreed that Child Paul should now be subject to MAPPA. Multi-Agency Public Protection Arrangements (MAPPA), is a set of statutory arrangements that govern the management of dangerous violent and sexual offenders in the community. MAPPA is enshrined in law by the 2003 Criminal Justice Act (CJA 2003).

Offenders aged under 18 are subject to the same procedures as other MAPPA offenders, but additional considerations apply. For example, the MAPPA agencies have a statutory duty to have regard to the needs of the offender as a child. Therefore, the youth offending team and children's services must be present at a MAPPA Panel when the case of an offender aged under 18 is discussed.

MAPPA is designed to reduce the risk of further serious violent or sexual offending, but from time to time offenders do go on to commit such offences. When the most serious offences are committed, the MAPPA Strategic Management Board must consider commissioning a MAPPA serious case review to examine whether the MAPPA were applied properly, and whether the agencies worked together to do all they reasonably could to prevent the further offending. In this case Child Paul committed serious sexual offences whilst under the MAPPA. It has been agreed by the Strategic Management Board in Knowsley that a serious case review will be conducted. That review will contain a detailed analysis of how well the MAPPA were applied in this case.

When a person is referred to the board they are categorised in the following way:

- **MAPPA Category 1** - individuals convicted of a sexual offence that requires mandatory Sex Offender Registration with the Police are cases.

- **MAPPA Category 2** - individuals who have been convicted of a violent offence (as defined by Schedule 15 of the CJA 2003 - details can be found on the MAPPA website) **AND** received 12 months custody or more (suspended or actual).

- **MAPPA Category 3** - individuals who do not meet the Category 1 or 2 criteria but have committed an offence indicating that he or she is capable of serious harm and requires active multi-agency risk management at Level 2 or Level 3.

There are different levels of MAPPA risk management, depending on the level of intervention and co-working required, as defined by the risk assessment and risk management plan.

- **Level 1** - ordinary agency management (although in reality the lead agency can and does work with other agencies in the delivery of its risk management plan).

- **Level 2** - where **active** multi-agency risk management is required for the risk management plan to be delivered effectively.

- **Level 3** - similar to Level 2 but requires senior representation from the responsible authorities and 'duty-to-cooperate' agencies. This may be when there is a need to commit significant resources at short notice or there is a high likelihood of media scrutiny / public interest in the management of the case.

At the end of April 2019, a MAPPA referral was submitted on Child Paul by the Youth Offending Service (YOS). It was considered at a MAPPA Threshold Panel in May and it was agreed that Child Paul would be managed under Category 3 at Level 2. The risk posed by Child Paul were described in the following terms:

- *"Pattern of aggression and violence to staff demonstrated by convictions. There have been numerous other reported incidents by support workers who have not wanted to report to police or proceed with a prosecution. Entrenched attitudes by Child Paul promoting violence as means of resolving problems. This is with all staff working with him.*
- *Concerns that behaviour is escalating – he has now made threats against YOS staff, this undermines any effective supervision taking place.*
- *Child Paul is seen 2:1 by YOS with no home visits. Children's social care have not had any face to face contact since a threats to kill incident in February 2019. EMS staff were threatened and stopped visits to property.*
- *Child Paul regularly carries a knife and is open about this and no insight into dangers of this. He will use other objects as weapons (furniture), and has used kettle to threaten to burn staff, and used lighter to burn a support workers arm.*
- *Assessed as high risk of exploitation/ County Lines. NRM referral has been made. He views himself as a "big time" drug dealer and older peers as high friends. No insight into risks to himself or others.*
- *Child Paul has experienced significant trauma in his life. Of the 10 ACEs (Adverse Childhood Experiences) that are assessed – he has experienced all of them. This has significant impact on his functioning and also risk he presents to others.*
- *Mental Health – Child Paul has previously attempted suicide but refuses CAMHS involvement. He has been assessed by FCAMHS. No enduring mental health condition identified but significant concerns around emotional regulation and anger. Four sessions of intervention can be offered on voluntary basis. Not yet completed due to missing episodes.*
- *There is need for much more intervention in relation to mental health/ trauma.*
- *YOGRS score – 74%. Assessed as high risk of re-offending. Convictions do not fully represent the number of offences committed by Child Paul.*
- *Child Paul is on 4th Order with YOS since June 2018. He is not complying with any agency. Therefore, work to reduce risks is not being completed, but there are growing concerns about his lifestyle and links to drug supply and his impulsivity and recklessness.*
- *There has been substantial multi agency working with Child Paul to share information for assessment and risk management. However, progress is not being made and the risks are escalating. Relationships with staff have broken down further. A co-ordinated response to risks is needed across agencies.*
- *YOS have tried to work with Child Paul in trauma informed way but consultation from other services may be needed to develop this further.*
- *There are significant concerns at present about risks he poses directly to those staff working with him and how agencies can manage these risks and ensure safety for their staff whilst delivering statutory risk management. Decisions about these strategies may need to be further escalated in light of new incidents.*
- *MAPPA management may allow us to access further resources in relation to mental health, experiences of trauma, and aid transitions that will also be coming given he is 18 in December 2019. There will be a need to find appropriate accommodation, and potential cognitive assessment required as to ability to live independently".*

An initial review of Child Paul's case concluded that managing Child Paul at Category 3 Level 2 was appropriate.

Child Paul was the subject of 4 MAPPA meetings.

The first meeting that had agreed the level at which Child Paul should be managed, also agreed the following actions:

- *"MAPPA to confirm and review what charges had or where to be bought against Child Paul.*
- *Community safety team manager to consider secure unit order at legal planning meeting.*
- *YOS officer to liaise with CAMHS to make referral to Merseycare mental health services".*

At the second review meeting in September it was agreed to raise the management level for Child Paul to category 3 level 3. It was noted that the actions from the previous meeting had been completed and also that Child Paul had been sentenced and released from custody on a Detention Training Order (DTO)[14] for offences of assault. It was also noted that between meeting 1 and meeting 2 he had been arrested for the rapes on his sisters and released on bail. This was a significant reason for increasing the management level.

The minutes note that Child Paul had continued to be exploited since release but that he did not believe himself to be the subject of exploitation. There was also an increase in reports that Child Paul was self-harming. Child Paul had been placed in independent accommodation and had started to comply with elements of the YOS plan of support. The minutes noted that he had had neurological issues from birth, which now needed to be considered. There is no evidence of follow up in this regard.

The third review meeting took place in October 2019.

Child Paul had started to show some motivation to engage with support services. In fact, since his release on licence he had demonstrated 100% compliance with YOS requirements. He had completed work around use of weapons and lifestyle issues. Child Paul had also engaged with education, training and employment (ETE) support and Shield the multi-agency exploitation team.

Agencies were working to consider what options may be available for Child Paul when he became 18 years old. Independent, private accommodation was being considered. Child Paul had been referred to Forensic Child and Adolescent Mental Health Services (FCAMHS). Further support was being arranged by YOS who were seeking to refer Child Paul to a voluntary organisation who dealt with serious violent offenders who are hard to reach. This work was seen as important as his Licence would end in early November.

The final meeting was held in December 2019 and further review date set for January 2020. However, he was remanded in custody and review meeting 5 was delayed until the conclusion of court proceedings.

There is little evidence contained in the minutes of the four MAPPA meetings that Child Paul was being considered as a child. Planning focussed on accommodation that was semi-independent, but his status as a Child Paul does not appear to have been fully considered. There was however considerable support planned and engagement for Child Paul with FCAMHS may have proved beneficial and this was as a direct result of the YOS plan that was in place.

Initially there was little evidence that placing Child Paul under MAPPA saw any further progress in his case other than that being achieved by the YOS plan that was already in place. It is clear that the work of the YOS and the MAPPA was in tandem and as such there is documented evidence of the engagement of support services. It is difficult to understand

[14] **Detention Training Order –** a court order that combines **detention** with **training** and will be used for young people who commit a serious offence or commit a number of offences. Half of the sentence will be spent in custody and the other half will be supervised by the Youth Offending Team (YOT) out in the community.

whether the fact that Child Paul was also under MAPPA arrangements actually added value to the process or the work being undertaken by YOS.

It is now known that Child Paul continued to offend, and his risk of exploitation were remained. By the end of 2019 there were signs, possibly for the first time, that Child Paul was willing to engage with support services. It does appear that those professionals engaged with Child Paul, under MAPPA, had a clear and accurate view of him and the issues that he had.

Summary

The Youth Offending Service conducted a multi-agency meeting (MARMM) every 3 months that resulted in a focussed and detailed risk management plan which was reviewed and updated at regular intervals. This plan was child centered.

The MAPPA referral and Panel correctly identified that Child Paul should be managed under MAPPA.

There is evidence that the YOS plan in conjunction with MAPPA arrangements resulted in support being put in place for Child Paul at this time.

The MAPPA arrangements did not significantly reduce the risk to Child Paul or protect those to whom he came in to contact. Following his placement under MAPPA and the YOS Child Paul did, for the first time, 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 but this was counter balanced by the YOS risk management plan.

Professionals on the MAPPA Panel clearly understood the problems that Child Paul 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.

The behavioural problems exhibited by Child Paul are highlighted in this report and supported by a risk assessment conducted in 2018 and included:

- Possibly becoming radicalisation.
- Child Paul stated he was dealing heroin and crack cocaine.
- Child Paul was regularly missing from home.
- A single assessment in July 2018 concluded that Child Paul was beyond parental and professional control and that his non engagement made it difficult to understand exactly what support he needed.
- Child Paul's violent and threatening behaviour meant that he was being cared for by two members of staff at a time and his contact with social workers had to be carefully managed, due to threats and assaults on staff.

- In a single assessment in April 2018 it was noted that staff could not identify what triggered his violence; staff did not know where Child Paul was during the day; they were afraid of Child Paul.
- Child Paul had threatened to kill a woman's son.
- At a professional's meeting it had been agreed that no professionals were to visit Child Paul whilst in placement due to the risk he posed.
- Child Paul was subject to the Multi-Agency Public Protection Arrangements (MAPPA) due to escalating concerns about the risk of violence he posed to staff and to the wider community and was assessed as being a very high risk.

Child Paul had demonstrated that he could be extremely violent and had criminal associates. Child Paul would not comply with the requests made to him. From April 2017 it is reasonable to say that Child Paul was out of the control of those trying to support him. Professionals that attempted to support or care for him were often abused, threatened or assaulted. It is recorded that professionals were in fear of him.

In these circumstances there needs to be support for those engaging with the child not only to protect the professional from harm, but to ensure that progress is made in supporting the child. Where a child is beyond control and is a danger to himself or others there must be a clear risk management plan. In this case that did not appear to exist until August 2018 when Child Paul was the subject of the MARMM process that was regularly reviewed and included a risk management plan that highlighted staff safety issues.

Summary

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 the MARMM plan in August 2018.

Section Four – Good Practice

This review has identified three areas of particularly good practice that should provide assurance that safeguarding a child with the severe issues faced by Child Paul has improved in Knowsley.

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.

Section Five – Key Findings

5.1 Contextual safeguarding and a trauma informed approach

The first 15 years of Child Paul's life fall outside of the review period; as defined by the terms of reference. However, these years in Child Paul's life, and the trauma he suffered, clearly impacted on his behaviour in his mid-teens and set the context for the events that occurred between April 2017 and July 2019.

There is clear evidence that Child Paul suffered from a large number of adverse childhood experiences. In terms of the research now available, it is easy to identify that Child Paul suffered adverse experiences under all ten of the main areas identified in that research.

In addition to the adverse childhood experiences suffered by Child Paul, there is clear evidence that he was influenced and exploited by those outside of his immediate family. This resulted in him being involved in numerous violent encounters and assaults. Child Paul both used and dealt in drugs and was known to carry a knife. He had been involved in an incident with a firearm.

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.

5.2 Multi-Agency Public Protection Arrangements

Child Paul was the subject of Multi-Agency Public Protection Arrangements. The arrangements were undertaken in conjunction with a Youth Offending Service risk management plan. This was the right thing to do and eventually saw some progress in Child Paul's behaviour. Child Paul was assessed at the right level. There is little evidence that Child Paul was treated as a child and that the plans for him were child focussed within MAPPA but this was counter balanced by the YOS plan. There will be a serious case review into the effectiveness of the MAPPA in this case.

Child Paul was correctly assessed for MAPPA, whilst these arrangements were not sufficiently child focussed they were counter balanced by the YOS risk management plan that provided detailed risk mitigation and was child centered. There was improvement in Child Paul's engagement with professionals and signs that he was progressing under MAPPA and YOS. A serious case review will determine the effectiveness of MAPPA in this case and make separate recommendations.

5.3 Child protection processes

A separate reflective review was conducted in this case that examined the interaction between Child Paul, his family and child protection partners; predominantly the review focussed on the interaction with children's services. There are recommendations made in that review that should be considered by the safeguarding partners.

There were long-standing child protection concerns in respect of all five children in this family and four of the children have been victims of sexual and emotional abuse. There were concerns about historical sexual abuse in respect of Father and Mother and evidence that both parents suffered from mental ill-health issues. There were issues of neglect of the children and drug use. The children were the subject of child protection planning on two occasions; initially in respect of the risk of sexual and emotional abuse.

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.

5.4 Mental Health support

This review has found that Child Paul and his family all required support with mental health issues and in particular those relating to the sexual abuse they had suffered.

Child Paul did receive some support through 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 need was at a very high level. At this point there is clear evidence that agencies worked well together to develop a multi-agency support plan. Unfortunately, this support was too late to effectively address Child Paul's mental health needs and he remained a high risk to himself and those around him.

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.

5.5 Accommodation

Child Paul was accommodated under section 20 of the Children Act. The local authority did not consider it necessary to put in place care proceedings. Over a 2 year period Child Paul was placed in a variety of accommodation settings. It is clear that these placements were largely unsuitable, failing to provide the support and control he required in his life.

There are very limited accommodation options for those children who are violent. This is a national issue and not peculiar to Knowsley. Whilst professionals tried to find suitable accommodation for Child Paul this was not available. Those commissioned to place Child

Paul did so, but had to balance the risk to other children. As a result, Child Paul would be moved out of accommodation when he had become violent or failed to comply with conditions.

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.

5.6 Dealing with violent children and engaging in specialist high level work

This review has found significant evidence that Child Paul had moved beyond the control of both his parents and professionals. Those that tried to support and assist him were often abused and assaulted. Given Child Paul's criminal behaviour, the fact that he carried a weapon and his criminal associations, it was an incredibly difficult task for professionals to engage with him.

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.

5.7 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.

Section Six – Recommendations

The trauma suffered by Child Paul over the first 15 years of his life clearly impacted on the extreme behaviours he exhibited in his late teens, and in particular the review period between April 2017 and July 2019. It should be acknowledged that much has changed over the period of Child Paul's life and there is clear evidence of improvements in practice across agencies in Knowsley. There has also been considerable change and development, both nationally and locally and the importance of early intervention strategies to deal with adverse childhood experiences and to understand a child in the context of their life outside the family unit, is now more clearly understood.

In the case of Child Paul, the biggest lessons and issues which would have had the greatest impact on his life, relate to these first 15 years and as such sit outside the review period. The biggest single factor that may have improved Child Paul's life and provided protection for himself and his victims would have been an early intervention strategy. The type of work that may have been effective in this regard was not in common use nationally and not in Knowsley.

That position has changed, and Knowsley is now at the forefront of these types of early intervention. These recommendations are therefore limited to dealing with the specific issues arising from the review period.

6.1 Recommendation one

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

6.2 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.

6.3 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.

6.4 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.

6.5 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.

6.6 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.

Appendices

Appendix One

Section 17 Children and Social Work Act 2017

"After section 16E of the Children Act 2004 (inserted by section 16 of this Act) insert—

"16FLocal child safeguarding practice reviews

(1)The safeguarding partners for a local authority area in England must make arrangements in accordance with this section—

(a)to identify serious child safeguarding cases which raise issues of importance in relation to the area, and

(b)for those cases to be reviewed under the supervision of the safeguarding partners, where they consider it appropriate.

(2)The purpose of a review under subsection (1)(b) is to identify any improvements that should be made by persons in the area to safeguard and promote the welfare of children.

(3)Where a case is reviewed under the supervision of the safeguarding partners, they must—

(a)ensure that the reviewer provides a report on the outcome of the review;

(b)ensure—

(i)that the reviewer makes satisfactory progress, and

(ii)that the report is of satisfactory quality;

(c)provide the report to the Secretary of State and the Child Safeguarding Practice Review Panel.

(4)The safeguarding partners must publish the report, unless they consider it inappropriate to do so.

(5)If the safeguarding partners consider it inappropriate to publish the report, they must publish any information relating to the improvements that should be made following the review that they consider it appropriate to publish.

(6)The Secretary of State may by regulations make provision about—

(a)criteria to be taken into account by the safeguarding partners in determining whether serious child safeguarding cases raise issues of importance in relation to the area;

(b)the appointment or removal of a reviewer by the safeguarding partners, including provision for a reviewer to be appointed by the safeguarding partners from a list provided by the Secretary of State;

(c)the time when a report is to be provided to the Secretary of State or the Child Safeguarding Practice Review Panel, or published;

(d)the procedure for a review;

(e)the form and content of a report.

(7)In this section "reviewer" means any one or more persons appointed to review a case under the supervision of the safeguarding partners for a local authority area."