Dudley Safeguarding Children Board

Serious Case Review

Child N

Author: Steve Ashley
Lead Reviewer: Mick Brims

Section One – Introduction

1.1 What this review is about

This serious case review concerns a young person known, for the purposes of this review, as N.

Dudley Safeguarding Children Board (DSCB) agreed this case met the criteria laid down in Working Together 2015 for a serious case review to be conducted.

The brief circumstances of this case are as follows; **N** had been known to Dudley Children's Social Care (DCSC) since 2008 and had spent several periods in local authority foster care and residential placements under section 20, Children Act, 1989. This was because her mother repeatedly stated she was unable to cope with her behaviour. In April 2015, following extended periods of going missing and possible CSE risks, **N** became subject of care proceedings. **N** became the subject of a Care Order[1] in September 2015, immediately before her 16th birthday.

N became pregnant and her unborn child was made subject to a Child Protection Plan in October 2015. In February 2016, **N** gave birth to a son (known in this review as **A**) and in August 2016, the court ratified a decision to pursue the adoption process for that child. The father of the child was initially believed to be a male known for the purposes of this review as **M1**. Subsequent DNA testing clarified that another male, known for the purpose of this review as **M2**, was in fact the father of **A**.

N had been in a turbulent relationship with **M1** since 2014. That relationship had involved domestic violence and the couple had separated and reunited several times. At these points, **N** had formed other relationships. In the early summer of 2016 the relationship with **M1** had resumed but this relationship again broke down after **M1** violently assaulted **N** on 2 August 2016. At this point, **N** was pregnant.

In September 2016, **M1** broke in to N's supported living accommodation and waited for her to return home. On her arrival an argument ensued and **M1** stabbed **N** 5 times. **N** received life changing injuries from this attack. **M1** was arrested, charged and was convicted. **M1** received a 10-year restraining order and four years detention for an offence of section18 Wounding, contrary to the Offences against the Person Act 1861.

1.2 Why this review was conducted

The Independent Chair of the DSCB agreed with a recommendation of the Serious Case Review sub-group that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the Local Safeguarding Children Board (LSCB) to undertake a review where –

[1] **Care order -** A Care Order can be made in Care Proceedings brought under section 31 of the Children Act 1989 if the Threshold Criteria are met.

(a) abuse or neglect of a child is known or suspected; and
(b) either –

(I) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of *Working Together 2015*. This version of Working Together was used when deciding upon the serious case review process, as it was the most current at the time decisions were taken around the review process (published in March 2015).

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of **N**, whether information was fully shared by the professionals involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people.

1.3 How this review was conducted

1.3.1 The Review Panel

The author of this report was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards. The lead reviewer was Mick Brims who is a qualified social worker and has extensive experience in children's social care in several local authority areas.

The author and lead reviewer are independent of Dudley Safeguarding Children Board in accordance with *Working Together 2015* chapter 4 (10*).*

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Dudley Safeguarding Children Board (DSCB) business unit supported the panel.

1.3.2 The Terms of Reference

This SCR has been conducted using a methodology adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals.

This review looks at the period of **N**'s life from September 2014 until the point of her injury. However, where appropriate, reference is made to the earlier periods of her life. This period was selected following a Serious Case Review Panel meeting and is of a sufficient range to include all key episodes of engagement that **N** had with agencies in Dudley. Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The review was conducted in a way which:

- Recognised the complex circumstances in which professionals work together to safeguard children;
- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did;
- sought to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- was transparent in the way data is collected and analysed;
- made use of relevant research and case evidence to inform the findings.

Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called *Working Together*. It contains all the processes that agencies are required to follow. Working Together has been through several iterations. This review benchmarks against the statutory guidance contained in *Working Together 2015*[2]. This is the version that professionals would be working to during the timeframe of this case.

The author took full cognisance of the third annual report of the national panel of independent experts on serious case reviews that was published in November 2016.

1.4 Methodology

The methodology agreed by the Dudley Safeguarding Children Board (DSCB) review panel is based on a model consistent with the requirements of *Working Together 2015*. It ensures that:

- A proportionate approach is taken to the SCR;
- it is independently led;
- professionals who were directly involved with the case are fully engaged with the review process;
- families are invited to contribute.

1.4.1 Chronologies and Management Reports

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement, and the work being undertaken to address those issues, was included. All the agencies that were asked for a report provided the information requested. In cases where further clarification was required agencies responded in an open and honest way.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology. In addition, interviews with front line staff and managers took place.

1.4.2 Learning Event

The learning event with front line practitioners is an essential part of the process. In the learning event front line staff and managers that had had contact with **N** were brought together

[2] ***Working Together March 2015*** - https://www.gov.uk/government/.../working-together-to-safeguard-children--2

for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of their engagement with **N** that enriched the information provided by agencies and ensured that all the relevant facts were recorded. It was the most effective way of triangulating the evidence and ensuring that an accurate picture of **N** and the traumatic events is provided.

This review seeks to determine **why** events occurred and not just record the facts of **what** happened. The front-line view is essential in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non-attributable and their comments are not quoted directly in this report. For many front-line practitioners, this was the first opportunity for them to discuss with other professionals their engagement with **N**; it was pivotal to the learning from these events.

1.4.3 Family Engagement

The period over which this review was conducted was parallel with criminal investigations and consequently no family members were interviewed.

1.4.4 Parallel investigations

Throughout the period covering the review there have been several police investigations concluding with the stabbing of **N**. This investigation resulted in the conviction of **M1**.

1.5 How this report has been structured

Following the introduction, section two provides the story of what happened to **N**. There is a description of **N** and her life and then the detail of what happened to **N** over the timeframe agreed within the terms of reference. It provides a synopsis, and tries to paint a picture, of the **N**'s world and the circumstances in which she lived during this period. Where an event or issue has proved to be significant, it is highlighted and any pertinent questions are raised at that point. These areas of significance are analysed in greater depth in section three.

Section three analyses the significant issues exposed in section two and explains **WHAT** happened and **WHY**. From this analysis, the key themes are discussed in section four. Section five contains the key findings. The recommendations in section six have been developed from these findings taking account of the work carried out by agencies since these events occurred.

This report has been written so that it can be read by the public without redaction. As a result, the names of the main subjects are not used and there are no dates that might readily identify **N**.

In this report, the following initials represent the main subjects:

- **N** – the subject of the review
- **MN** –mother of N
- **A** – child of N and M2
- **S1** – sister of N
- **M1 -** boyfriend of N and offender
- **M2** – boyfriend of N and father of A
- **M3** – boyfriend of N

Section Two – The Story of N

2.1 Introduction

This section sets out the facts in this case. It begins with the background of **N** and her closest associates. This provides an insight to the type of child **N** was at this time and those she associated with.

2.2 The background

N is a woman who has had contact with DCSC and other key agencies in Dudley for most of her life. Her early life could be considered as chaotic.

N attempted to deliberately harm herself aged 4 years old. There had been a further 4 self-harm incidents reported between that time and 2014. **N** first reported an incident of domestic violence in May 2012. **N** had been arrested for criminal offences including 24 charges of criminal damage and 2 assaults prior to September 2014. By September 2014, there had already been 13 reports of **N** going missing, but conversations with front line practitioners indicate that it was many more times than this.

N's mother (**MN**) reported to DCSC on a number of occasions over time that she was unable to cope with **N** and DCSC would become involved with the family. At one point, **N** had allegedly threatened her mother with a knife.

In September 2015, **N** became subject to a Care Order and became a Child Looked After[3] (CLA). Prior to this, in mid-January 2015 **N** had been placed with experienced foster carers who specialised in looking after adolescents. At that point she was in a relationship with **M1**. The placement came to an end within a month because **N** was continually allowing **M1** and other males in to the house through her bedroom window. Over the next 2 years at least two other males – **M2** and **M3** - also feature as her partners. **M2** is the father of **A**, **N**'s child who later came into care of the local authority. It is unclear exactly when these relationships commenced and finished, however there is a suggestion that **N** was in a relationship with each of these males over time, both separately and simultaneously.

These relationships often included incidents of domestic abuse and **N** was continued to be regularly classified as 'missing from care'.

N gave birth to a son, **N**, in January 2016. The father of this child was believed at one time to be **M1**, although it was later established in **A**'s care proceedings (by means of paternity testing) that his father was **M2**. In March 2016, **N**, **A** and **M2** moved to a residential placement for the purposes of a parenting assessment as part of **A**'s care proceedings. In April 2016, **M2** was asked to leave the residential parenting placement after a domestic abuse incident with **N**. In June 2016, **N** decided to leave the residential parenting placement and **A** went into foster care. In August 2016, **A** was placed for adoption. In July 2016, **N** was again pregnant, but it has not been established who is the father of that child.

The offender in this case was **M1**. **M1** had also had a turbulent and troubled childhood. Whilst there can be no excuse for the violence perpetrated against **N** and others, it is worth providing some information regarding his background. **M1**has had little or no contact with his father and contact with mother has been characterised by ambivalence and rejection. At the age of 4

[3] **Child Looked After -** A child who is being looked after by their local authority is known as a child in care. They might be living: with foster parents. at home with their parents under the supervision of social services. in residential children's homes.

years **M1** found his step father dead, having taken an overdose of drugs. At aged 7, **M1** was made the subject of a section 31 Care Order to Dudley Metropolitan Borough Council, on grounds of neglect. **M1** had at least 8 different foster placements and was placed in 3 residential units. **M1**'s secondary education took place at a school reserved for young people with statements of special educational needs relating to emotional and behavioural issues.

M1 had a criminal record that began on 3 December 2014. Most of the offences he has been arrested for are criminal damage and theft. The non-violent nature of his criminal antecedents escalated in severity on 2 August 2016 when he became involved in the assault on **M2**. This was followed by further violent offences.

M1 received a 12 month Youth Rehabilitation Order for an offence of being in possession of an Imitation Firearm on 4 August 2015. **M1** had a history of missing episodes.

All of the young people involved in this case were Children Looked After (CLA) and subject to statutory guidance relating to the way in which they are accommodated and supported.

Significant Issue One

N was a looked after child. CLA processes should have incorporated consistent overview of the holistic range of **N**'s needs (including mental health, personal safety needs and domestic abuse support) - outside of crisis events. Pathway Plans should have consistently considered the wider range of **N**'s needs in achieving positive transition to adulthood.

2.4 The facts of this case

2.4.1 Phase one – **N**'s journey from September 2014 to February 2016

When **N**'s mother reported her missing in September 2014 she also told the police she had been self-harming. The police reports reflect that she had returned home and that she was reporting self-harming to get engagement from DCSC. No further action was taken.

A month later **N** reported she had been raped. The circumstances described to the police were that she had been with **M1**, but they had argued, and she then met some boys; one of whom raped her whilst his friends watched. The police began enquiries but **N** then admitted it was a false allegation; she said she had made it up to get moved away from her mother.

Significant Issue Two

N had a troubled childhood, including documented issues with her mental health. It would be expected that **N** would be referred for support to CAMHS and other adolescent support services.

At the beginning of 2015, **N** was again reported missing and was subsequently located in North Wales with **M1**.

Several other missing person reports are made about **N** over the next month and in February 2015 the police made a referral[4] to DCSC and a strategy discussion[5] was held. This followed the West Midlands Police missing person strategy. The meeting agreed that a section 47 investigation[6] should take place. It is unclear what action took place as a result of this investigation.

There was an agreement that **N** would move to Wrexham to go to college and stay with her father. **N** remained with her father a few days before this arrangement ended and instead **N** was placed in residential accommodation in Staffordshire that she had resided in previously.

Over the next month **N** was missing virtually every day. There were numerous missing reports and logs of checks made across a range of addresses. In the majority of cases, it seems **N** was with **M1** who had been relocated to Manchester, however he was also regularly reported as missing.

On 19 March 2015, **N** disclosed a serious incident by **M1** the previous month. The police recorded the incident and began an investigation. The report had been made in the late evening by staff at her care home. Police contacted the DCSC Emergency Duty Team (EDT) and liaised with them. **N** did not want to be spoken to that night and, as there were no forensic issues, an appointment was booked for her to attend the police station the following day. **N** went the next day with a staff member from the care home and was ABE[7] interviewed. The detective constable called the DCSC duty social worker to update **N**'s social worker with the result of the interview. **N** withdrew the allegation saying she had now resumed her relationship with **M1**. There is no evidence, in the information provided, as to whether a section 47 investigation commenced following this allegation or whether appropriate support (whether Victim Support, Respect Yourself or CAMHS) was offered to **N** at this time. The detective in the case stated that it had been agreed DCSC would arrange for any further support. Considering events over the following month, it may be that DCSC's immediate focus was on securing placement stability for **N**.

On 24 March 2015, police utilised Powers of Police Protection (often referred to (erroneously) as a 'Police Protection Order' (PPO),)[8] to place **N** in to a place of safety. At this point, **N** had been placed in residential accommodation in Dudley. Staff at that accommodation stated she could no longer be protected and would break windows to allow males in to the premises and despite their efforts, repeatedly went missing. Information suggests that police used powers of police protection as they felt the current placement was not suitable for **N**. After the Police Powers of Protection were utilised, **N** was moved to a rural placement in Somerset.

On 3 April 2015, **N** was arrested and later convicted for assault on a police constable after being located after a missing episode. **N** was taken to hospital whilst in custody and attempted to escape, causing damage. The carers who were sent to bring **N** back to the West Midlands reported that she had absconded from them. It was believed that **N** was in Manchester looking for **M1**. Once located, it was agreed that **N** could remain at her sister's home for a brief period and strategy meetings would be held the following week.

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[4] **Referral** - The referring of concerns to local authority children's social care services, where the referrer believes or suspects that a child may be a Child in Need or that a child may be suffering, or is likely to suffer, Significant Harm.

[5] **Strategy meeting -** A Strategy Meeting (sometimes referred to as a Strategy Discussion) is normally held following an Assessment which indicates that a child has suffered or is likely to suffer Significant Harm.
The purpose of a Strategy Meeting is to determine whether there are grounds for a Section 47 Enquiry

[6] **Section 47 investigation -** Under Section 47 of the Children Act 1989, if a child is taken into Police Protection is the subject of an Emergency Protection Order or there are reasonable grounds to suspect that a child is suffering or is likely to suffer Significant Harm a Section 47 Enquiry is initiated.

[7] **ABE interview -** Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, Including Children. The Crown Prosecution Service, 2001.

[8] **Police Protection Order -** In England and Wales, **Police** child **protection powers** concern the **powers** of the individual local **Police** forces to intervene to safeguard children. ... Under this law, the **police** have the power to remove children to a safe location for up to 72 hours to **protect** them from "significant harm".

On 24 April 2015, Police Powers of Protection were again utilised again for **N**. Information provided suggests that this decision was taken due to concerns about **N**'s being frequently reported as missing, but also due to her staying in accommodation with a 52-year-old male in Manchester, who was known to be under police investigation for a sexual offence. Information provided suggests that authorisation was received from DCSC senior managers for **N** to immediately enter a secure placement for 72 hours to ensure her safety, in line with section 25 Children Act 1989. It is noted however that despite the gravity of this decision, **N**'s casefile does not contain a detailed record of the rationale taken by DCSC senior management in authorising this 72-hour period of secure accommodation for **N**.

On 27 April 2015, following a strategy discussion between Police and DCSC, agreement was reached that DCSC would apply to the Family Court for a Secure Accommodation Order[9] and an Interim Care Order.

These court applications were refused on 28 April 2015, however care proceedings continued. **N** moved to the care of her adult sister, **S1**. **N** was referred to CAMHS and support services. A CLA review was conducted.

Significant Issue Three

N and **M1** went missing on a continual basis and considerable resources were put in place to locate them. **N** was graded at high risk from CSE and at high risk when she went missing. Agencies should have a plan for regular and high risk missing persons.

Over the next 2 months **N** went missing on several occasions and was convicted of breaching bail conditions and assaulting her mother. At this point, **N** was pregnant and the father was believed to be **M1**.

N had been referred to CAMHS but failed to attend appointments and in August 2015, the care proceedings concluded with **N** being made subject to a Care Order. This judgment was against the care plan proffered by DCSC, who sought to support **N** on an ongoing basis under section 20 Children Act 1989 rather than via an order under section 31, Children Act 1989. As **N** was pregnant she was also receiving ante-natal care from midwives and support from the Family Nurse Partnership.

In October 2015, an Initial Child Protection Conference took place in respect of **N**'s unborn child **A**. It was agreed the unborn baby would be placed on a Child Protection Plan.

At this point, **N** had begun a relationship with **M2** and was housed in a hostel under section 20. **N** was continually being reported as missing and graded as being at high risk. In November 2015, **N** twice reported incidents of domestic abuse by **M2**. In the first incident, he broke her phone and in the second he threatened to kill her with a knife. **N** later stated she was not willing to cooperate with the police and withdrew her statement and allegation.

[9] **Secure Accommodation Order –** Section 25 Children Act 1989. These orders permit a local authority to place a child in secure accommodation. The court can make a secure accommodation order where a young person has a history of running away, is likely to run away from any other kind of accommodation and if they do so is likely to suffer significant harm.

Significant Issue Four

N was graded as at high risk of CSE, was continually missing and committing criminal offences. **N** had contact with several agencies including children's social care, the police, health and housing. **N** was later at risk of and suffered serious incidents of domestic violence; including life-changing injuries. Many of the children **N** was associated with also had the support of a number of safeguarding agencies. There should be clearly documented evidence of multi-agency working, the use of statutory child protection procedures, consultation between professionals working with all linked children and effective use of supervision to keep the child's needs in mind.
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In February 2016, **N** gave birth to her child, **A**, who was subject to a child protection plan. **A** was made subject to an Interim Care Order and both mother and baby were moved to foster care in Birmingham.

At this point it seemed that the chaotic life style **N** had been involved in over the previous 2 years with regards to missing episodes, frequent placement changes and youth offending may be coming to an end.

2.4.2 Phase two – March 2016 to September 2016

In March 2016, **N** and **M2** moved to a residential unit out of borough with **A**.

In April 2016 **M2** was asked to leave the residential unit following an incident where he head-butted **N**. **N** was assessed by the police as being at high risk of domestic abuse. **N** stated she was in low mood and wanted to leave but was persuaded by staff to stay. **N** also made further disclosures of domestic abuse from **M2**, including that she had been assaulted by **M2** over a period of weeks, in which on one occasion, he had placed his hands around her throat and choked her. She also stated on another occasion that he had pushed her onto the bed and cut her calf with a small knife.

On 28 April 2016, **N** was referred to the Respect Yourself team. The team provided one to one sessions and home visits as part of a support programme for persons involved in domestically abusive relationships. On a number of occasions, these sessions included other professionals. The Intensive Family Support Worker/Independent Domestic Violence Advocate allocated to **N** remained engaged with her up until the significant event in September 2016.

In June 2016, **N** went missing and was found with **M2** at his grandmother's house in the West Midlands. In July, it appears there was a further domestic incident between **N** and **M2**.

In June 2016, **N** was again subject of a CLA review by DCSC and it was agreed to find her supported accommodation. It also seems that **N** had renewed her relationship with **M1**.

On 2 August 2016, police received a report that **N** had been assaulted by **M1** at her sister's flat. **M1** was reported to have dragged **N** around the flat by her hair and caused criminal damage. **N** was taken to hospital and **M1** was arrested. A DASH[10] assessment was completed which graded **N** as 'high risk'. **N** received significant injuries as a result of the

[10] **DASH -** Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model

assault by **M1**, including internal bruising to her ribs, grazing to her arm, scratches and a loose tooth.

The Domestic Abuse, Stalking, Harassment and Honour based Violence (DASH) risk assessment makes the following observations:

- *"Incident has resulted in injury, internal bruising to ribs, grazing to left arm and scratches, scratches to back and soreness to head. Loose tooth in bottom set right hand side.*
- *Victim is frightened of what he is capable of as felt in fear of life today when he was strangling her.*
- *Afraid he will either kill her or seriously injure her.*
- *Tries to stop her seeing her friends.*
- *Separated 18 months ago.*
- *Offender constantly texts and follows her.*
- *Had a baby boy 6 months ago who is currently in care [A].*
- *Abuse is happening more often even though they split up 18 months ago.*
- *Abuse getting more violent.*
- *Offender is very jealous.*
- *Offender has threatened to kill the victim.*
- *Attempted to strangle the victim today.*
- *Offender has had problems with drugs, alcohol and mental health in the last year according to the victim.*
- *Victim states that he previously self-harmed and also tried to hang himself.*
- *Victim believes he has had contact with police due to sexual offences and also other violence matters."*

This information would have been of use to a number of partners and the use of the DASH risk assessment should be shared so that agencies have a full picture of a young person's circumstances.

Funding was agreed to place **N** in a Churches and Housing Association of Dudley and District (CHADD)[11] (On Route) placement. Funding for CHADD On Route was agreed until **N** was 18 years old and a referral made to Dudley Adult Social Care for transitional arrangements to be put in place.

Significant Issue Five

N suffered numerous episodes of domestic abuse and two of her boyfriends were identified as domestic violence perpetrators. There are clear processes, including the MARAC process, that would be expected to put plans in place to protect **N**.

N remained in her accommodation but there were concerns raised that she was allowing male visitors in to the premises. One of those males was **M3**. A MARAC[12] meeting was held on

[11] **CHADD** provides a safety net of supported homes and community-based services for people in Dudley who may be experiencing crisis or challenging transitions, homelessness, domestic abuse or may need support with independent living. – it is a local, voluntary sector organisation fulfilling a charitable and social mission, exclusively in the metropolitan borough of Dudley.

[12] **MARAC –**multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists

25 August 2016. There were considerable concerns raised around both M2 and **M1**. MARAC minutes indicate feedback from some agencies that **N** was still in fear of **M2**, who was in prison, but had sought to contact **N** from there. Information in the DASH risk assessment suggests that **N** was also scared of what **M1** was capable of, highlighting stalking behaviour (constant texting and following **N**) as part of her concerns. It is unclear from the information provided to reviewers what, if any, protection was put in place to protect **N** from **M1** or **M2**. **M1** was later charged and remanded in custody by the police. The following day he was released on bail by magistrates. On 12 September 2016 **M1** was found guilty of various offences (including Battery) relating to this domestic abuse incident against **N**.

MARAC minutes on 25 August 2016 also indicate that **N** had been referred by Black Country Women's Aid to the IDVA service due to fears of violence from **M2** and possible post-natal depression. The reviewers are of the view that this feedback to MARAC actually reflects the original referral made to the IDVA service in April 2016, after the incident where **M2** headbutted **N** in the residential placement and that support was ongoing when MARAC convened in August 2016.

Information provided suggests that due to **N**'s age, an Intensive Family Support Worker/IDVA from Respect Yourself was provided for **N** in April 2016 and it appears that engagement was ongoing from that point forward between Respect Yourself and **N** around domestic abuse support. At the end of August 2016, **N** stated she would like her own property because she still felt like she was in care and needed to move on. **N** was engaging with the IDVA but stated she was worried that **M1** knew her address.

On 11 September 2016 **M1** was arrested for an offence of threatening **M3** with a hammer and charged with several offences including several public order offences, possession of an offensive weapon, criminal damage and breach of a youth rehabilitation order. **M1** was again remanded in custody by the police to appear before magistrates the following day.

On 12 September 2016 **M1** appeared in court and was found guilty of a range of violent offences relating to the domestic abuse incident with **N** on 2 August 2016 and the instance of threatening the **M3** with a hammer on 11 September 2016. **M1** was released by the court pending a sentencing hearing.

On 14 September 2016 **M1** went to the accommodation **N** was residing in and, following an argument, stabbed her 5 times. **N** received life changing injuries.

Statements made by **M1** later provided some detail to the relationships between **N**, **M1**, **M2** and **M3**. The three young people had known each other for a number of years and **N** was in relationships with each of them during that time. **M1** stated that when he resumed his relationship with **N** in August 2016 she had told him that his child, **A**, had died at birth and been buried. **N** told him that **M3** had desecrated the grave and this had caused him to lose his temper and seek out **M3** to cause him harm. This information contrasts with the established facts of **A**'s circumstances (that he was in fact the child of **N** and **M2** and that he was alive and in foster care at the time that **N** was stabbed).

There is clearly no excuse for the behaviour of **M1** or **M2** with regards to the assaults they perpetrated on **N**. It is acknowledged however that these were clearly complex and difficult relationships between young people with challenging pasts, who were moving in to adulthood.

Significant Issue Six

The transition process from childhood to adulthood is a difficult period and this is more significant for children who are Looked After. There should be clear support processes for Children Looked After as they move through this transition, which is underpinned by consistent planning and review to ensure that positive outcomes are clearly outlined and achieved wherever possible.

Significant Issue Seven

Child **N** came from a family that had been subject to significant involvement from safeguarding agencies over many years. Clear processes are required to swiftly identify children who are or could become part of inter-generational involvement with safeguarding services and what support can be offered to 'break the cycle' of involvement.

Section Three – Analysis of Significant Issues

3.1 Introduction

This section looks at the issues highlight in section 2 and provides an analysis of each of those areas.

3.2 Significant Issues

3.2.1 Significant issue one

N was a looked after child. CLA processes should have incorporated consistent overview of the holistic range of N's needs (including mental health, personal safety needs and domestic abuse support) - outside of crisis events. Pathway Plans should have consistently considered the wider range of N's needs in achieving positive transition to adulthood.

Work to safeguard children who are 'looked after' and plan for their welfare and pathway into adulthood are documented in two key processes. Children Looked After (CLA) reviews and Pathway plans. This section contains an analysis of the work that was conducted using these processes.

Reviewers have examined the four CLA reviews that took place between October 2015 and June 2016 and have noted the following key points:

Children Looked After Review – October 2015

- The review does not reference that **N** was made subject to a Care Order a month earlier in September 2015, after proceedings commenced on 28 April 2015. The review does not reflect on the outcome of the care proceedings or the potential impact of this upon **N**.

- This review contains input from **N**, although the minutes are brief and erroneously references the pre-birth Initial Child Protection Conference (ICPC - held subsequently in November 2015) as a forum to decide on the future care arrangements of the unborn **A** rather than the appropriate forum to decide whether the unborn child was at risk of significant harm (planning for any legal action takes place outside of the ICPC process). The minutes do not contain evidence of exploration or challenge around key issues such as mental health, domestic abuse and relationships with other boys/father of unborn child.

- The review does not reference any of the key incidents later recorded in the combined chronologies. For example, incidents such as **M1** being upset (via Facebook research) in August 2015 that **N** may have been involved with someone else; that **N** had recently missed a CAMHS review in late August 2015 (significant given **N**'s history of concern with regards to mental health and traumatic experiences of domestic violence she had experienced to that point in time); that she had breached her Youth Referral Order in late September 2015, leading to a plan for **N** to move to 'Higher Level' care.

- The review also contains limited reference to key issues of concern regarding **N** being connected to both **M2** and **M1**. At the learning event, it was noted by professionals that for some time, concern had been held regarding **N** having been involved at different points with both boys (along with a third male child, **M3**). However, there is no real mention of **N**'s relationships with these boys – all of whom had a history of being Children Looked After themselves - despite domestic abuse concerns and previous potential pregnancies prior to **N** being pregnant with **A** in October 2015.

Children Looked After Review- February 2016

- The CLA Review in February 2016 occurs when the birth of baby **A** is imminent. Understandably, there is considerable focus on arrangements and support for **N** and soon to be baby **A**, given the concerns identified around parenting capacity and the need to locate a mother and baby residential placement. It is also noted that the allocated social worker had experienced a period of illness in the lead up to this CLA Review. However, whilst these practical support issues are taken into account, there is only mention of 'concerns' regarding **N**'s relationship with her boyfriend (who is not identified). Similarly, there is no evidence of attempts to gain information or an update from **N** or the allocated social worker as to what level of concern existed around domestic abuse or what strategies may be being employed to try and engage with **N** (and potential child perpetrators) around this issue, which would be significant given that **N** was soon to become a parent.

- There is a review of a plan from the previous CLA Review in February. However, this plan, which was then reviewed, does not include information as to when listed actions should have been completed or how outcomes from these actions would be measured.

Children Looked After Review- April 2016

- In the April 2016 CLA Review - which occurred just two days after the incident where **M2** allegedly head-butted **N** in the residential mother and baby placement - the chair acknowledged that professionals present expressed sympathy for **N** as a domestic abuse victim, however there is no reference in the meeting discussion as to how **N** would be supported around domestic abuse (from any party or whether liaison should occur with other social workers around the perpetrator.

- The review is a detailed document that spends considerable time working with **N** and professionals present to stabilise her current mother and baby placement. The document also references concerns that **N** was experiencing low mood and refusing/unwilling to eat, there is a reference made to her being advised to see her GP for support and for the health visitor to see **N** regarding possible post-natal depression. It is of interest however that **N** notes in the CLA Review minutes that she had not eaten and felt low in mood *"since the incident with **[M2]**",* suggesting that the domestic abuse itself may have been a possible cause of these issues.

- Despite a referral having been made in early 2015 to CAMHS, when care proceedings commenced, and a previous CLA review making mention of CAMHS involvement with **N** – there is no reflection of work that may have been conducted or whether CAMHS would be contacted as a result of current circumstances to provide input and support for **N**.

Despite the documented history of alleged domestic violence from both **M1** and **M2**, it is unclear how the CLA reviewing process sought to support **N** around understanding this abuse and empowering her to remain safe to this point. It is unclear whether any actions were explored with professionals responsible for working with the abuser/s.

Children Looked After Review- June 2016

The minutes of this CLA Review have now been sighted by reviewers. Some key areas noted from this document include –

- Considerable, good quality information was included in terms of input from **N** regarding her wishes and feelings and the wishes and feelings of her family in this CLA Review;

- CAMHS were invited to attend this review but were unable to attend. The social work team had contacted CAMHS on 25 May 2016 to explore whether further support could be offered, with the allocated social worker to facilitate **N** attending a CAMHS appointment in the next two weeks. Information obtained from CAMHS for the CLA Review indicated that **N** had been known to that organisation at different times since she was 13 years of age and that a further CAMHS appointment was scheduled for 24 June 2016. CAMHS also undertook to oversee the process of linking **N** in with Adult Mental Health Services as part of transition planning as she approached 18 years of age.

- Information was considered at this CLA Review as to the work of the Respect Yourself Intensive Family Support/IDVA worker, who had been completing one-to-one sessions with **N** until a space on an upcoming 'Freedom Program' (empowerment and support for women who have survived domestic abuse) was available. **N** was reported to have engaged well with Respect Yourself around domestic abuse.

- Other aspects of **N**'s needs were considered, such as her education needs and follow-up from the previous CLA Review indicated that **N** had seen her GP around feelings of low mood and had been diagnosed with mild depression and prescribed medication for this.

- As with other CLA Reviews, this meeting occurred near a significant event in **N**'s life, in this case, **N** had taken the decision on 12 June 2016 (approximately 2 weeks earlier) to end her involvement with the residential parenting assessment around her retaining care of **A** going forward. **A** had subsequently gone into foster care. The CLA Review

sought to make parallel plans for **N**, who had indicated regret at this decision and would be seeking a further period of parenting assessment. **N** was residing with her mother on a temporary basis and the social work team had recently made a referral to CHADD ON Route for supported accommodation for **N** should any further assessment period with **A** not be granted or not be successful.

- This CLA Review also makes some limited reference to concerns about **N** being back in Dudley borough and the risks this might pose in terms of becoming involved or having contact with past associates. The need to engage with support was also emphasised to give **N** the best opportunity to have **A** returned to her care.

There is no evidence in any of the CLA Reviews sighted as to whether information had been obtained by the allocated social worker or Independent Reviewing Officers (IROs) from other allocated social workers or professionals working with the partner of **N** at the time. Whilst this may have occurred, this is not evidenced in CLA Review minutes. **M1** for example is known to have had ongoing absconding issues and had unfortunately been involved in several youth offending incidents (some of which were with **N** in 2015). It is possible that when considering the needs of **N** in the reviewing process this context may have been useful in considering risk to both **N** and - where applicable - her child.

The challenges of working with a young mother who is also a Child Looked After are evident in these CLA Review documents. It is apparent that the Independent Reviewing Officer/s had to spend considerable time considering and addressing arrangements and risks with regards to the care of **A**, which may have reduced the time available and ability to engage with **N** around her own needs and vulnerabilities, in the face of the pressing demands of working to safeguard an unborn/new-born infant in her mother's care.

Pathway Plans

Pathway Plans are intended to be living documents to assist 16+ children on the path to independence. Guidance suggests that these should comprise of an assessment of need and how any needs identified as the child moves forward into adulthood will be supported. The 2 pathway plans analysed do not suggest an evidence-based approach to providing **N** with the right support.

Pathway Plan – October 2015

The first plan reviewed, commencing in October 2015, contains an update from a previous plan, which notes that support such as CAMHS, Youth Offending Service, Pace Education and Respect Yourself has been implemented and work carried out to address issues such as attachment problems between **N** and her mother (including family therapy), educational support and 'keep safe' concerns. It also addresses **N**'s offending behaviour at the time and describes plans to try and get her back into education. However, the document is essentially left blank thereafter, with key areas around what evidence supports the proposed plan, the input of the child and mother around the plan and whether key CLA processes had been followed missing or not being completed. There is limited evidence of an assessment of needs informing future planning. It is notable that the referrals and associated work with **N** from these agencies are not then referenced in the October 2015 CLA Review. Finally, this Pathway Plan does not contain a clear statement as to what the plan for permanence is for **N** and what actions are required to implement this.

Pathway Plan – June 2016

The second plan, commencing June 2016 does contain a clear statement around what the Pathway Plan is – namely to support **N** into semi-independent living whilst enabling her to provide care for **child A**. It also outlines several actions required to make this occur, although this is not presented in a SMART format and it is unclear when these actions should be undertaken and by whom; the reviewers understand that the actual Pathway Plan actions are typically located in a separate document on Dudley's IT system and may exist in this format.

The actions in this Pathway Plan do not relate to support around domestic abuse, healthy relationships, CAMHS support - in fact the actions outlined relate exclusively to **N** in terms of her care of **A** and transition to new supported accommodation with him; despite the fact that by June 2016 there had been a recent history of concern around domestic abuse from **M2** and recent contact with CAMHS to provide **N** with support. It is acknowledged that action around these issues may cross over somewhat with the purview of the CLA Reviewing process, however Pathway Plans seek to address key outcomes such as healthy relationships for children, career success and being healthy amongst other issues, all of which are related to good mental health, basic safety and the ability to maintain healthy, boundaried relationships. Actions were completed around some of these issues in the previous Pathway Plan, however do not seem to have been considered again when the June 2016 Pathway Plan was devised.

This Pathway Plan does contain more detailed information in other sections such as the views of the mother/child this time and more detailed analysis of the accommodation and **N**'s financial circumstances.

Information provided does note that **N**'s case was considered at Dudley's Access to Resources Panel in August 2016, where funding was provided for accommodation at CHADD On Route and that a referral would be made to Adult Services for transitional support.

Overall, based on the Pathway Plan document provided, the focus of the Plan whilst aspiring towards semi-independent living with **A** seems to focus more on current accommodation needs and does not appear to be informed by a Pathway Plan Needs Assessment; information suggests that this Needs Assessment was commenced on 10 June 2016 but was incomplete.

In contrast, a much more detailed Pathway Plan on file dated 30 August 2016 provides a much more in-depth look at **N**'s circumstances. This document directly considered key issues such as mental health and domestic abuse as part of the pathway plan going forward and highlighted current support in place at that time (CAMHS, Respect Yourself IDVA and the impending Freedom Program). This document seems to have planning steps for **N** within it that are based on an assessment of **N**'s needs.

Therefore, as with other aspects of work done with **N**, Pathway Planning at times has focused on presenting issues and work around **N** as the parent of **A** without necessarily fully supporting **N**'s personal needs as part of reaching positive permanence outcomes around relationships, mental health and safety from violence. Elements of these varying needs have been addressed at different times, but do not always appear to have considered on a consistent basis.

3.2.2 Significant issue two

N had a troubled childhood, including documented issues with her mental health. It would be expected that N would be referred for support to CAMHS and other adolescent support services.

Child and Adolescent Mental Health Service (CAMHS)

Information provided suggests that CAMHS had been engaged with **N** since she was 13 years old, although this information comes from various sources and it is not always clear when CAMHS periods commenced and ended. CAMHS had engaged with **N** periodically and continued to try and maintain their involvement even when she made it clear she did not want to engage. At times, work with CAMHS ceased because of non-attendance at appointments. There is mention in case files of **N** being referred to CAMHS in April 2015 after care proceedings commenced.

The Pathway Plan in October 2015 notes that 'attachment work' was undertaken and completed by CAMHS and the Youth Offending Service together, including CAMHS offering family group therapy to **N** and **MN** (mother), which was also completed.

On 25 May 2016, the social worker contacted CAMHS to ascertain whether there was any further support that could be offered via CAMHS, as **N** had spoken of wanting to get back in touch with her CAMHS worker. The social worker agreed to contact **N** to facilitate re-engagement – it appears that **N** was still open to CAMHS at this time, thus if **N** was not willing to engage with CAMHS within the following two weeks, she would need to be discharged from the service.

Supervision records on 17 June 2016 note that **N** had requested a referral to CAMHS again – it is noted that this is a few days after **N** had decided to end the mother and baby parenting placement with **A** and DCSC were also seeking to support **N** through upcoming legal processes, including possible adoption. At the CLA Review on 28 June 2016, information from CAMHS suggested that a successful appointment had taken place on 24 June 2016. Whilst CAMHS were not in attendance at this review, consideration was given to CAMHS overseeing **N**'s transition to Adult Mental Health Services.

However, information provided by CAMHS to DCSC indicates that this involvement was around accessing the ADHD Clinic and that involvement ceased in August 2016 due to 'non-engagement'. It is noted that information about **N**'s involvement with CAMHS suggests that she was diagnosed with ADHD and prescribed medication prior to **N** becoming pregnant with **A**, at which point the medication ceased. The request for further ADHD work by CAMHS may have come from the MARAC meeting on 25 August 2016, where this is listed as an action going forward.

It could be extremely difficult to convince **N** to attend services consistently. There is evidence that **N** was offered appointments with CAMHS but that she failed to attend. It is recognised both locally and nationally that CAMHS resources are stretched; despite this, CAMHS continued to try and engage with **N** on several occasions.

It is not clear that CAMHS, or other services (e.g. Domestic abuse support services), were consistently kept in mind when reviewing **N**'s CLA circumstances. It is also unclear if these services were fully considered in pathway planning going forward; until much closer to **N**'s transition from a Child Looked After to a Care Leaver.

Other Services

N also received support through CHADD On Route after being referred and placed in CHADD supported accommodation when **N** decided not to continue with the mother and baby placement with **A**. **N** was also supported by Respect Yourself and the IDVA service (see below).

Whilst there is no evidence that the support provided to **N** had a positive effect, considerable effort was made to support her; including attempts to link her to the Connexions team and the FAST team which she failed to respond to.

Whilst there is evidence of considerable multi-agency work taking place over time, there is a lack of coordination in planning for **N**. Whilst the CLA processes outlined above did at times consider the various issues **N** was facing, this was not always done holistically and on a consistent basis. CLA Reviews or Pathway Planning was often, understandably, concerned with serious presenting issues such as: the lack of mother and baby placements; **N** threatening to leave a mother and baby placement; **N** having just decided to leave the mother and baby placement and being in crisis.

3.2.3 Significant issue three

N and M1 went missing on a continual basis and considerable resources were put in place to locate them. N was graded at high risk from CSE and at high risk when she went missing. Agencies should have a plan for regular and high risk missing persons.

It is impossible to calculate the number of times **N** was 'missing'. At some points in her life she was missing virtually every day. The police and children's social care always responded to missing reports and used considerable resources over this period looking for **N** and then returning her to accommodation.

Professionals have expressed frustration at dealing with **N** and her missing episodes. At various points professionals used all of the tools they believed were available to them. The police used their protection powers and children's social care placed **N** in accommodation out of the area in an attempt to break the cycle of missing episodes. They used section 25 powers to place **N** in secure accommodation for 72 hours and applied to the court for a Secure Accommodation Order. Family members were used to accommodate **N** and she was placed in the full range of accommodation options open to DCSC. None of these options worked for any length of time. It is understandable that professionals became frustrated and seemed to run out of ideas.

There are areas that agencies can improve on and in fact have already made changes to improve missing from home processes.

In particular, the following points highlight areas where the response could have been improved:

- Agencies lacked a coordinated response and often took individual action rather than considering a multi-agency response. One example was the police use, in March 2015, of Powers of Police Protection. At this point, **N** was in residential accommodation in Dudley but was regularly missing so police used these powers to place her in a 'place of safety'. As a result, **N** was moved to new accommodation in Somerset. It is understandable that the police became frustrated and took the action they did, but there seems to have been little consideration of how this fitted in to a longer-term plan and does not appear to have been a co-ordinated response.

- There was no documented plan regarding **N**'s missing episodes. It seems that each episode was dealt with in isolation. On some occasions (as documented in the previous point) frustration would result in single agency action. The failure by agencies to understand the relationships between **N** and her friends (particularly **M1**) resulted in action that was almost certain to be ineffective. For example, at one point **M1** was moved to the north of England. **N** went missing on numerous occasions to meet up

with him. **N** often went missing with other Children Looked After and in fact her patterns of behaviour were predictable. The failure to bring all the information and intelligence about **N** and her associates together resulted in inappropriate responses that were unlikely to succeed.

- The multi-agency forum in place at this time to review missing persons cases reviewed **N** on one occasion but there is no record of the decisions taken. An effective multi-agency panel is essential to produce meaningful plans and ensure that one agencies actions do not contradict the work of another. This matter has now been addressed.

- Arrangements for accommodation were put in place reactively rather than pro-actively. Where was the voice of the child? **N** was often in placements away from her peer group and there is nothing to suggest that she was ever asked for a view on where she should be placed.

In December 2017 Dudley Metropolitan Council published new guidance for agencies[13]. The guidance addresses a number of the issues raised in this report. The guidance lays out the processes to be followed and contains detail in each of the following areas:

- Why children go missing;
- risks of going missing;
- 'Missing' and 'Absent' definitions;
- reporting to the police and police response;
- thresholds for strategy meetings;
- location and 'Return of Child Return Interview';
- 'Out of borough' placements;
- children missing from care.

The guidance also introduces and describes the role of the Adolescent Response Team (ART) in dealing with children who go missing. This team review all missing episodes on a daily basis.

In terms of improved management oversight, a Child Missing Operational Group (CMOG) chaired by a senior manager from DCSC meets every 3 weeks to review those children identified as high risk, to ensure appropriate referrals have been made and to consider patterns and trends in missing behaviour.

Clear pathways have been established to ensure front line professionals have clarity around roles and responsibilities. The pathways can be found at the following link:

http://www.proceduresonline.com/dudley

[13] **"Children Missing from Home and Care" –** Dudley Metropolitan Council *http://www.proceduresonline.com/dudley/childcare/user_controlled_lcms_area/uploaded_files/MISSING%20FROM%20CARE%20PROCEDURES.pdf*

3.2.4 Significant issue four

N was graded as at high risk of CSE, was continually missing and committing criminal offences. N had contact with several agencies including children's social care, the police, health and housing. N was later at risk of and suffered serious incidents of domestic violence; including life-changing injuries. Many of the children N was associated with also had the support of a number of safeguarding agencies. There should be clearly documented evidence of multi-agency working, the use of statutory child protection procedures, consultation between professionals working with all linked children and effective use of supervision to keep the child's needs in mind.

N was initially graded as at high risk of CSE, was continually missing and committing criminal offences. **N** had contact with a number of agencies including children's social care, the police, health and housing. There should be clearly documented evidence of multi-agency working and the use of statutory child protection procedures.

The issue of CLA Reviews and Pathway Plans is dealt with at section 3.2.1. It is not clear in the files presented to the review, where any multi-agency collaboration took place in the months leading up to the stabbing of **N** with the exception of the MARAC meeting in August 2016. It remains unclear as to whether section 47 investigations were commenced after some key violent incidents.

At the learning event, the network present were clear that the social worker for **N**, **M2**, **M3** and **M1** all met to systemically look at the interactions of these four children, yet the documents provided do not reference or evidence this and review of CSC records does not contain evidence of documented multi-agency discussions across professionals working with the various CLA children referenced in this review document. This appears to highlight a weakness in recording and supervision.

Furthermore, **N**'s case highlights the importance of professionals actively looking beyond the 'silo' approach of working with one child/family without considering how to work closely with professionals working with linked children or families. As noted elsewhere in this document, **N**, **M2**, **M1** and **M3** were all CLA children and thus each had their own range of professionals working with them. They were inherently vulnerable and some of these children appeared to be engaging in violent behaviour against **N**. Whilst there is evidence of **A** and **N**'s social worker having some contact, and professionals at the learning event spoke of meeting as a group to consider all 4 children together; evidence of this collaboration across children's services has not been located.

Multi-agency meetings (e.g. CLA Reviews) have occurred, however as noted above, there are areas where the needs of **N** may not have been consistently followed through over time (see 3.2.4). In terms of CSE, there is acknowledgement that **N** is at high risk of CSE, but no action plans have been presented detailing how agencies will protect **N**.

As documented throughout this report there were a number of occasions when referrals could have been made and section 47 investigations instigated. Whilst **N** was CLA and so was subject to supervision by DCSC the lack of recorded adherence to child protection guidance remains a cause for concern.

Social Worker's files show poor levels of recording with brief notes kept that do not always provide case context. Supervision for frontline social workers, as reflected in DCSC records, whilst at times frequent, was often of poor quality. Many supervision records were brief, task-oriented and often did not record reflective thinking about **N**'s circumstances and overall vulnerabilities or provide clear consideration of risks at different points. Reflective supervision

may have enhanced the prospect of considering **N** within an enmeshed group of CLA children and how these children as a group needed to be supported; on the evidence provided these children had been involved in domestically abusive relationships over a considerable length of time, combined with risk-taking behaviour such as frequent missing episodes, often involving travel over considerable distances. Reflective supervision may also have assisted frontline staff in keeping issues such as mental health and domestic abuse in mind at different junctures whilst also responding to the challenging, intensive crisis events that did arise over time in **N**'s life.

It is noted that DCSC will shortly be moving to a new electronic recording system. This will provide considerable support to frontline staff in evidencing the work they are carrying out with children and families.

3.2.4 Significant issue five

N suffered numerous episodes of domestic abuse and two of her boyfriends were identified as domestic violence perpetrators. There are clear processes, including the MARAC process, that would be expected to put in plans to protect N.

Multi-agency Risk Assessment Conference

This report details several domestic violence incidents that **N** was subjected to. This included at least two serious assaults by two perpetrators. At least two DASH risk assessments were completed in respect of **N** and in both she was classed as being at high risk.

As noted elsewhere, the domestic abuse that **N** suffered in 2016 were both serious incidents. On 4 April 2016, **M2** attempted to head-butt **N** in a mother and baby residential placement and was subsequently removed from the placement. No evidence of a section 47 investigation following this event has been identified. Information shared by the police indicates that on 5 April 2016 *"…West Mercia added the victim to their MARAC agenda and are managing safeguarding"*. The reviewers have not received any information indicating **N**'s case was ever presented to MARAC thereafter or that a multi-agency safeguarding plan was put in place to protect **N**.

On 2 August 2016, **M1**violently assaulted **N**. The MARAC referral document suggests that this included - *"* **M1** *grabbing* **N***'s mobile telephone and throwing it on the floor causing it to smash.* **N** *was upset because she had photos of her child on there that is in care.* **M1** *then grabbed her around the throat with both hands and tried to strangle her.* **N** *believed he was going to kill her. She describes him as being very angry. She tried to push him off her. He then punched her on her head and kneed her on the leg.* **N** *shouted for her sister to call the Police.* ***S1*** *entered the bedroom and told them both to calm down.* **N** *called the Police using* **S1***'s mobile telephone and tried to stop* **M1** *leaving before the Police arrived. She grabbed the front door key which he wanted. He then assaulted* **N** *again by throwing her to the floor. He then grabbed the key and jumped out of the window and walked off.* **N** *wanted the key back and followed* **M1***. They were arguing, and he assaulted her again by punching her twice on her face causing her to fall to the floor."* It is entirely possible that **N** could have been seriously injured in this incident.

DCSC records contains a MARAC invitation letter dated 18 August 2016, noting that the case was to be heard at MARAC on 25 August 2016. Information provided suggests that no section 47 investigation commenced following this incident.

Minutes of the MARAC Meeting on 25 August 2016 note that CHADD On Route (housing provider) felt that they were not worried about the current offender (**M1**) but were concerned

about **M2** (**N**'s previous partner) as he had contacted **N** from prison. The MARAC were also aware that **M1** had *'Eight convictions, noted whilst in 2015 he was in public brandishing an imitation firearm. Violence, suicide and self-harm markers.'*

N was engaged with the Respect Yourself team; MARAC minutes indicate that - '*Referral received from West Mercia Women's Aid after scoring 16 on DASH. Suffering from postnatal depression, afraid of* **A***'s father,* **M2***. Due to her age, she is being supported by Respect Yourself.'* It is the view of the reviewers that this information refers to Respect Yourself/IDVA becoming involved with **N** after the headbutting assault by **M2** on 4 April 2016, not in immediate response to the assault by **M1** on 2 August 2016. Thus, whilst **N** had not been discussed at MARAC in April 2016, support around domestic abuse had been in place since that time via Respect Yourself.

The only MARAC actions in August 2016 were for CHADD On Route to provide an update which was completed (part of which is in the information above) and for **N** to be linked back in with CAMHS regarding an ADHD assessment. There are no references to any pro-active protective work, for instance consideration as to whether injunctions could or should be sought or other direct actions to address potential domestic abuse from **M1** (or **M2**). It is likely that the CLA status of **M1** and **M2** were known to MARAC, however no actions were outlined with regards to DCSC and the wider safeguarding network to come together operationally to consider domestic abuse risks across this group of children and how these might be mitigated. Given the severity of the assault and that **N** may have been the victim of two significant domestic abuse incidents from two different child perpetrators within 6 months, the MARAC actions could have been more specific in generating swift multi-agency consideration and response to mitigate domestic abuse risks. If this was an adult male offender to an adult victim, would the response have been different?

There is mention in information provided of **N** being referred to, and receiving, support from CHADD On Route – her accommodation provider - in the weeks prior to the stabbing incident. At the learning event, it was stated that CHADD and the Youth Offending Service had both sought to work with **N** around domestic abuse issues, but the exact nature of that work has not been provided.

Respect Yourself and the Independent Domestic Violence Advocate

Information provided suggests that early parts of **N**'s relationship with **M1** were also violent. For example, it is noted in March 2015 that **N** had been moved out of Dudley in order to safeguard her from the 'volatile' relationship with **M1** – this is some 18 months prior to the stabbing incident in September 2016. As noted earlier in this review document, prior to March 2015, **N** had made and retracted serious criminal allegations against **M1**.

A supervision record on 9 March 2016 notes that that the relationship between **N** and **M2** is *"volatile"*, yet at this time there is no evidence of domestic abuse support or planning around this relationship, despite **N** and **M2** being about to enter the intensive environment of a 'parents and baby' residential assessment setting.

It is important to note the multiple descriptions of abusive relationships as *"volatile".* This speaks to a possible minimisation of the abusive incidents within these relationships and may reflect the need to re-frame how domestically abusive relationships between children are viewed by safeguarding professionals.

As noted elsewhere in this document, following the headbutting assault and disclosures of additional abuse perpetrated by **M2** against **N** in April 2016, Black Country Women's Aid referred **N** to Respect Yourself on account of her age (under 18 years) for support around

domestic abuse. An Intensive Family Support Worker/Independent Domestic Violence Advocate was appointed to work with **N** after the referral to Respect Yourself on 28 April 2016.

Feedback at the CLA Review on 28 June 2016 suggested that **N** continued to engage with Respect Yourself and that one-to-one sessions would continue until a space on the next available Freedom Program could be obtained. File information suggests that there was contact between DCSC and Respect Yourself over time to see how **N** was engaging with domestic abuse support. A brief update on 2 September 2016 suggested that **N** continued to work with Respect Yourself and by 6 September 2016 a Freedom Program place had been identified.

What remains unclear from file information is what immediate protective measures were put in place following the assault on 2 August 2016 at **N**'s flat by **M1**. The police chronology notes that **N** scored 14 (high) on a DASH risk assessment, stating that she was afraid of what **M1** might do and that he continued to constantly text her and was following her. It is unclear what measures may have been taken to strengthen security at the CHADD On Route placement, or what advice given, or safety planning considered with **N** if **M1** were to present to the flat again. A CLA visit to **N** at her accommodation on 6 September 2016 does not document discussions around immediate domestic abuse safety measures or considerations. This is relevant given that there is a history in 2015 of **N** reporting domestic abuse allegations about **M1**, thus there could be a possibility of further incidents of violence from **M1**.

Reviewing the incidents thereafter (with the benefit of hindsight), it appears that **M1** was in an escalating pattern of violence. Following his arrest after assaulting **N**, he was then arrested after seeking to assault the child **M3** with a hammer on 12 September 2016, just two days before he then stabbed **N** at her accommodation.

There needs to be review and improvement of the way domestic abuse is dealt with by individual agencies and multi-agency forums in Dudley when dealing with children and young people.

3.2.5 Significant issue six

The transition process from childhood to adulthood is a difficult period and this is more significant for children who are Looked After. There should be clear support processes for Children Looked After as they move through this transition, which are underpinned by consistent planning and review to ensure that positive outcomes are clearly outlined and achieved wherever possible.

This issue has been largely dealt with in section 3.2.1. The transition period between 16 years and 18 years is particularly difficult for Children Looked After. CLA reviews and Pathway Plans hold the key to this transition.

It is also noted that **N** regularly presented at panels likely to be chaired by senior managers, such as the 'Access to Resources Panel'. This panel was often concerned with understanding **N**'s accommodation needs and associated risks and authorising placement options for her. Due to **N** moving amongst various placements, initially due to ongoing missing behaviour in 2015 and latterly due to the need to find specialist mother and baby provisions, her case was considered on a number of occasions. Similarly, in 2015, **N** was open to the 'Missing' Panel, although in 2016 this behaviour appeared to abate considerably. As noted elsewhere, DCSC has implemented new procedures around missing children.

Information provided suggests that this panel did not consistently seek to understand or address wider issues such as mental health, domestic abuse or the concerns raised by the

interactions of this group of children. It may be that this was simply not the function of the Access to Resources Panel, although on occasions these needs were considered, such as the Access to Resources Panel on 9 August 2016, which directed that Adult Mental Health Services should be invited to attend the next CLA Review for transition planning and to ensure that **N** was provided with all relevant information and support around the upcoming adoption of her son **A**. As noted in concerns regarding supervision, it was not possible to identify a thread of ongoing management and review of the needs of **N** given the level of risk she was exposed to within her personal circumstances. It may be that in addition to structures put in place around missing children that DCSC considers how it retains oversight of children in other high risk situations.

The front-line practitioners interviewed in this review showed no lack of care or compassion but did exhibit considerable frustration about the options open to them when dealing with **N**.

It should not be under estimated how difficult it was for professionals to protect **N**. **N** had had a troubled childhood as had her mother and sister and it is true to say that **N** was part of a family that had suffered inter-generational abuse and need for care services.

N engaged in relationships which were high risk, with other children who had been in the care system most of their lives. There is no doubt that **N** did not understand the risk she was facing and clearly did not feel that agencies were likely to offer the type of support she felt she needed – at times it may have felt to **N** that these relationships were meeting her needs. **N** had known her associates in this report for many years and there are school records of **N**, **M1** and **M2** running away from school when they were 14 years old. When offered help and support, **N** declined services or failed to keep appointments. **N** stayed in different types of accommodation, in numerous locations and huge resources were expended attempting to keep her safe. It is important to acknowledge that taking into account all of these factors, **N**, as a 16 or 17-year-old child, may have exercised her ability at times to choose whether to engage or not engage with services at different times and that it may not always be possible to ensure that young people will choose to take up support offered.

However, whilst this review concludes that it was extremely difficult to keep **N** safe through this transition period, consistency in application of child protection procedures when risks arise and consistency in CLA Reviewing and Pathway Planning to maintain an holistic overview of children's needs are crucial in working towards a safer and less troubled transition to adulthood.

3.2.5 Significant issue seven

N came from a family that had been subject to significant involvement from safeguarding agencies over many years. Clear processes are required to swiftly identify children who are or could become part of inter-generational involvement with safeguarding services and what support can be offered to 'break the cycle' of involvement.

Information was clearly provided at the learning event that **N**'s elder sister, had been known to Children's Services and was herself a Child Looked After and presented with similar vulnerabilities and behavioural issues. Information gathered at the learning event also suggested that **N**'s mother, was a Child Looked After. File information suggested that a chronology had been compiled of the family history over the last 30+ years, which was good practice.

Sadly, **N**'s own child, **A** was taken into Local Authority care on a permanent basis, meaning that **child A** may now be the third generation of this family that has at some period been a Child Looked After.

A clear focus at the learning event for the professionals present was around the offer available in Dudley for children and mothers who had been in care and themselves and/or who may be vulnerable to their own children entering the care system. Professionals felt that consideration should be given to projects that have been considered in other authorities that work to 'break the inter-generational cycle', such as the 'Pause Project' or other examples where mothers who have had children taken into care receive significant support and input to equip them to avoid this outcome for future children.

It is noted that **N** became pregnant again later in 2017. This type of support may therefore still be very relevant to **N**, as well as other mothers in Dudley.

Section Four – Key Themes

4.1 The application of child protection processes

This review has established that whilst many child protection processes were followed there were key times when referrals were not made and strategy meetings and section 47 investigations did not take place or were not properly recorded.

CLA reviews and Pathway Plans did take place and there was a level of SMART planning within reviews. However, some of these reviews did not consistently consider **N**'s needs holistically and at times – possibly out of necessity – have focused on crisis events. CLA Reviews and Pathway Plans need to ensure that all aspects of a child's needs are considered despite current events and are kept in mind when planning for transition phases.

Recording by social workers on DCSC systems was generally very brief and whilst supervision often occurred quite frequently, it was difficult to obtain a clear outline of planned case direction due to the brevity and often task-focused nature of supervision records. Reflective supervision may also have led to a greater focus on the wider needs of **N** outside of the crisis situations that arose.

4.2 Dealing with domestic abuse in teenage children

N was subject to a number of incidents of domestic abuse, including a number of historic allegations in 2015, some of which were later retracted. Prior to being stabbed in September 2016 she had been seriously assaulted by two different perpetrators in 2016 alone. Two DASH risk assessments were completed for **N** and her cases were referred through the MARAC. It is unclear what plans were put in place to protect and support **N** as a victim and what preventative measures were in place to ensure that two known and identified perpetrators could not harm her again. One of those perpetrators (**M1**) went on to stab **N** causing life changing injuries just 2 weeks after a MARAC meeting had discussed the case.

Despite meeting to consider these risks, it must be concluded that the MARAC failed to implement effective plans to protect **N**. The DASH risk assessment should be shared between partners to ensure that agencies have a full picture of a young person's life and fears.

4.3 Dealing with 'missing' episodes with Looked After Children

This case involves a child who went missing on a huge number of occasions. Whilst missing reports were taken seriously by agencies and the police and children's social care took some reactive steps, there was a failure to work together. Agencies did not consider the whole picture concerning **N** and her associates. There was a lack of multi-agency planning and little managerial oversight.

Whilst individual professionals took action and did what they could, the collective effort by agencies to deal with **N**'s missing episodes was insufficient.

New guidance introduced in December 2017 is clear and addresses many of the issues raised in this review.

4.4 Multi-agency working and working with a group of children who are engaging in abusive behaviour to one another

There are a number of examples of agencies working together when dealing with **N**, such as liaison between CAMHS, DCSC, YOS, Connexions, Respect Yourself/IDVA and other agencies. However, given the high risks **N** faced and the issues that a number of agencies identified around the high-risk nature of her behaviour and the behaviour of those around her, there is not sufficient evidence of multi-agency information sharing or multi-agency action plans to address the risks faced by **N**.

This review concludes that individual's actions were not sufficient to protect **N** and despite CLA Review planning around some of **N**'s needs, there was no overall multi-agency plan to address the risks posed by the children highlighted in this document individually and as an enmeshed group. Work with **N** lacked grip, leadership and long term multi-agency planning.

Another key issue in this case is the ability to consider **N** not only individually but as part of a group of enmeshed children who appear to have moved towards negative, abusive behaviour towards one another over time. It is crucial in multi-agency safeguarding partnerships that active consideration is given to bringing together professionals who are working across children in groups such as that encountered in **N**'s case. Whether under the guise of a strategy meeting or a professionals meeting, this will allow the safeguarding network to share information about risk and need and develop plans that will work to enhance safety across all children involved. As noted above, professionals at the learning event feel that this did occur to some extent, although records of this could not be located. Ensuring that safeguarding professionals work outside of 'silos' is crucial to ensuring that the most effective support and intervention can be identified and implemented to keep children safe.

4.5 Transition issues for Children Looked After

The transition in to adulthood is difficult for all young people. These issues are more acute for Children Looked After. They have, by definition, suffered a difficult childhood and face issues around accommodation and support that others do not.

CLA Reviews and Pathway Plans are an essential element in preparing Children Looked After for this transition. Whilst they were conducted regularly, they were not always consistent in reviewing the whole spectrum of **N**'s needs, to provide effective support and challenge. It is noted that an Independent Reviewing Officer on one occasion challenged the social work team about why they were unable to find a mother and baby placement for **N** and **A**. Whilst this is an example of positive challenge, there is no evidence of similar challenge being exerted as

to why safeguarding procedures were not followed after incidences of violence or whether appropriate safety measures were taken following these violent assaults.

Similarly, Pathway Planning may have benefited from consistent consideration of needs such as mental health and healthy relationships alongside pressing accommodation priorities and other types of support that arose around **N** in this complex case.

4.6 Accommodation issues for Children Looked After in transition to adulthood

N was offered a variety of accommodation through this period. In fact, she stayed in: supported accommodation**;** with specialist foster carers; in specialist residential assessment accommodation; and with her sister. The accommodation she was offered was both local and further afield. On one occasion she was placed in secure accommodation.

Despite the efforts to find suitable accommodation **N** was at times disruptive or went missing. CLA Reviews could have considered a longer-term solution for **N** earlier, however the landscape around accommodation changed considerably with the impending arrival of **A**, then followed by the need for further accommodation following **N** deciding not to continue the residential parenting process. The review accepts that finding suitable accommodation that **N** would have remained in was an extremely difficult task, whilst the changing accommodation needs of **N** in 2016 to some degree made it difficult to plan for longer-term accommodation until after the residential parenting process ended in June 2016.

4.7 Approaches to children who are part of 'inter-generational' need and/or abuse

One of the sad facts of this case is that **N** was a Child Looked After as were her mother and sister. **N**'s first child has been adopted. This is not a problem that is suffered by one Child Looked After or is only apparent in Dudley. It is a national problem and the evidence of the outcomes in adulthood for Children Looked After reflects that.

Consideration needs to be given to the current offer available in Dudley for children and mothers who had been in care themselves and who may be vulnerable to their own children entering the care system. There are projects that have been successful elsewhere that Dudley may consider examining (for instance the 'Pause Project') where mothers who have had children taken into care receive significant support and input to equip them to avoid this outcome for future children.

Section Five – Key Findings

N and her associates (including those who assaulted her) were Children Looked After. **N** was a troubled child who suffered from mental health issues and had been subjected to domestic abuse from two different perpetrators. Attempts to support her and find suitable accommodation, prior to the birth of **A**, often failed because **N** refused to cooperate and actively sought to distance herself from those seeking to help her.

Following **A**'s birth, **N**'s accommodation situation was slightly more stable, although her life was adversely affected on several occasions by violent instances of domestic abuse, culminating in the life-changing injuries sustained on 14 September 2016.

Agencies in Dudley were aware that **N** was at high risk of suffering from further domestic violence but did not put in place sufficient protective measures, or apply sufficiently robust

child protection measures, to prevent the serious assault at the hands of a **M1**; a previous perpetrator of violence against her.

Section Six – Recommendations

6.1 Recommendation one

Dudley Safeguarding Children Board should consider a review of the effectiveness of the new guidance on missing persons published in December 2017. This review should be completed by November 2018.

6.2 Recommendation two

Dudley Safeguarding Children Board should consider requesting evidence of how DCSC senior management retains effective oversight of children identified at being at high risk of harm, whether by virtue of domestic violence or other risk factors and seek assurance regarding the supervision of cases. Agencies should consider the role of the MASH in these circumstances.

6.3 Recommendation three

Dudley Safeguarding Children Board should consider holding a learning event for front line professionals, to review and discuss the learning from this and other recent cases. The event should focus on statutory child protection procedures, leadership, reflective supervision and effective working with enmeshed groups of children who may be involved in violent or other negative behaviours.

6.4 Recommendation four

Dudley Safeguarding Children Board should consider a review of the way in which children who are involved in domestically abusive relationships are assessed in terms of risk of harm. They should also review the provision of support and effective action planning that takes place through the MARAC process for young people. This review should be conducted by September 2018. Consideration should be given to ensuring DASH risk assessments are appropriately shared by agencies.

6.5 Recommendation five

Dudley Safeguarding Children Board should consider the current quality of CLA Reviews and Pathway Plans, whether sufficiently robust challenge is received from Independent Reviewing Officers to safeguard the interests of Children Looked After and consider whether current systems are effective in protecting Children Looked After whilst providing meaningful plans to ensure their safe transition to adulthood.

6.6 Recommendation six

Dudley Safeguarding Children Board should work with key partners to examine the level of support for children and mothers who have become part of inter-generational cycles of children coming into local authority care. Consideration should be given to projects that might help support children and mothers in these circumstances.