ANALYSIS of SAFEGUARDING INCIDENTS RELATING to LOOKED AFTER CHILDREN –June18-June 20

Obtained by Article 39 children's rights charity following FOI tribunal
Judgment here (12 September 2023): https://www.bailii.org/uk/cases/UKFTT/GRC/2023/733.html

CONTENTS

Item	Page
1. Introduction and background	3
2. Methodology and headline data	4
3. Looked After Children- context	5
4. Findings & analysis	7
THEMES 5- Commissioning and sufficiency of placements for LAC 6-Mental health of LAC 7-Sexual/criminal exploitation of LAC 8- Peer on peer abuse	7-8
9 Recommended further areas for Review/review questions.	8
10 Safeguarding notification process-proposals	9

1 BACKGROUND/ /SCOPE of ANALYSIS

1.1 In March 2020 the National Child Safeguarding Practice Review Panel published their annual report for 2018-19 and committed to understanding how safeguarding partners interpret the statutory guidance about when to notify the Department for Education, Ofsted and the Panel about serious incidents involving abuse or neglect of a child. This was particularly pertinent for notifications when an incident involves a looked after child. As part of fulfilling the commitments outlined in their annual report, the Panel commissioned a thematic analysis of serious incident notifications they have received regarding looked after children to inform any future guidance /further review.

1.2 The scope included analysis of cases notified to the Panel where the child was looked after to:

- identify themes and potential review questions arising from these cases; and
- analyse why the incidents were reported to the Panel and whether this was an appropriate notification.
- produce a report outlining the findings of the analysis

1.3 This analysis will cover cases of serious incidents of abuse and neglect of a child notified to the Panel between its inception in June 2018 and 29th June 2020 involving the following categories identified previously by the Panel:

Category A-Looked after children who are harmed by their carers
Category B-Looked after children who suffer significant harm as a consequence of the abuse/neglect that led to them being in care in the first place.
Category C-Looked after children who suffer significant harm, where the fact they are LAC may have contributed
Category D-Looked after children who suffer significant harm unrelated to their looked
after status

2. METHODOLOGY

2.1 This analysis involved reviewing 98 Rapid Reviews notified to the Panel over a two year period and identifying where they were best matched against the four categories previously identified by the Panel. Looked after children are not an inherently homogenous group and there was much variation in incidents reported to the Panel ranging from NAI of babies and gang related criminal behaviour and some overlap of categories.

2.2 Of the 98 cases, the reviewer identified that 9 were not looked after children but had been identified as such.

2.3 In addition there were a further 8 children who were LAC but were identified in the cohort of analysis of children who committed suicide who are not included in this analysis. Additionally this analysis did not identify the ethnicity of the LAC children as this was not identified in a number of the reviews.

2.4 **Overall headline data**

Of the remaining 89 cases:

20 were deaths of Looked After children and 69 harm/serious harm

- 7 were death by suicide and 4 were attempted suicides
- 5 where the mother or child was LAC but death SUDI
- 13 where serious harm due to abuse by: foster carers; connected carers; parents if child placed at home and residential or secure care settings.
- 3 involved NAI of babies
- 3 children where the child had health needs/disabilities and 2 died.
- 13 were victims of stabbing/assaults
- 5 were alleged perpetrators of stabbing/assaults
- 6 were children who assaulted other LAC/peer on peer abuse.
- 11 were alleged victims of rape/sexual assault
- 4 were alleged perpetrators of rape/sexual assault.

2.5 In relation to age of the child:

- 11 children were aged 0-5
- 2 children were aged 6-10
- 32 children were aged 11-15
- 43 children were aged 16-18

2.6. In relation to the notifications from regions, all regions were represented – the highest rate of notifications was from the South East and North West and the lowest from Eastern and Yorkshire and Humber.

2.7 In relation to the four categories identified by the national Panel:

Category A- Abuse by foster carer/connected carer/residential/secure care= **13**
Category B- Death/Serious Harm as a result of abuse/neglect that led to children becoming LAC= **48**
Category C- Death/Serious Harm where being LAC contributed= **7** including harm in same residential unit
Category D-Death or Serious Harm but unrelated to LAC-**21** including 4 SUDI and 3 with disabilities

2.8 It became clear that the primary focus of this analysis should relate to the 48 children in Category B.

2.9 Of these 48 children:

- 11 were victims of alleged rape/sexual assault- all female
- 4 were perpetrators of alleged rape/sexual assault-all male
- 6 victims of stabbing/assault-all male
- 3 were perpetrators of stabbing/assault-all male
- 3 were drug related overdoses
- 2 were accidental death due to road/train.
- 7 were suicides
- 4 were attempted suicides.

3. **Looked After Children- context**

3.1 Looked after children are the most highly vulnerable group of children for whom the state nationally and locally is the corporate parent. 63% of looked after children in England became looked after in 17/18 due to abuse/neglect. Many, but not all looked after children will have suffered prior adverse childhood experiences before they became looked after, for example:

- Anxious, insecure attachments or multiple care givers
- Separation and loss of significant people in their lives, including siblings, through death or major disruption in family relationships
- Physical and emotional neglect associated with parental alcohol and drug misuse or parental mental illness
- Exposure to domestic abuse and parental relationships characterised by conflict
- Physical or sexual abuse perpetrated by a close family member without a protective parent
- Unstable and insecure family life with frequent changes of address including periods of homelessness exacerbating the detrimental impact of poverty and deprivation.
- Disrupted education
- Offending and criminal or sexual exploitation

3.2 Much research on outcomes for looked after children have shown that these experiences will impact on their functioning and behaviours and lead them to be more vulnerable to experiencing poor mental health and demonstrating risk taking behaviour. A consistent feature of research into looked after children has been the identification of long-standing needs in terms of mental wellbeing caused by early childhood trauma. The mental health system has not always served children well. Prior to becoming looked after many children have self-harmed and frequently identified as experiencing suicidal thoughts or making suicide attempts and engaging in substance misuse/anti-social/offending behaviour. They were referred to child and adolescent

mental health services but rarely diagnosed with a recognisable mental illness, which met eligibility criteria.

3.3 In 2001/2 the Office of National Statistics conducted a survey of the mental health of looked after young people aged 5-17 in Great Britain. This research, which remains the most comprehensive data available on the mental health of children in care, found that overall in Great Britain 45% of looked after children aged 5-17 had a mental health disorder as defined by the International Statistical Classification of Diseases and Related Health Problems 10th Revision, compared to 10% of the general population (Meltzer et al., 2003). In addition, in terms of their additional needs, 27% of looked after children in England have SEN/EHCP plans and 36% of Care leavers aged 19 were NEET in England in 17/18.

3.4 Older looked after children are frequently involved in risk taking behaviours associated with contextual safeguarding issues. The processes within the looked after system and the criminal justice system have not been effective in recognizing the risks and mobilizing the resources and support required to keep children safe. There have been improvements but the Panel's first thematic review provides real opportunities to consider the most timely processes needed to address risk caused by looked after children becoming involved in high risk behaviours and the particular challenges faced by those living away from their home area.

3.5 The key issues to improve outcomes for looked after children relate to:

- Effective commissioning and sufficiency plans for placements for looked after children, which meet their needs and provide choice.
- The need for effective multi-agency Corporate Parenting arrangements with an unrelenting focus on the child and meeting their needs
- Ensuring looked after children are prioritised for provision of mental health and specialist health services even if placed out of area.
- The effectiveness of the interface for those children involved in the looked after system, the criminal justice system and the mental health system
- Effective permanency strategies.
- Continuity of care by carers and consistency of relationship with a lead professionals despite cross boundary moves/disruption
- Access to education which is maintained and provides good outcomes
- Seamless transition to adult services
- Procedures and processes that provide timely multi-agency responses to contextual safeguarding risks.
- Effective IRO and quality assurance arrangements.

4. ANALYSIS/FINDINGS

4.1 From reviewing these cases, the key themes that I identified which were evidenced in the Rapid Reviews include:

- Children coming into the Looked After system in adolescence with a history of parental abuse/neglect and significant trauma.
- Children coming into the system in adolescence due to previous involvement in gang related/criminal activities, which continues once in the system.
- The historical trauma experienced by these children leads to high levels risk taking behaviour as perpetrator/victim ie missing from placements and substance misuse, child sexual exploitation/sexual abuse, criminal/gang involvement and high levels of self harming behaviour.
- High level of placement breakdown evidenced in most of these children resulting in: emergency unregulated placements and disruption of any mental health support.

5-THEME ONE- COMMISSIONING and SUFFICIENCY of PLACEMENTS

5.1 There was clear evidence that for many of these children due to their high level of complex and challenging needs mainly as a result of childhood trauma (mental health, self harm, substance misuse, aggression, offending) placements are at times impossible to commission

5.2 There was significant evidence of multiple placement disruption-often with little, if any notice from the provider.

5.3 Many of the children who are 16+ are placed in "semi-independent" unregulated provision as this is the only available placements which however do not have residential staff and struggle to meet their needs and do not reduce risk taking behaviours.

5.4 There were many examples of secure welfare criteria under S.25 had been met but there was no placement availability of secure welfare beds.

5.5- Given the intention of the government to undertake a Care Review and given this increasing issue is well known to all stakeholders, this may be a recommendation from the Panel informed by this analysis.

6 THEME TWO- CHILDREN's MENTAL HEALTH

6.1 Many of these children demonstrate challenging behaviour. Much of this will be due to their trauma, which results in an inability to sustain relationships and leads to exclusions from school and all types of care placements

6.2 Children frequently have historically had no therapeutic work to help them with their childhood trauma/behaviour- i.e. not met criteria/WNB to CAMHs by their parents/carers in earlier childhood.

6.3 Agencies are therefore left to simply focus on the presenting issue ie criminalisation/gangs/CCE/CSE without addressing the underlying cause.

6.4 There was a relatively small number of LAC in Tier 4 provision at time of their death/SH, which implies that when metal health criteria are met children are being protected.

7. **THEME THREE- CONTEXTUAL SAFEGUARDING SEXUAL ABUSE /CSE and CCE**

7.1 A high number of vulnerable females in the analysis who are LAC appear to be victims of rape/sexual assault/CSE.

7.2 A smaller numbers of male LAC are perpetrators of CSA/CSE

7.3 High numbers of males who are LAC are victims or perpetrators of stabbing/assault due to criminal/gang related associations. This occurs even when children are being placed in other LA areas to minimise risk.

7.4 The Panel have recently undertaken a thematic review into criminal exploitation and the considerable learning gained from that review is relevant to the looked after children.

7.5 There is however a question of how can we support practitioners better to support this cohort of children involved in sexual abuse/exploitation reduce risk taking behaviour/develop positive self image/healthy relationships.

8 THEME FOUR-PEER on PEER ABUSE

8.1- The reviewer received a request from the Panel to consider peer on peer abuse. This was evidenced in 7 Rapid Reviews.

8.2. They mainly involved the stabbings/assault and sexual assault of children- 4 in the same residential unit/foster care.

8.3 Although this is not an apparently high level of incidence abuse by children within or by staff in residential/foster care settings is a continuing issue.

9. POTENTIAL AREAS/QUESTIONS for FUTURE ANALYSIS

9.1 The panel may wish to consider if the themes and questions identified and evidenced from this analysis should be included in the scope for the national Care Review.

Commissioning and sufficiency of placements for looked after children

9.2- How can the multi-agency care system in its national and local role as corporate parent ensure sufficient high quality and suitable residential /foster placements for LAC

displaying high risk and challenging behaviours? What can be learnt from alternative models of care delivery undertaken in other countries?

9.3 How can the care system align with the criminal justice and mental health system better to ensure there are sufficient and appropriate residential placements for children that can meet their high levels of need and challenging behaviour?

Addressing childhood trauma for looked after children.

9.4 How can treatment for children's mental health be prioritised and addressed in earlier childhood where there is known abuse/neglect and trauma within current CAMHS eligibility constraints prior to becoming LAC?

9.5 How can children in the LAC system access high quality, consistent mental health services to address their complex needs/trauma without a diagnosed mental illness to support reduction in high risk taking behaviours and achieve better outcomes?

10. The Safeguarding incident notification process:

10.1 Working Together 2018 requires a) Local Authorities to notify **all** incidents where a looked after child has died to OFSTED, CSPRP –irrespective of abuse/neglect and b) requires all Local Authority areas to notify where death/serious harm to a child where abuse/neglect suspected.

10.2 Of the 89 notifications/Rapid Reviews: 7 were notified because of death of LAC but were not safeguarding incidents; 1 was notified but no evidence of Serious Harm but because the child was LAC.

10.3 My proposals for consideration are:

- It needs to be considered if statutory guidance needs to be amended requiring Local Authorities to notify the death/serious harm of a LAC only **if** abuse/neglect are known/suspected. Child death review processes will consider all other LAC deaths and refer if appropriate to Safeguarding partners
- Further clarity is needed on which Local Authority should undertake the notification if LAC child in another LA area -as there were examples of both.
- Further clarity is needed on status of child if remanded to custody and not LAC prior to remand and released.
- Further clarity is needed on notifications relating to foster carer/connected carer allegations if more than one child is abused. There was evidence of some notifications simply identifying the foster carer.

[Article 39 removed author's name]

13/8/20