Croydon Safeguarding Children Partnership

Child Safeguarding Practice Review

'Chloe'

20th July 2021

(including post inquest review Sept 2023)

“There’s a bomb in my heart”.

Chloe

Being traumatised means continuing to live your life as if the trauma were still going on – unchanged and immutable – as every new encounter or event is contaminated by the past.

Van der Kolk – The Body Keeps the Score 2014

Contents

Executive Summary

At the heart of this Child Safeguarding Practice Review (CSPR) is Chloe. Chloe was 17 when she sadly died. She took her own life however the inquest verdict was 'accident'; that she did not freely intend to take her own life. When she carried out the fatal act she was in a state of mental crisis.

The coroner noted that several factors contributed to her death as they negatively impacted her mental health. Many of these findings are included in this report. They have not been included in full in an effort to protect the identity of Chloe.

Publication of this CSPR has been delayed as the inquest concluded 3 years after her death. The CSCP Executive Partners have considered the inquest findings and where appropriate, this final version of the CSPR includes references to it. Additionally, an Addendum will be published alongside the report, which helps the reader to see what progress has been made against the original recommendations of the CSPR.

Chloe was a child who experienced early trauma and who came into statutory care just before her teenage years. Her story illustrates the appalling legacy of sexual abuse, exploitation, trauma and re-traumatisation. Chloe lived in multiple homes throughout her life in care, she never experienced a safe loving home or a safe loving adult on whom she could consistently depend. Sadly, this is a familiar story for children who come into care late and who face extreme risks at the hands of those who seek to exploit them. This review examines Chloe's story and the services that were provided.

As identified in relevant guidance [1], it is not the purpose of CSPRs to conclude issues such as predictability or to hold organisations or individuals to account; there are separate processes for this purpose that must be followed. The purpose of CSPRs is to focus on a child and family, often in extremely tragic circumstances, to try and understand and make sense of their experiences of multi-agency services, to consider what these experiences might tell us about the health of the multi-agency safeguarding system and decide what is needed to strengthen the way children are safeguarded.

There were many practitioners who knew Chloe at different times, a conservative estimate suggests that the number would be in the hundreds. There were also multiple services involved. There are examples of highly committed practitioners/clinicians/teachers/police officers/key workers who showed care and compassion and did their very best to provide Chloe with what she needed. It is almost inevitable that any case that is the subject of a CSPR will identify a need to improve service provision. This CSPR does not conclude that, had these things been in place, Chloe would be with us today.

This CSPR considers relevant legislation, policy, practice, and procedure, reflects on research, literature and national guidance, and draws learning from the extensive experience and wealth of knowledge held by those who work within the multi-agency safeguarding arena. As this CSPR was being completed, a national review of children's social care was underway. The findings of this national review paint a stark picture of a system that is not fit for purpose and almost entirely mirrors Chloe's experiences from her early years to her death. Fundamental systemic changes are needed, these changes have been identified in perennial national reports stretching across Chloe's entire life. Few recommendations are made in this CSPR, the handful that are will merely tweak the system.

[1] Working Together to Safeguard Children 2018 & Child Safeguarding Practice Review panel: practice guidance DfE 2019.

The Case for Change: **The independent review of children's social care. June 2021**

My hope is that as a country we are better able to understand how life changing it is for children to grow up without the safe and loving foundations many of us can take for granted. These foundations are the first base for a good life and without them everything else is harder. One of our most fundamental obligations to children in care should be that they grow up and grow old with a strong loving tribe of people around them. We are currently not meeting this most basic of obligations.

Our children's social care system is a 30-year-old tower of Jenga held together with Sellotape: simultaneously rigid and yet shaky. There have been many reviews and attempts at reform since the landmark introduction of the 1989 Children Act and though each has ushered incremental progress, we are now left with a high stack of legislation, systems, structures, and services that with their sheer complicatedness make it hard to imagine something different, let alone address foundational problems.

Improving children's social care is not something that national government, local authorities or other partners can achieve on their own. The statutory children's social care "system" is only the tip of the iceberg: promoting and protecting children's welfare and rights must be a priority that goes beyond any single agency. Government's primary focus should be on supporting the resources of families and the wider community to keep children safe as close to a family environment as is possible, whilst still acting decisively and swiftly where children require protection. Too often we are allowing situations to escalate and then being forced to intervene too late, severing children's relationships and setting them on a worse trajectory.

As this version comes to completion, the Government has since published its response: Stable Homes, Built On Love. There is much intended in the report to improve outcomes for children who experience many of the features seen in Chloe's life, however this will take time. Professionals and their systems must continue to press for change as identified in this report.

Examples of intended changes include: The proposal to make 'Care Experienced' a protected characteristic. The publication of a National Kinship Care Strategy and equipping the system to respond to the complexity of the harms all children face, whether from inside or outside their homes.

Reason for this review

Chloe's body was found in a public building, she had a ligature tied around her neck. Chloe was a dual heritage British child who was living in a semi-independent unit in the London area. Chloe was the subject of a Care Order. After Chloe's death, Croydon Safeguarding Children Partnership held a Rapid Review to consider the circumstances of her death. It was concluded that her death met the criteria for a Child Safeguarding Practice Review and the National Child Safeguarding Review Panel were advised.

Purpose and methodology

The purpose of a CSPR is to learn lessons through a systems analysis of the single and multi-agency work undertaken to support children[2] and their families. The methodology used in this CSPR endeavours to understand professional practice in context, identifying systemic factors that influence the nature and quality of work with children and families. By using one case the aim is to get to systemic patterns, which are generalisable beyond this particular case. The purpose is to provide a proportionate and meaningful account of what happened from the perspective of the child and to add reflection and learning into the local safeguarding system.

Process of review

Independent reviewer and CSPR chair: A key aspect of the model is for an independent reviewer to work with a review team to plan and organise the key tasks, participate in the meetings, read key documents and analyse the data in order to produce the findings. An independent reviewer, Bridget Griffin [3], worked alongside an independent chair, Elizabeth Murphy [4]. Bridget has significant experience as an author of Serious Case Reviews and more latterly Child Safeguarding Practice Reviews. Elizabeth is a Child & Adolescent Psychotherapist who has extensive experience of clinical work and of leading child and adolescent mental health services.

CSPR Panel: A panel was appointed to work with the independent reviewer and chair during the review process. The panel was comprised of multi-agency representatives from across the different services who provided services to Chloe. These representatives were independent, in that they had no direct involvement with Chloe or her family and no management responsibility for the services that were provided during the period under review.

Research questions & documentation: Independent agency reports, and an integrated chronology informed this review. The independent reviewer and chair had access to a range of other relevant reports from across the agencies. Several panel meetings were held to analyse the data and discuss the emerging findings. Several key lines of enquiry were set at the start of the CSPR, which included a request to reflect on the learning from the Croydon Safeguarding Children Board Vulnerable Adolescent Thematic Review [5]. These lines of enquiry are addressed in the findings.

[2] In line with legislation, the term child, or children (applied to all who are under the age of 18) will be used throughout
[3] CQSW, BA (Hons), MA (Tavistock & Portman and MHT), SCIE accredited reviewer.
[4] MSc, MACP (Member of the Association of Child Psychotherapists)
[5] Croydon Safeguarding Children Board Vulnerable Adolescent Thematic Review (2019)

Involvement of families & practitioners

Family perspectives: The independent reviewer and chair had the pleasure of meeting Chloe's mum, dad and sister during the course of the review. The following quotes are an extract of what they shared.

Chloe was a bubbly child who loved to share, she loved family parties and always wanted to help. I feel sad that because we could not cope with her behaviour she wouldn't be invited to some of our family gatherings or would not be allowed to see her grandparents – all she wanted was family.

When she was little she needed someone to talk to, she wouldn't talk to me. As she got older, she acted in ways that I did not understand – I did not know what was wrong – I did not know how to help her – I was frightened (mum).

Chloe was such a sweet little girl; we had such happy times together - something happened when she was 8 – I don't know what, but she changed. She always loved being an auntie and often brought presents for her niece. She was so caring of her family and friends (sister)

We loved her - everyone loved her – I was scared for her – I didn't feel able to help her – I felt I was treated like the enemy – that I was a bad person (in the eyes of services). She had 2 brothers – we are all feeling guilty that we weren't able to help her or see her more when she was alive – we didn't know how to cope with her sometimes – we did not understand what was wrong (dad)

Grateful thanks are extended to Chloe's family for the time they willingly gave in being part of this CSPR. Their commitment to contribute to the learning, and their desire to prevent other families from suffering such unbearable loss, cannot be commended highly enough.

Practitioner involvement: Practitioners who knew Chloe were invited to contribute to this review. The views of practitioners were sought in a number of ways; they were invited to contribute to the agency reports, one to one meetings took place with the independent reviewer and chair and two learning events took place. These events were attended by practitioners who had known Chloe and included other experienced practitioners who are currently working with children in the local area. It is clear that practitioners and clinicians were deeply committed to Chloe; they worked hard to try and support her and were deeply saddened by her death. Practitioners engaged well in this process and offered several insights into service provision based on their wide experience of partnership working in Croydon.

Summary of Chloe's life

Chloe was living in another London borough in her early years. She was known to multi-agency services when she was 2 years old and was made the subject of a child protection plan as a result of concerns about domestic violence. Chloe was referred to a Children's Social Care service (CSC) when she was 11, at this point she had not been in school for several months. A Children's Social Care (CSC) assessment identified that Chloe was at risk of sexual exploitation; referrals were made to the local Child and Adolescent Mental Health Service (CAMHS) and the NSPCC, a child protection plan was put in place and multi-agency network meetings took place at regular intervals. Just before her 12th birthday, Chloe alleged she was raped by an adult male, and she was found to have 3 sexually transmitted infections. The court case concluded with a not guilty finding – the reasons for this outcome are unclear [6].

Chloe was missing from home on several occasions and there were ongoing concerns about sexual exploitation. Parents were concerned that they could not keep her safe; Chloe was placed in foster care which lasted only one week as carers struggled to provide her with the care that she needed. Subsequently, a care order was granted.

Over the following months and years Chloe was placed in 18 different homes[7] across the country. These included foster homes and residential homes. On four occasions, Chloe was placed in a secure unit, on four occasions she was detained under Sc136 (Mental Health Act 1983) [8]and on two occasions she spent a few days on a psychiatric intensive care unit. Throughout her life Chloe was often missing, there were significant concerns about ongoing sexual exploitation by a range of perpetrators across the country. Chloe often misused drugs and alcohol and she was extremely vulnerable to being exploited in a range of situations. Chloe could be violent and aggressive, she experienced feelings of low self-worth, she self-harmed and there were many occasions when her mental health/emotional wellbeing was of significant concern. Chloe was also a child who could be bright and funny, playful and creative, who loved her family and had hopes and dreams for the future. Her overriding desire was to live an ordinary life, in an ordinary home.

[6] Note: police colleagues did try to ascertain the reason, but records do not show the reasons for a particular verdict, just the verdict itself

[7] Children who have experienced care by local authorities have said that they do not like use of the term 'placement' – when referring to their homes. Therefore, when referring to the different places Chloe lived – the word 'home' will be used throughout

[8] Under Sc136 police can take someone to a place of safety if there are significant concerns about their mental health, an assessment by a mental health clinician is then completed to determine whether compulsory detention under the MHA is needed.

Findings

Compassionate Care

The overall response by practitioners, clinicians, police officers and key workers was characterised by sensitivity and compassion. The following are of particular note:

- The relationship formed with Chloe by several social workers, clinicians, key workers, and her guardian ad litem, who demonstrated they knew her as a person and responded to her with thoughtfulness, kindness, compassion and generosity.
- The relationship that was formed between a number of Independent Reviewing Officers (IROs) and Chloe whose consistent involvement over time, and evident empathy, led to her investment in an IRO as a trusted adult who she called when in crisis.
- The response by the majority of police officers to Chloe when they were called on multiple occasions to intervene/ locate her. The compassion and sensitivity demonstrated was noteworthy and there were examples when Chloe seemed to trust that the police would provide protection and containment.
- The response of ambulance crews who responded promptly and provided Chloe with sensitive care and containment.
- The care provided in one of the secure units and the trusted relationships that were formed that led to Chloe seeking and receiving comfort and reassurance.
- The work of the Adolescent Outreach Team (AOT) who were persistent, consistent, and compassionate in their approach.
- The trusted relationship that was formed with Chloe by the manager of the semi-independent unit when Chloe's likes and dislikes, joys and sadness were understood and, despite the vast damage she caused to property on numerous occasions, the manager's commitment to providing Chloe with a home.

Working hard to catch up

With increasing demand at the acute end of the system, the costs of children's social care are spiralling and shifting towards crisis management [9]

It was clear that multi-agency intervention in Chloe's life was characterised by crisis intervention - as one practitioner put it – *constantly firefighting*. Social workers (SWs) frequently contended with missing episodes, placement moves, placement searches, placement planning meetings, strategy meetings, court appearances, court reports, information sharing, moving Chloe/collecting Chloe, collecting her belongings & dealing with a vast array of practical and bureaucratic tasks. Working hard to catch up was an enduring feature of multi-agency involvement.

The unintended consequence of this crisis mode was that, too often, the urgent drove out the important. This resulted in important actions/interventions that were needed being missed, especially if they fell outside statutory or procedural requirements, and opportunities to pause and reflect were lost. An example of this was noted at the inquest where insufficient attention was placed on her anxiety at attending court, resulting in her heightened risk not being recognised (or recorded) and therefore she may not have been adequately supported at court.

[9] The Case for Change: The independent review of children's social care. June 2021 DfE

Given the size of caseloads, and the volume of work in Croydon at this time, it is remarkable that much of the required timescales were met (such as: visits, Looked After Reviews, strategy meetings and court appearances).

Early Help

Reviewing the involvement of services during Chloe's early childhood is not within the scope of this review. However, it is not possible to understand how agencies were in a position of working hard to catch up without reference to these early years. As a small child Chloe lived in a neighbouring London borough, she was 2 years when she first came to the attention of statutory services. There were concerns that she was suffering from significant harm as a consequence of living in a household where there was domestic violence.

Results from Myer's et al (2002) research findings[10] show that the adverse impact on children's development who are exposed to family violence is similar to the adverse impact for those who directly experience physical violence. There is little evidence that the impact of these early experiences were addressed when she was 2 or during the rest of her life.

Conclusion

Chloe's mother spoke about Chloe's early life, she acknowledged that she needed significant support at this time and asked why she couldn't have been taken into care with Chloe so that she could have learnt how to parent Chloe. There is almost a timeless quality to the research and national reports that have been produced for many years about the importance of these early years, and the need for resources to be available to support families to prevent difficulties escalating. The national review of Children's Social Care is underway, the interim report repeats the messages known and known well that creative, flexible approaches are needed underpinned by resources that stand the test of time. This is not something that local areas can resolve; it requires national action. Therefore, no recommendations are made.

The language we use and the meaning of this

Realities are socially constructed, constituted through language, and organised and maintained through narrative.

Communication is the creation and exchange of meaning[11]

Whilst compassion and sensitivity was an important theme, there were also examples of professionals and clinicians from across the multi-agency network using language to describe Chloe that suggested she was making informed lifestyle choices by *placing herself at risk* &/or conveyed negative attitudes/ inferred judgement about her behaviour. This is of particular note during the start of the timeline (when Chloe was 11) and although this improved over time, it was a consistent theme. This has been highlighted in many of the agency reports, examples of phrases include:

[10] *The APSAC handbook on child maltreatment (*2nd ed.). Myers, J., Berliner, L., Briere, J., Hendrix, CV., jenny, C., & Reid, T. (2002). Thousand Oaks, CA: Sage

[11] From the work of M White & D Epston

She is engaged in sexually harmful behaviour and (needed to) acknowledge the risks she posed to herself. *Superficial cuts were seen on her arm*. S*he can be spiteful and defiant*. *She is resourceful and street wise. She has been putting herself at risk with older males. She is having sex with adult males for money. Her early sexualisation experiences* (when referring to the rape at 11). *She is now known to have been sexually active with an adult*.

The use of this language was important, it has the potential to:

- minimise, hide, confuse, and truncate trauma and vulnerability
- shape service response by inappropriately conferring choice, and therefore culpability
- shape a child's internal narrative by inadvertently conferring shame and responsibility
- strengthen an abusers' power and control over victims
- compound the silence that shrouds sexual abuse & exploitation
- inadvertently support an abusers' internal narrative that the victim is to blame

A summary of key issues taken from SCRs between 2018 – 2019[12] highlights that practitioners sometimes struggle to work with teenagers who are experiencing complex issues. The report identifies that the language used about teenagers by professionals can mask a child's vulnerability and convey that a child is responsible for making choices to engage in harmful high-risk behaviour.

The adults in a young person's life, and young people themselves, sometimes viewed sexual activity as a "lifestyle choice", rather than recognising it as a potential indicator of abuse. This meant there was a perception that the child was responsible for what had happened to them, and appropriate action was not taken to keep them safe.

The use of language has broader ramifications. At various times, the words used to describe Chloe's help seeking behaviour was peppered with inferred judgements or nuanced negative undertones. This language can shape an internal narrative of being bad/out of control/ difficult/ challenging to love or provide care to, and this remained an important theme.

Conclusion: The view expressed by panel members and practitioners was that the use of language remains an issue today and work is in place to raise awareness of the impact and address the language that is used. The question that needs to be asked is why is this language used? The reasons for this are not completely clear. In the practitioner learning events the following was observed: *The language used by professionals is a reflection of what they feel*. This is a valid observation – as was the observation that *practitioners experience the trauma of a child's experiences vicariously*. In other words, repeatedly seeing, hearing and reading about the experiences of a child who has been hurt and abused (and who may feel lost and alone) leads to anxiety and has an emotional cost – a cost that may lead to unconscious defences[13] being constructed. These defences can provide an individual and collective buffer within a system that faces the unbearable reality of a child's suffering, and few viable options to provide meaningful help. This may provide an explanation for why this language continues to be used – it may sanitise a child's experiences, place responsibility on the child and thereby make the unbearable bearable. Relevant issues are discussed in the section: Trauma informed approaches.

[12] Teenagers: learning from case reviews briefing. NSPCC Feb 2021

[13] Jacques, E. (1953) On the dynamics of social structure: a contribution to the psychoanalytic study of social phenomena deriving from the views of Melanie Klein, in E. Trist and H. Murray (eds) 1990 27 Menzies, I.E.P. (1960) 'Social systems as a defence against anxiety: an empirical study of the nursing service of a general hospital', in E. Trist and Murray (eds), 1990. The Unconscious at work: Individual and Organisational Stress in the Human Services. The Members of the Tavistock Clinic Consulting to Institutions Workshop: Eds: Obholzer & Roberts 1994

The importance of family, friends and kinship

Changing the trajectory of children's lives, and making a significant difference to children's outcomes, cannot be achieved by professional intervention alone. There is a need to understand and embrace family, kinship, and communities[14]

She made it clear to me that memories of her past are constantly in her mind – I was struck by the significant sense of sadness about her life experiences and that she felt alone – family separation was a measure of her despair and loneliness.[15]

Throughout the five years Chloe was looked after, her most consistent wish was to be placed close to her friends and family and to have contact with them. In the records seen, there are frequent references to a close family friend, various passing references to a sister and brothers, and to long term friends in the local area. The records of Chloe's missing episodes (66 reported to police over the timeline) show that Chloe was frequently found in the local area, often after travelling some distance from her placements. Whilst it is not entirely clear where Chloe had been, she often mentioned seeing her family and friends.

As discussed later, Chloe's Looked After Reviews (LARs) repeatedly recorded a need for contact to be arranged between Chloe and her mother (and on occasions her father) and attempts were made to enable this to happen. However, the CSC agency report provided for this review makes the following comment**:** *Chloe was just over 17 years old when she took her life. Throughout the years in care it is sad that little was done to connect her more with her sister and brother. If there was a connection of contact that would be because Chloe arranged it herself. There is little information in Chloe's file about her family.*

There are numerous benefits in mapping and understanding a child's family, kinship and friends. It can promote a sense of belonging, nurture connections, establish sources of safety and risk, engender a felt sense for the child that they are held in mind and facilitate a collaborative approach to care and safety planning. Whilst the various practitioners, key workers and clinicians may well have held knowledge about Chloe's kinship - this did not translate to a coherent picture. Chloe's journey in care, characterised by the involvement of multiple practitioners and numerous transitions, meant that this knowledge was lost over time and is an example of how Chloe's identity and sense of belonging was fragmented and scattered – this is discussed later.

The independent review of children's social care interim report makes a powerful case about the basic human need for children to grow up with a *loving tribe* around them, and that this is not being provided for children who are in state care. There are many complex reasons for this. In Chloe's case, this was partly due to the reasons discussed later (about whether contact was thought to be harmful). In part, it is attributable to the constant flux of social workers in children's lives which is a national issue. However, overall, the central issue relates to the issues raised earlier about working hard to catch up. When responding to children who are at high risk, it is simply not possible for social workers (who carry high caseloads and who are dealing with extensive tasks/legislative and procedural requirements) to do the extensive work that is often needed to build a *loving tribe* of family and kinship around a child.

[14] CSCB VA Thematic Review 2019

[15] Quote from a psychiatric assessment of Chloe at a secure unit

If we consider that the greatest value of social work is in the interaction between social workers and children and families, then it should be an ongoing source of alarm that 1 in 3 of all social workers in children's services do not work directly with children or families (Department for Education, 2021a). Even those in direct practice spend less than one third of their time with families (Department for Education, 2020a). This is a staggering misuse of the greatest asset that children's social care has - its social workers[16]*.*

Conclusion: The need to nurture this tribe for children who are looked after is recognised in Croydon – it is known well and understood. The inhibiters are having the skilled resources and capacity to do the work. There is a plan in place to recruit systemic practitioners who would be able to do this work. However, once again, the issue remains that if insufficient financial resources are available, and if social workers continue to be unable to do their jobs, this will not be possible. These are issues that are well known to government across all political groups, they have existed for many years and have been identified in numerous reports[17] over time. National action is needed; therefore no recommendations are made.

Wishes and feelings

i. Placement in foster care

Chloe was often asked about her wishes and feelings on a range of subjects, and she frequently gave her views. Her most consistent wish was to be placed in a foster home in close proximity to her family and friends. This was achieved, it seems more by accident than design, after her first period in secure accommodation when she was placed in such a foster placement. It was clear that she was very happy in this home. However, the plan agreed at court had been to move Chloe from secure to a therapeutic residential placement. It was difficult to find a residential placement that would be able to meet her needs and was prepared to accept her. As a result, she was placed in an emergency foster placement in her local area. Sadly, within weeks, she was told she would be moving to a residential placement out of borough.

The SW who informed her of this decision described Chloe's distress on hearing this news – *Chloe remained quiet as tears streamed down her face.* From this point Chloe's behaviour changed, and as to be expected, she then had to be moved in a hurry – the pattern of moving in a time of crisis continued. The CSC and IRO reports express concern about this period stating that although there was no guarantee, there appeared to be signs that this placement might have worked. It has been described within the CSC agency report and by the IRO *as such a missed opportunity* and as Chloe said *she was not given a chance*. Risk sensible decision making, transition, discharge planning and placement options are discussed later in this report.

ii. Contact with family: *Care must build rather than break relationships* [18]

> *One of our most fundamental obligations to children in care should be that they grow up and grow old with a strong loving tribe of people around them. We are currently not meeting this most basic of obligations* [19]*.*

[16] The Case for Change: The independent review of children's social care. June 2021

[17] Such as: *The Munro Review of child protection: a child centred system*. 2011 DfE. *No Good options*: Report of the Inquiry into Children's Social Care in England. All Parliamentary Group for Children. NCB March 2017. *Storing up trouble. A post code lottery of children's social care*. All Parliamentary Group for Children. NCB July 2018

[18] The Case for Change: The independent review of children's social care. June 2021 DfE

[19] The Case for Change: The independent review of children's social care. June 2021 DfE

Her parents might not have been able to always act in her best interests, but they had a special place in her heart and professionals have not considered that well enough[20].

Chloe consistently expressed her wish to have contact with family and friends and her desire to be close to her mother (both physically and emotionally) remained evident throughout. This was apparent to her IROs who were frequently clear that contact should be facilitated and supported. At times, due to her distance from the family home, this contact was difficult to achieve but it is clear that creative ways of achieving contact with her mother were made at different points.

At various times, Chloe was distressed after contact with her mother or father. During a LAR, when Chloe had been admitted to PICU, she told the IRO that on her birthday (a few days before admission) she had felt upset after seeing/speaking to her parents. There were differences of opinion about whether contact with her mother and father met her needs. Whilst it is understood and appreciated that risk sensible decisions about contact must be made, it is simply not possible for professionals to prevent young people seeing their parents if they choose to do so.

Many children, particularly those who come into care during adolescence, will return 'home' in some shape or form. The reasons are numerous; it can be driven by a simple reality that they have no other options, it can be driven by anger, resentment or blame, a desire to understand the past, to establish a sense of connection and belonging &/or a wish to seek parental love. Therefore, there is a need to prepare children for lifelong relationships with their families. Facilitating contact is one aspect of this but in the absence of attempts to make these relationships the best they can be, there is a risk of compounding harm and perpetuating harmful dynamics in the short and long term.

Both Chloe and her mother were vulnerable, there was a need to support their relationship to enable this relationship to be the best it could be – an emotional scaffold needed to be built. An IRO observed that Chloe seemed to take a paternal position in this relationship, this needed to be better understood. Understanding this within the context of Chloe's early childhood experiences, Chloe's unrelenting desire to be placed close to her mother and her frequent missing episodes (when she returned to Croydon and often visited her mother) may have had the added benefit of supporting efforts to keep her safe.

Conclusion: At various times there was an acknowledgement that relationship work was needed but this lacked a coherent plan. It seemed that the requirement to deal with urgent matters drove out the capacity to deal with important matters such as this. This has been acknowledged in the independent review of children's social care interim report: *Process continues to dominate over direct work with families.* Recommendations could be made that CSCP should ensure SW caseloads are reduced to enable social workers to take on direct work with children and families, and that there are sufficient resources in place to ensure that skilled practitioners are in place to facilitate this work. These would be unrealistic recommendations that are beyond the gift of CSCP. The issues discussed in previous sections are relevant, as stated - these are systemic national issues that require a national response.

[20] Croydon Children's Social Care Agency Report for the CSPR

A sense of self

i. Enabling a unique sense of self

Chloe consistently expressed her interest in animals and spoke of her desire to study catering or hair and beauty in further education. Various practitioners identified; her interests, her likes and dislikes, areas where she excelled (such as gardening and art), areas where she excelled (such as maths), areas that calmed and soothed her (such as being with horses) and areas that filled her with joy (such as dancing). Sadly, the sheer number of professionals involved in her life, and the multiple placements, scattered this knowledge and Chloe's sense of self was fragmented. This is not unusual for children looked after by the state whose experiences are similar to Chloe.

Within the fragmented system that we call 'corporate parenting', Looked After Reviews (LARs), Personal Education Plans (PEPs), health assessments and pathway plans (PPs) have the potential to hold a composite memory of a child and paint a unique portrait of self that stands the test of time. In a sense, they are the documents that can represent and hold innate 'parental' memory and knowledge about a child – this is discussed later.

ii. I belong in this world - identity and belonging.

Relevant research and literature about adolescent development describes the formation of personality during this time. Critical components of this include identity formation and a search to belong. For children who are looked after by the state, a sense of belonging can be difficult to achieve - although a stable placement and a school place can facilitate this. Chloe had neither, as a result her sense of belonging was thwarted, and her scattered and fragmented memories undermined a sense of self.

A child's understanding of their story is carried with them throughout their life journey. How a child makes sense of this journey provides an internal narrative that gives them a sense of who they are. LARs repeatedly recommended that life story work (LSW) was needed, but this was not achieved throughout Chloe's life. During this review, it was said that LSW was just not possible as this work required consistency and stability - LSW seemed to be a mountain that practitioners felt was just too high to climb. Whilst this is understood - to consistently note this as an ambition (within LARs) and for it never to be achieved, did not meet Chloe's needs. At the Practitioner Learning Event, it was said that the lack of life story work was common.

As suggested in the children's social care report (CSC) and Independent Reviewing officer (IRO) reports, LSW needs to be demystified. Flexible and creative opportunities should be found to engender a sense of identity and belonging. Storing cherished memories is one aspect and, as discussed below, one way this can be achieved is by using the established recording mechanisms.

There have been promising developments in CSC which include IROs writing letters to children and examples were seen of letters written by IRO's to Chloe that contained important memories and offered validation that she had been heard. Further work is currently in place to enhance the potential therapeutic value of these letters, this is excellent practice. In addition, CSC staff spoke about the use of memory boxes which allows a child to hold mementos of their past - providing sensory triggers to unlock memories. Whilst this is also a good practice, it was not something that happened for Chloe.

Throughout the Child Looked After Reviews, Chloe persistently asked for a number of things that she wanted, such as:

- a passport
- her birth certificate
- a provisional driving licence
- a record of her savings
- her exam certificates
- return of belongings from previous placements.

The reviews repeatedly made recommendations that these needed to be gained, and at each review Chloe's frustration about the lack of action was clear. Just before her death, Chloe was given her passport and birth certificate. Sadly, at the time of her death, she was still waiting for some of her belongings. It is understood there were concerns for her safety should she have a passport. Whilst this is appreciated, the symbolic meaning of these items as a reflection of her identity had the potential of promoting a sense of self and a feeling of belonging in this world.

iii. Hopes and Dreams and the Importance of Ordinary Things

Chloe's Looked After Reviews, and conversations with practitioners, revealed that Chloe had aspirations and dreams. This was regarded as a mark of her resilience and engendered a sense of hope for Chloe's future. The chaos of her life in care; the repeated trauma and cycling of unresolved trauma, was mirrored in the chaos management within the system. The unintended consequence was that the urgent obscured the need to celebrate and promote the intrinsic value of ordinary life and to honour Chloe's ordinary hopes and dreams.

There were some exceptions to this, as demonstrated in the attempts to give Chloe an experience of ordinary life in the semi-independent unit at the end of her care journey. Amongst other things, it was impressive to note that Chloe was supported to secure employment for a short while in a well-established fast-food restaurant. However, throughout her life in care, there was no holistic view of Chloe. Reviewing the records and speaking to practitioners revealed that; Chloe aspired to working *to earn money by legitimate means*, she loved receiving something that showed the person knew what she liked (such as a box of Maltesers), she enjoyed experimenting with her hair and makeup and found joy in ordinary things. She was described as *astute, empathetic, engaging, bright* and *articulate*. One practitioner said that *a light shone through her,* and others said that *at heart she was an ordinary girl who wanted ordinary things.*

As already described, the fragmentation of her care journey and the involvement of multiple practitioners resulted in a fragmented 'knowing' of Chloe. Sadly, this can be a familiar experience for children in care. Children living in foster homes have a better chance of this knowledge being held by their carers but for children who experience multiple moves, or who spend much of their lives in residential placements, this innate knowledge can be fragmented and lost. Once again, the question that arises is where can this vital 'parental knowledge' be held to stand the test of time?

The need for a lead professional has already been discussed but it is important that this is not regarded as an aspirational panacea. Other established mechanisms need to play a part in the gathering and storing of innate parental knowledge. Child Looked After Reviews are one way this can be achieved, and the recent initiative of IROs writing letters to children is an excellent development. Contributions from the Independent Reviewing Officer (IRO) service to this review highlighted that the Child Looked After Review process is peppered with targets and performance indicators which can have the unintended consequence of placing an undue emphasis on process checking.

Whilst this has certainly improved over time, it was clear that the weight of process checking can skew an IROs valuable time and attention away from understanding the uniqueness of a child. This is discussed at the end of this report.

Other established mechanisms that are well embedded in the Child Looked After systems and processes are Child Looked After health assessments, Personal Education Plans (PEPs) and Pathway Plans.

PEPs were not consistently completed, those that were completed were characterised by a narrow focus on formal education achievements and there were blank spaces throughout. Chloe engaged in completing her PEPs, she wrote about the activities she enjoyed and her dreams and aspirations – it was sad to see what little attention was paid to these things. It seemed these PEPs were a sign of hitting the target but missing the point. This has been recognised by the Virtual School and the considerable changes that have been made to build capacity, and improve the focus on pro-active oversight and intervention, is encouraging. The need to celebrate and promote a child's talent and aspirations (within and beyond the confines of what is judged to be formal educational success) has been recognised and is now actively promoted.

Child Looked After (CLA) health assessments are not intended to have a linear focus on health needs/outcomes alone, instead - a child's holistic needs are considered, including a child's identity and their wishes and feelings. The relevant agency report to this review addresses the CLA health assessments that were completed and identifies that these assessments, by necessity of Chloe's placements out of area, were frequently completed by various health professionals and were not consistently completed. As a result, it was difficult to get a sense of Chloe's health and wellbeing from these assessments. This, together with the limits of how a trauma informed approach was enacted (as below), meant that Chloe's identity and lived experiences were difficult to see. Several recommendations have been made in this agency report about how this will be better achieved in the future.

Pathway Plans should be written three months after a child's 16th birthday, it is written with a child and sets out the plans for a child's future. Included in this plan are steps that need to be taken to meet a child's needs as they move into independence and covers areas such as identity, family contact, health, education/employment, finances and accommodation. It provides a platform for future planning so that a child can feel confident of this future, and how they will be supported. In addition, it provides another opportunity to; promote a sense of belonging, to reflect a sense of self, to hold parental 'knowing' and engender a sense of future. IROs made repeated recommendations that a pathway plan needed to be completed. Just before Chloe's death, a pathway plan was completed. Again, it was sad to see the scarcity of information contained in this document.

Recommendations & Conclusion

A sense of self.

The interim report, setting out the initial findings of the independent review of children's social care, states: *When we do remove children from their birth parents, we need to ensure they are cared for in consistent and loving relationships that support their development and identity. We agree with the Care Inquiry that permanency should mean children feeling security, stability, love and a strong sense of identity and belonging (The Care Inquiry & Family Rights Group, 2013).* These are unquestionable truisms that all those in children's social care, and across the multi-agency network, would agree with and there is a collective desire to achieve these things for all children. The issues identified earlier (about the lack of capacity within CSC to complete direct work with children) are relevant, as are the issues raised later (about a system which is not designed or set up for the task of caring for children like Chloe). However, children cannot wait for the national changes that are needed. CSC, together with the multi-agency workforce, need to find flexible and creative approaches to build a sense of self and belonging in real time for children. Therefore, it is recommended that the opportunities currently available within the multi-agency system should be used to maximum advantage. This requires a collective understanding about the importance of a child's identity, and a multi-agency approach to identify the opportunities that will enable this work to happen. These opportunities need to be scoped and built to enable children to understand their life story, including their racial and cultural origins - their lineage and heritage. Thereby, a positive narrative of self and a sense of belonging in this world may be constructed.

Recommendation 1

Multi- agency partners to consider how identity will be prompted within the current system by using existing processes (such as care plans, Child Looked After plans, Personal Education Plans, health assessments and Pathway Plans) and other multi-agency processes/points of contact with a child. IROs to lead on scoping opportunities within the child's network for building a positive identity. CSCP to maintain on overview of progress and provide support and challenge.

Trauma- informed approaches

Taking a trauma informed approach in our work can enable this shift away from asking "What is wrong with you?" towards an orientation of "What has happened to you?", enabling the possibility of survivors of abuse being seen by themselves and others as just that – survivors. With this change in ethical orientation a child or young person's responses to trauma are seen as understandable and courageous attempts to survive which were absolutely necessary at the time [21].

Chloe's variable relationship with practitioners was frequently noted. Whilst it is completely normal for children and adolescents to have a preference about which adults they like or can trust, research suggests that children who experience trauma are often in a state of hyper vigilance and alert to the body language of others, and what they feel is being communicated: Am I being judged/criticised? Is there threat? Can I trust this person? Am I safe? Tomlinson[22] describes this as an attempt to survive.

[21] *Trauma – informed approaches with young people*. Research in Practice Front Line Briefing 2018

[22] *Communicating with Traumatised Children* P. Tomlinson, 2013.

At various times, it was clear that trauma informed approaches were enacted when working with Chloe. Examples that stand out include the care provided by the Adolescent Outreach Team (AOT), the work of several IROs, social workers and key workers, who clearly understood her trauma and provided a trauma informed response. However, the extent and consistency of these approaches were variable.

As identified in the CSC agency report - *the majority of Chloe's social workers do not appear to have been trained in trauma-informed practice*. Early involvement with Chloe suggested little understanding of trauma and impact - instead, a behaviour management approach was adopted: *There is a sense at times that Chloe is being judged for her behaviours rather than them being understood through a trauma informed lens.* The Croydon Health Services (CHS) agency report identifies a need for health professionals to focus *not just on risk but on how the trauma is being reflected in behaviours*. The author observed: *The shift in language* (from describing a set of needs) *from complex to more trauma informed can move the paradigm from the child is complex to the child has experienced trauma.*

It is fair to say that in Chloe's early years, the concept of trauma informed practice was not understood and there was little in place to guide practitioners in this approach. Since then, there has been an expansion in how trauma informed approaches are understood and can be enacted[23] and the phrase 'trauma- informed' has become part of the language used by the children's workforce and is promoted in various national reports and research. However, as noted in many of the agency reports, this is not consistently applied/understood. In addition, it is not clear whether foster carers are trained in trauma-informed approaches or whether external placements are expected to base interventions informed by the principles of trauma informed practice.

It is recommended that approaches are adopted that seek to address the child's trauma and services provided that are flexible enough to adapt to the child's circumstances and needs. The benefits of a key worker relational approach[24] needs to be better understood and the barriers to this approach addressed.

Recommendation: CSCP to consider best practice examples of implementing a trauma informed response[25] (demonstrated elsewhere in the UK) and consider how the multi-agency workforce might be suitably supported to implement this approach [26].

Conclusion: There have been local and national initiatives to support trauma-informed approaches; this CSPR has found that these approaches are inconsistent. The question that must be asked is: What gets in the way of providing a consistent approach? - there are multiple reasons for this. First and foremost, it is important to recognise the issues raised in the section – *working hard to catch up*; not only were practitioners working hard to catch up with Chloe's movements (in completing the multiple tasks involved and contending with a system that is not fit for purpose) they were also providing care to a child who was the victim of frequent re-traumatisation. This was happening not only as a result of the abuse perpetrated by multiple adults in the community, but also as a result of system failures. The trauma was ever present for Chloe, and the secondary trauma was ever present for practitioners.

[23] Such as: Research in Practice: Trauma- informed approaches with young people 2018
[24] *That Difficult Age: Developing a more effective response to risks in adolescence*. ADCS Research in Practice 2014
[25] Developing and leading trauma-informed practice: Leaders' Briefing Research in Practice 2018
[26] Croydon Safeguarding Board Vulnerable Adolescents Thematic Review 2019

The independent review of children's social care has made the case for national change, these national changes offer a hope that the system may prevent retraumatising children such as Chloe. A further important issue that was identified by practitioners was that unless practitioners are supported by their organisations to cope and recover from the secondary trauma experienced when working in a human service (that routinely faces the pain of children and adults and the challenges of an imperfect system), it is not possible for trauma-informed work to be consistently provided. *The emotional burden of the work squeezes out our capacity to provide an empathetic human response – if this is not acknowledged or understood no amount of trauma-informed training will help*. Relevant research supports this position and strongly encourages organisations to embed the principles of a trauma-informed approach in strategic plans, policies, procedures and in day-to-day management and leadership [27] to enable consistent trauma informed services to be provided.

Elements of this approach have recently been set out in the National Institute for Health and Care Excellence consultation document [28] : *This guideline covers how organisations, professionals and carers can work together to deliver high quality care, stable placements and nurturing relationships for looked-after children and young people. It aims to help these children and young people reach their full potential and enjoy the same opportunities in life as their peers*. A key aspect of the guidance highlights the need to provide good quality supervision to staff, characterised by reflective practice and emotional support.

Recommendation 2:

CSCP to review what progress has been made following the recommendation made in the Vulnerable Adolescent Thematic Review, with a particular focus on identifying evidence to demonstrate how trauma-informed practices are being enacted in services provided to children (including commissioned services/homes) and how trauma-informed organisational approaches are supporting the multi-agency workforce.

Providing support to survivors of sexual abuse

> *The consequences of child sexual abuse can include depression, eating disorders, post-traumatic stress, and an impaired ability to cope with stress or emotions (Allnock et al 2009). Self-blame, self-harm, and suicide are commonly mentioned as consequences of sexual abuse.*[29]

There are two important issues that arise in this review about the therapy Chloe received; one relates to availability and the other to suitability. This section covers the availability and suitability of therapy for survivors of sexual abuse.

It is unclear from the records what therapeutic intervention Chloe received to enable her to start her healing journey from the pernicious harm caused by sexual abuse and exploitation. The Child Looked After Reviews in the early part of the timeline, when Chloe was in various residential establishments, raise concern about the lack of therapeutic intervention. In part, this was due to the number of times Chloe was missing however, there were periods when therapy could have been undertaken.

[27] *Developing and leading trauma-informed practice: Leaders' Briefing*. Research in Practice. Dartington (2018)
[28] https://www.nice.org.uk/guidance/gid-ng10121/documents/draft-guideline
[29] NSPCC Practice Briefing: Sexual Abuse 2013

The variable provision in residential units provides a partial answer as to why this was not achieved, and the fragmentation in CAMHS provision (caused by referral, rereferral, and delay) was also a critical factor - this is discussed later.

Chloe was referred to various services to address her need for therapeutic intervention - this included Safer London, the NSPCC and various private and voluntary (charitable) providers. It is unclear what was provided and there was little seen to suggest that this work was reviewed, evaluated, or integrated within Chloe's care plan. The IRO agency report identifies this as a missing component as does the CAMHS agency report. A systematic review[30] reveals the scarcity of research about the different treatment approaches/modalities available for survivors of Child Sexual Abuse (CSA), and the current lack of evidence to demonstrate effectiveness. It is suggested that the provision of therapeutic support to survivors of sexual abuse requires review and that some approaches are at best unhelpful, and at worst harmful. Work is currently underway, led by the Home Office and the Centre of Expertise (CoE), to review therapeutic services for survivors of CSA and national guidance is expected in the coming months.

A further aspect of therapeutic intervention for survivors of CSA is criminal injuries compensation. Whilst the therapeutic benefits are not widely recognised, panel members have rightfully raised this as an important oversight. On one occasion the need to pursue criminal compensation was recognised in a Child Looked After Review but as with a number of other recommendations made in Chloe's Reviews, this recommendation was lost overtime (Child Looked After reviews are discussed at the end of this report). Research emphasises the critical importance of justice for survivors of sexual abuse/exploitation - this can restore dignity and promote feelings of validation in being believed, of not being responsible, and thereby alleviate feelings of shame.

Recommendation 3

CSCP to be guided by the national reviews and embed relevant learning in the future service provision of mental health and wellbeing services for survivors of CSA. This should include the services provided by the voluntary sector and commissioned services that are provided to Looked After Children who are living out of area.

Recommendation 4

The therapeutic work a child needs should be detailed in a child's care plan. Child Looked After reviews to monitor what therapy is being provided, evaluate outcomes and determine what future services are needed. Criminal compensation should be pursued for all children who have been the victim of sexual abuse, Child Looked After Reviews to maintain oversight.

[30] Systematic Review: Effectiveness of psychosocial interventions on wellbeing outcomes for adolescent or adult victim/survivors of recent rape or sexual assault. Jane Lomax and Jane Meyrick. SAGE 2020.

A place called home.

Few good options

We continue to hear that there are not enough of the right homes for children with the most complex needs…... What is clearly true is that at present the state is not meeting the needs of a very vulnerable group of children. We desperately need better planning, coordination and investment for this group with leadership across health, justice and children's social care. Instead of simply doing more of the same, we need to consider the needs of these children and ask whether any home that currently exists is able to meet their needs while still providing a loving environment[31]*.*

Chloe spent five years in the care of the Local Authority. She moved across the country living in at least 18 different 'homes'. The longest period she lived in a home was 12 months, this was a residential children's home. Chloe was placed in secure accommodation on 4 occasions – 10 months in total. She spent brief periods in foster care, but the majority of her placements were in residential care. Few placement endings were planned; they happened as a result of concerns that a particular establishment could not keep Chloe safe, or at the request of the placement due to their difficulties in managing her aggressive outbursts, assaults on staff &/or destruction of property.

There were 3 homes that stood out as important for Chloe; the first was the 1st secure unit, where she accessed therapy and seemed to respond well to containment and care, the 2nd was the foster home she moved to from this secure placement, where she wanted to stay, and the 3rd was her final placement within the semi-independent unit that provided her a home in spite of assaults on staff and extensive destruction of property. There were differences of opinion about whether her last home met her needs, and these concerns were the subject of active multi-agency debate and challenge when Chloe was alive, and during this CSPR. The harsh reality is that there are few good options.

Placement planning and sourcing include a matching process (where a child's needs are matched with a provider/foster carer) however, it is clear that placement decisions were driven by an overriding desire to keep Chloe safe. In reality, the only placement that achieved this was secure accommodation. Finding placements for children with needs such as Chloe's is extremely difficult. Decisions about placements are often not about choice but based on which placements are willing to provide care – it is an extremely time consuming and costly endeavour where compromises have to be reached. Experienced practitioners and managers in CSC said there was no such thing as a placement resource that would have met all of Chloe's needs regardless of the amount of money that CSC were prepared pay. As identified by senior managers in CSC - it is a very sad reality that sourcing placements for children who are in state care is a marketplace: *residential placements (businesses) are paid very significant sums of money to care for a child but there are no incentives for the business to contend with the challenges of a child with complex needs, when they can be replaced with another child who is less challenging/less risky to provide care to.*

Chloe's experience of care; characterised by swift moves from one foster home to another, to placements in various residential homes across the country and punctuated by frequent placement breakdowns and periods of secure accommodation, is familiar. It has been identified in the independent review of children's social care interim report that placement options for children who are exploited, and at high risk within communities, are few and far between.

[31] The Case for Change: The independent review of children's social care. June 2021 DfE

Sadly, this is often the experience of children who come into care late who have a history of trauma, high risk behaviour and exploitation. Relevant CSPRs, concerned with children who have been criminally and/or sexually exploited, are a testament to this. [32]

Changes in statutory guidance and safeguarding practice over the past few years have prompted a necessary shift from seeing a child's high-risk behaviour in teenage years as a lifestyle choice to seeing these children as requiring robust state intervention to safeguard them from harm. The CSC agency report emphasises that *use of secure units should be a last resort* and that *risk sensible decisions* about placements need to be made, these are relevant and important principles. However, it seems that the resources needed to realise these principles (including viable local placement options, flexible and creative intervention across the multi-agency partnership, multi-agency ownership of risk and responsibility at a senior level) are not in place. As a result, what appears to have happened is that without the necessary infrastructures and resources on the ground, the clear commitment to protect these children, supported by statute, has swung the pendulum from laissez-faire to restrict and confine.

We would question whether there is no other alternative for the two thirds of children currently placed in secure children's homes who are the victims of sexual exploitation (A. Williams et al.2020)[33]

Despite all the best intentions, Chloe returned to the local area a more traumatised child then when she had left home 5 years ago. This meant that the risks she faced were considerable and the challenges of providing stability and containment were more complex. It is a tragic irony that at this late stage there was an acceptance that continuing to confine Chloe would not be in her best interests. The involvement of the AOT, and the relative stability of her placement, offered a glimmer of hope that she might have been safely held.

Conclusion: Chloe's enduring wish was to live in her local area close to her family home, this was achieved at the end of her life. The question that arises is whether this could have been achieved at a much earlier point. It seems that two main factors stood in the way. One relates to the local and national shortage of suitable homes for children who are at high risk and have complex needs. The other relates to how risk is managed within organisations. During the practitioner learning event, experienced managers spoke about the fear and anxiety that can be felt in organisations about risk. This can lead to risk adverse decision making at a senior level which can close down options. There are number of systemic reasons for this; not least the political context within which public services operate, the search for certainty in an uncertain world, the inspection regime and the individual, collective, organisational and political costs of failure. During the period when Chloe was in and out of secure accommodation, an inspection of CSC was being carried out by Ofsted. It was said that at this time there was an *organisational freeze*; fear and anxiety pushed the organisation into a position where risk was intolerable and as a result locking Chloe away, and others like her, felt like the most sensible thing to do and the numbers of children in secure accommodation rose.

Care for children who need secure accommodation reflects short term siloed thinking across government [34].

[32] A local example: CSCB Child Q Where were you when I was six? 2019
[33] The Case for Change: The independent review of children's social care. June 2021 DfE
[34] The Case for Change: The independent review of children's social care. June 2021 DfE

Risk sensible decision making, supported at a senior level within organisations and within the local and national political landscape, is a perennial issue that will continue to influence decision making regardless of the amount of homes that are available. Making recommendations about how the workforce can be supported to make risk sensible decisions or about increasing the quality and availability of resources, including a place to call home, is beyond the gift of CSCP. Once again these issues are recognised in the independent review of CSC; they are issues that require a national response. However, once again, children cannot wait for these changes. Panel acknowledged that there was little practitioners could do on the ground to make the systems changes that were needed but were committed to making the best of the limited resources that are available. Therefore, the following recommendation is made:

Recommendation 5

CSCP to identify opportunities within the current system to provide multi-agency support to carers in the local area (informed by initiatives in other areas) and for this scaffold of care to be detailed in a child's care plan and reviewed in Child Looked After reviews and multi-agency planning meetings.

Transition & discharge planning

Transition: The multiple placements and practitioners involved in Chloe's life meant that there were multiple points of transition. For Chloe this meant there were frequent endings and frequent beginnings. Children's experiences of ordinary transitional points is widely researched and the need to pay attention to a child's response, and provide careful management by an adult, is recognised. Chloe's experience of transition was extra-ordinary, the inherent loss, confusion, fear, and rejection in so many of these transition points was stark.

Transitions between services and across geographical boundaries must always be considered from the point of view of the young person [35].

Conclusion: These transition points would have been overwhelming for Chloe and for the practitioners involved. There did not seem to be space within the system to pay attention to the impact of these multiple transitions on Chloe's wellbeing. It is simply unreasonable and trite to suggest that more training is needed or more policies are required – these things will not make any difference to children. Once again, Chloe's experiences are a reflection of a national picture that requires fundamental changes to be made to a system that is broken. The question that arises is what can be done in the meantime; children cannot wait for the national changes that are needed.

A number of themes discussed in this review may assist in reducing transitions although the central issue about use of secure accommodation, and the limitations of viable placement options, are fundamental issues that are beyond the power of CSCP to resolve.

However, it may be fruitful to consider how 'false' transition points within services could be avoided. An example of this is provided in the later section about how CAMHS are commissioned, and CSC have commented on the number of Social Workers involved and how consistency might be better achieved: Chloe had 9 Social Workers – some of whom she clearly trusted and felt a strong connection with – sadly, each of these relationships ended. Research suggests that having a long-term relationship with a trusted Social Worker is of critical importance to children who are looked after away from home.

[35] CAMHS agency report

The Social Worker workforce is highly transient, as a result it is not possible to guarantee a long-term Social Worker. However, as identified by the CSC report author, there are examples of service structures that follow the journey of a child thereby avoiding 'false' transition points (that lead to a change of Social Worker). There are examples of this kind of structure across the country, Camden CSCs was provided as an example. The action required to remedy these issues require fundamental systemic changes including changes in commissioning and organisational structures.

Recommendation 6

Multi–agency partners to consider how false transition points within agencies (including the private and voluntary sector) might be reduced to maximise the opportunities for practitioners to build consistent relationships with children. CSCP to maintain overview and provide support and challenge.

Discharge planning

> *Importantly we must remember that any secure intervention must be purposeful and prepare a child for returning to a home, whilst the trusted adults around that child are using the time to ensure appropriate support in the community. Secure settings must not be seen as a place to merely 'contain' a child [36].*

On occasions plans were made for Chloe's discharge from a service (such as from the Psychiatric Intensive Care Unit - PICU) and although her discharge from secure accommodation involved planning meetings, it is unclear how these meetings supported Chloe in real terms once she was in the community. This was particularly apparent when she moved from the 1st secure placement. During the Child Looked After review that took place just before she moved back into the community, the following was noted by the IRO: *Her demeanour and presentation is entirely different – she presents as happy and relaxed for today's review; she has made considerable progress emotionally socially and educationally whilst in the Secure Unit.* However, once in the community, it was apparent that very little was in place to meet Chloe's emotional, educational, social and mental health needs. As a result, the progress Chloe had made was reversed and this glimpse of Chloe faded.

It is fully accepted across the multi-agency workforce that discharge planning meetings are critical to enable smooth transition and after care. There are several CSPRs that identify how the decisions made at discharge planning meetings have not translated into the care provided in the community. The CSC report identifies the problems associated with the variable responses across the agencies in terms of holding responsibility for children who are placed out of area in a secure unit: *When young people are placed in secure units local agencies should all retain responsibility and plan 'safe' discharge [37].* This is relevant for all agencies and services, including services provided by the private and voluntary sector and (as highlighted in the next section) is particularly relevant to CAMHS: *……the originating CAMHS and/or the CAMH service covering the area where the young people will be discharged needs to be involved in the planning arrangements for mental health care at the earliest opportunity, ideally at the point of the young person accessing secure accommodation [38].*

[36] The Case for Change: The independent review of children's social care. June 2021 DfE
[37] Children's Social Care CSPR agency report
[38] CAMHS CSPR agency report

Conclusion: Planning for a child's discharge from secure accommodation must start at the point they are admitted, this planning should include the full multi-agency group that are involved with the child prior to their admission. There are specific planning mechanisms in place when a child is in secure accommodation which are additional to Child Looked After reviews. The discharge meetings that took place did not translate well across the Child Looked After reviews. The reason for this may lie, in part, with the timing of these (which are required to take place at set intervals and may be out of sync with discharge planning meetings). Although it seems reasonable to suggest that there should be sufficient flexibility within the system to better synchronise planning meetings and for Child Looked After reviews to address discharge planning at the earliest possible point.

Recommendation 7:

Multi-agency services to review how changes in the current system can be achieved to provide consistent intervention and oversight of children placed in secure accommodation, and robust discharge planning at the point of admission. CSCP to maintain oversight and provide support and challenge.

The mental health needs of looked after children.

A consistent finding in repeated surveys has found that Children Looked After are more likely to have psychological difficulties of such severity that warrant mental health services (Tarren- Sweeney, 2008) and have higher incidents of learning & language difficulties and poorer physical health (Crawford, 2006). Studies using standard caregiver reporting scales e.g. CBCL, SDQ and Rutter Scales have consistently found that the mental health difficulties of Children Looked After is in a similar range to children referred to mental health services[39]. Children in residential care are identified as having greater need than children in foster families[40]. It is appreciated that Children Looked After present with a more complex constellation of social, emotional, developmental, and mental health needs but there is a need to consider the type of service provision required to ensure a sufficient and effective response to the needs of this vulnerable, at risk, disadvantaged population.

[39] Armsden, G., Pecora, P.J., Payne, V.H., & Szatkiewicz, J.P. (2000). Children placed in long-term foster care: An intake profile using the child behaviour checklist/4-18. *Journal of Emotional & Behavioural Disorders*. Cappelletty, G., Brown, M., & Shumate, S. (2005). Correlates of the Randolph Attachment Disorder Questionnaire (RADQ) in a sample of children in foster placement. *Child and Adolescent Social Work Journal,* Crawford, M. (2006). Health of children in out-of-home care: can we do better? *Journal of Paediatric & Child Health.* Tarren- Sweeney, M., & Hazell, P. (2006). The mental health of children in foster and kinship care in New South Wales, Australia. *Journal of Paediatrics & Child Health*. Tarren- Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry,* 21:345-349. Burnes, B.J., Phillips, S., Wagner, H., Barth, R.P., Kolko, D., Campbell, Y., et al., (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of American Academy of Child & Adolescent Psychiatry,* 43(8): 960-970.

[40] Hukkanen, R., Sourander, A., Bergroth, L., & Piha, J. (1999). Psychosocial factors and the adequacy of services for children in children's homes. *European Child and Adolescent Psychiatry,* 8: 268-275.

i. Meeting Chloe's therapeutic needs

We have repeatedly heard from parents, carers and care experienced adults that there should be an assumption made that therapy should be provided to any child in care, and not something which needs to be argued or pleaded for. This does not necessarily mean that every child and family will require CAMHS clinical support, but it does mean we should be exploring who is best placed around the child to provide consistent therapeutic support. Lack of mental health support, a lack of understanding of attachment and trauma and the impact this can have on children in care and care leavers is too high a price to pay for us as a society. We see the human cost of not properly supporting children and families in the increasing need for acute services and homes [41].

As discussed earlier in this report, Chloe had little therapeutic intervention throughout her life. The therapy that was provided in the community was provided either by the residential establishments or was commissioned through the private/voluntary sector. This was inconsistent and the evidence base underpinning the therapy provided, and outcomes, were unclear. Chloe received therapeutic support at the secure units although again, this was inconsistent, and the evidence base and outcomes were unclear. During Chloe's first stay in secure accommodation, there was one notable exception to this. The following was noted by the IRO: *Being placed in secure accommodation has afforded Chloe the time and space to reflect and process her life to date. She has demonstrated ability of self-analysis and is displaying emotional intelligence. A much softer, vulnerable side has emerged. At times, Chloe has broken down and cried, needing hugs and reassurance that she will be supported in overcoming past, negative experiences.*

On occasions, Chloe was described as not wanting therapy or of being ambivalent about therapy. However, it was clear that she did engage with therapy when it was offered and at various times she asked for a referral to be made to CAMHS. Whilst Chloe's need for therapy was an enduring part of her care plan, it is clear that there was little understanding within CSC about what kind of therapy Chloe needed.

Given that ambivalence towards accepting help is common for young people who have experienced severe trauma and disruption in their life, the multi-agency plan should include specification of available advice and guidance for foster carers and/or residential carers and other relevant adults in the young person's life. This should focus on how to support ongoing conversation about the dilemmas of accepting help for mental health needs as well as access to crisis care, as needed. The development of a multi-agency care plan should be supported through regular opportunities for professionals to meet and review, the identification of a lead agency (if not Children Social Care) and the inclusion of all relevant agencies working with the young person [42].

Conclusion: Important factors that inhibited the provision of 'therapy' was the fast-paced nature of Chloe's movements and constant moves across geographic boundaries which required multiple referrals and re-referrals to be made. This was combined with delays in the referrals made to CAMHS, and the variable urgency applied to the referrals by local CAMHS across the country. Of greatest importance seems to be the local commissioning arrangements for the provision of CAMHS to Children Looked After. Other issues underpinning this theme include the gap between community (Tier 3) and inpatient (Tier 4) CAMHS provision, the limited understanding about the acute vulnerabilities of children in care, the possible implications of a lack of diagnosis and the absence of multi-agency ownership and joint planning. These issues are discussed below.

[41] The Case for Change: The independent review of children's social care. June 2021 DfE
[42] CAMHS CSPR agency report

ii. Responding to the mental health needs of Children Looked After

Service boundaries that are threshold led, rather than needs led, often result in multiple people working with a child and frequent changes of worker, a different approach is needed that places the needs of the child as central to the decision making [43].

The lack of CAMHS provision for children who are looked after was said to be a perennial issue. There was a sense of fatigue felt by practitioners that nothing will change: *It's an age-old exhausting cycle.* It was clear that this had significant implications for how a child, like Chloe could be supported with her mental health needs/emotional wellbeing. It was equally clear that this issue can lead to frustration and exasperation about the lack of provision. This has the potential to cause splits in the safeguarding workforce and a despondency that no matter how many referrals to CAMHS are made, a child will not get the help they need. However, it was equally clear that within the local CAMHS there is a strong desire for this status quo to be different.

Transitions between services and across geographical boundaries must always be considered from the point of view of the young person. At times this will require flexibility with regard to service provision: for example keeping an episode of care open after a young person has moved out of area and until they have engaged with local services, agreeing arrangements for joint working, ensuring contact with young people who are inpatients etc. The accommodation of more flexible working models requires clarity of commissioning arrangement and between different providers[44].

Conclusion: As discussed, Children Looked After have complex mental health needs by the sheer nature of being removed from their families of origin and living in the care of the state. It is not unusual for children to be placed out of borough and, for children like Chloe, it is not unusual for there to be frequent placement moves across geographic boundaries. Chloe, and others like her, need to be supported by a mental health service that hold them in mind and assists the network to provide a prompt and a consistent approach to meet their needs. The current commissioning arrangements in Croydon CAMHS does not allow this to happen, the result is a cycle of referral, re-referral and delay with no oversight. The result for Chloe was that her mental health needs were not understood or met, her internal journey was not held in mind and the network were adrift. The agency reports to this review clearly evidence that this is a systemic issue that has implications for a large group of children. It is of such importance that it was the most consistent and most highly rated learning identified in the agency reports and by practitioners.

*ICB's should consider commissioning a Child Looked After CAMHS team to follow children across local boroughs and enable an element of consistency of care[45]***.**

Having a lead clinician involvement in formulating and co-ordinating mental health support, even if trauma related, would have greatly benefitted Chloe- CAMHS local to the child's local authority should lead on this provision[46] .

[43] Croydon Safeguarding Children Board Vulnerable Adolescents Thematic Review 2019
[44] CAMHS CSPR agency report
[45] Southwest London & St Georges MH NHS Trust
[46] Croydon Children's Social Care

More robust arrangements need to be in place to address the mental health needs of Children Looked After placed out of Borough, with clarification of the role of the Child and Adolescent Mental Health Service in the Local Authority looking after the child/young person (the originating CAMHS). The provision of day-to-day mental health care from the originating CAMHS would be difficult and arguably unsafe in cases where risk is a significant factor; therefore, this arrangement would best work on a consultation only basis. Nonetheless, for young people frequently moving across geographical boundaries, it would be highly desirable to retain this indirect connection with the originating CAMHS, with the aim of supporting access and engagement with local services, clarifying thresholds across different provisions as well as identifying and avoiding gaps. If adequately resourced and appropriately staffed, this resource would undoubtedly add value to the professional network of care supporting the young person and minimize the impact of frequent changes to the access and quality of services received by the young person[47].

Recommendation 8

CSCP to strongly request that the local Integrated Care Board (ICB) take steps to commission a ringfenced CAMHS team for Children Looked After which provides a flexible approach to meeting the needs of looked after children in the local area and across borough boundaries.

iii. Service Gaps

The many gaps in resources and infrastructure, and the part this plays in the life experiences of Children Looked After, have been discussed. The variable provision sitting between community (Tier 3) and inpatient (Tier 4) CAMHS is another example. Children who have mental health needs that sit between these tiers require an outreach home based service and at the end of Chloe's life she was provided with support from a team that provided intensive outreach support, this was an excellent example of how a child with significant mental health needs can supported in the community. However, the variable provision across the country means that this kind of service is not always available, and it is a tragedy that this service was only available shortly before Chloe died. The variable commissioning of these services is a national issue: *Community-based services as an alternative to inpatient admission or as an adjunct to discharge planning following admission for young people presenting with significant risk behaviours also vary in their availability, access thresholds and levels of provision across different areas*[48]. The result is a post code lottery, and this is particularly important for children who are looked after and are living across the country.

Recommendation 9

On behalf of looked after children living across the UK, CSCP to make representation to NHS England about this variable provision and ascertain how this might be addressed.

iv. Thresholds & the possible value of diagnosis

As described by a renowned trauma expert [49]: *there is no other diagnostic entity that describes the pervasive effects of trauma on child development, these children are given a range of comorbid symptoms as if they occurred independently from the PTSD symptoms.*

[47] SLAM: South London & Maudsley NHS Foundation Trust – local CAMHS
[48] Local CAMHS agency report
[49] Bessel A. van der Kolk, MD

Chloe was known to self-harm, and she had various tentative diagnoses. The most consistent diagnosis was depression, for which she was prescribed medication. She was also variably diagnosed with possible conduct disorder, bi-polar affective disorder, affective instability, drug induced psychosis and emotionally unstable personality disorder[50]. Apart from depression, these diagnoses did not appear to be known to CSC - they were not recorded within the care plan or within Child Looked After reviews. As stated in the CSC agency report to this review: *Chloe did not have a specific diagnosis.* In part, this is correct, Chloe did not have a formal mental health diagnosis.

Chloe's background was of multiple traumatic experiences from the age of 2. She suffered from depression, had extremely low self-worth, exhibited emotional dysregulation, had aggressive and violent outbursts, self-harmed (cutting but also extensive drug and alcohol misuse) was known to tie ligatures, to precariously run-in front of traffic, she attempted to jump from a window and at various times she expressed a wish to die. She told police officers and her drugs worker that she was suffering from Post-Traumatic Stress Disorder – this appeared to be a self-diagnosis.

Chloe was regarded by mental health clinicians as having psycho-social needs – with an emphasis on social rather than psychological. This meant she was not regarded as having a diagnosable mental health condition and this was universally accepted by clinicians and seemed to have an impact on whether her needs met a threshold for intervention, and the speed at which referrals were responded to.

It is argued that diagnoses per se are not as important as the formulation and the approach that is enacted and of critical importance is the meaning the diagnosis has for a child/young person. For Chloe, the diagnosis of PTSD made sense to her. It is accepted that a formulation and an approach, rather than a diagnosis, is the key to providing children with the support they need. However the question that arises for Chloe is what difference it would have made if a diagnosis had been made?

The view of practitioners in CSC is that approaches can be lost over time and for children who are looked after within an infallible system; where knowledge and memories about a child are fragmented and lost, their care is chaotic and crisis management holds sway. It was also their view that current thresholds within CAMHS services means that if a child does not have a formal diagnosis – they do not meet a threshold for provision. This was challenged by some CAMHS clinicians saying that a child does not have to have a diagnosis in order for treatment to be provided. Senior managers in CSC strongly disagreed pointing to numerous examples of children living across the country who are not in receipt of CAMHS treatment because they do not have a formal diagnosis. There is wider evidence that supports this view.

Conclusion: It is clear that with all the best possible intentions, underpinned by research and evidence-based practice, that children should not be unnecessarily labelled/given a diagnosis. However it is a harsh reality that for children such as Chloe, formulations and approaches are easily lost. It is beyond the role, remit and scope of this CSPR to enter the ethical debate about the helpfulness, or not, of diagnoses. What seems of utmost importance is the need for commissioning arrangements to change to enable local CAMHS to provide a service to children in Chloe's circumstances. This would go a long way to resolve this issue and potentially render this issue about diagnosis redundant. However, as previously highlighted, there is a need to provide a response to children in real time.

By the very nature of being in state care, all Looked After Children have experienced complex trauma - this should be consistently acknowledged and responded to.

[50] Emotionally Unstable Personality Disorder is also known as Borderline Personality Disorder

Recommendation 10

A child's mental health needs should be prioritised in all planning meetings and care plans and should include an accurate recording of these needs and an informed approach to meet these needs. CSCP to maintain an overview of implementation and provide support and challenge.

v. Drugs, alcohol and mental health

Chloe told her drugs worker that she started to smoke cigarettes and cannabis when she was 11 years old and drank alcohol from the age of 12. She said that by the age of 14 *she was smoking 1-5 spliffs a day* and although said she wanted to cut down she felt unable to do so. Chloe said that cannabis *chilled her out* and was a coping strategy when she was stressed. She spoke of taking *spice*, lean and cocaine at various points in her life and said she started taking MDMA (ecstasy) regularly when she was 16. Chloe did not hide her use and spoke freely about her intake; therefore, her misuse of drugs and alcohol was well known. Referrals were made to local drug and alcohol services, services were provided/offered and there was communication between these services and other agencies. It is unclear what was provided to Chloe when she was not in Croydon, and it seems that nothing improved her misuse of drugs and alcohol [51].

Panel members and practitioners have asked: What was the meaning of drugs in Chloe's life? There is no indication that this was thought about in depth and there seemed little in place to facilitate agencies coming together to think about this, and to plan for how Chloe's drug use might be addressed. As a result, the effect of these drugs on her short- and long-term mental health and on all aspects of her social and emotional functioning and wellbeing was unclear. Panel members and practitioners spoke about how the separate commissioning arrangements has led to tenuous links between mental health services and drugs and alcohol services. They raised concerns about the lack of integrated work which seems to impact on a number of levels including, at minimum, a lack of shared IT systems.

The CAMHS agency report makes the following recommendation: *The access to and provision of advice and support regarding alcohol and drug use for Croydon Children Looked After, placed out of Borough should be reviewed in light of the known negative impact on mental health presentations and alongside risk, for example, of sexual and criminal exploitation.*

Recommendation 11

CSCP to ascertain how improved integrated work between drug and alcohol services and mental health services will be achieved and how the recommendation made above will be taken forward.

The risk of suicide

> *The endpoint of chronically experiencing catastrophic states of relational trauma in early life is a progressive impairment of the ability to adjust, take defensive action, or act on one's own behalf, and a blocking of the capacity to register affect and pain, all critical to survival[52].*

[51] Drug use was a significant precipitating factor in her presentation prior to both of her admissions to the psychiatric intensive care unit when she it was concluded she was experiencing a drug induced psychosis.

[52] Relational trauma and the developing right brain: the neurobiology of broken attachment bonds. In T. Brandon (Ed.), *Relational trauma in Infancy*. Shore, A. London: Routledge. 2010

Chloe experienced multiple traumas, she was depressed and self-harmed from the age of 9 years. There were frequent references to Chloe using sharp objects such as a knife to cut her forearms. At the end of her life it was described that: *there were no areas on her fore arms that were not scarred.* Chloe took a range of drugs over many years; she was often the victim of sexual exploitation and frequently in situations of high risk when she was repeatedly harmed. There are references to Chloe tying ligatures, being restrained from running in front of traffic and prevented from jumping out of a window. Chloe was unable to protect herself, her care givers and other adults/professionals/practitioners could not keep her safe but there appeared little attention to the risk that Chloe would take her own life.

When speaking to practitioners, many spoke about their shock at hearing that Chloe had taken her own life and said that although they feared she may die by other means, they never considered she was at risk of suicide. The Adolescent Resource Team were an exception to this, and safety planning took place. However, it was clear that the risk of suicide was not universally understood or factored into the care and safety planning that took place within CSC or across the network. Given Chloe's history, the question that arises is why not? When considering this question it is easy to fall into the alluring trap of hindsight bias and it is important to hold in mind contemporary research [53]; that there are limits to the interventions provided to people intent on taking their own lives, people have ultimate autonomy including a freedom to occasion their own death if they are really committed to do so.

That said, there has been considerable attention paid to the prevention of suicide by government[54] and public services. Guidance suggests there should be 'zero – tolerance'[55] to any suggestion that little can be done to prevent someone taking their own lives. It is recognised that prevention remains difficult *so many times people will say that it was a complete surprise when someone they knew died by suicide* and that: *Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity [56].*

Recommendation 12:

The CSCP should promote the briefing by the NSPCC on findings from young people who complete suicide, in particular the advice that suicide threats should be routinely assessed for motivation and level of intent.

Conclusion: When considering the question of prevention it seems of greatest importance to children that the inherent limitations in the system, identified across the entire range of findings in this CSPR, need to be addressed. However, as said before, children cannot wait for these changes to happen. The following section suggests some practical ways in which children might be helped in real time.

Working together

The teenagers in these case reviews had long-standing and complex problems and received a wide range of support from different agencies. If services work in silos, this can mean that there is no overall picture of the young person's situation and no overarching plan about how to support them in the best way[57].

[53] Why People Die By Suicide. T. Joiner 2007.
[54] Preventing suicide in England A cross-government outcomes strategy to save lives. Department of Health 2012 Cross-Government Suicide Prevention Workplan HMG 2019
[55] Zero Suicide Policy NHS England 2015
[56] Dr David Fearnley Associate National Clinical Director for Secure Mental Health at NHS England
[57] Teenagers: learning from case reviews briefing. NSPCC Feb 2021

i. Across the multi-agency network

Professionals and parents trying to safeguard teenagers facing harm outside of the home, are being faced by a system that was not designed for the task[58].

There were several occasions when meetings took place within the network involving different services and professionals. Some of these were professional meetings (when a meeting was called to discuss a specific issue), others were more formal meetings such as Looked After Reviews/ meetings held in secure accommodation and Care Programme Approach (CPA) meetings held at the end of Chloe's life. So whilst interagency communication took place, there was incomplete and inaccurate information held across agencies and there was little sense of a shared knowledge and understanding about Chloe, or a shared ownership of her needs and plans. This compromised care and safety plans and decisions about risk.

A failure to grasp the complexity of these cases where children are open to numerous services, are both victims and perpetrators, and face harm from different and harder to manage sources has led to ineffective and confused responses and lack of accountability. Different parts of children's social care, justice and health systems are responding differently to the same teenagers. This leads to confusion, gaps and ultimately the worst outcomes for these children[59].

All CSPR agency reports identified the limitations of multi-agency work and the pressing need for this to be resolved: For *young people with the high level of need and complexity experienced by Chloe, it is crucial that a multi-agency care plan is in place and that it includes consideration of mental health needs and emotional wellbeing, alongside risk and safety planning.*

The system is complicated, bureaucratic and risk averse[60]

Practitioners identified these issues as critical shortcomings in the system. The lack of multi-agency ownership and responsibility for risk sensible decision making at a senior level was highlighted. Practitioners were challenged about this and were reminded that Chloe's case was discussed at 2 senior multi-agency panels. The response from practitioners who knew Chloe well was that they were not aware of this, and it seemed to make no difference to how risk was held within the organisations and across the hierarchies or to risk mitigation.

The review of children's social care interim report describes a *disjointed national picture* which *translates into a similarly complicated picture locally where multi-agency boards and meetings dominate*. As pointed out in this report: *each service has its own footprint, objectives, accountability arrangements and inspectorates, which in turn leads to a system that is confusing and difficult to navigate for professionals let alone children and families.* It describes these siloed approaches as creating a *bureaucratic labyrinth.*

[58] The Case for Change: The independent review of children's social care. June 2021 DfE
[59] The Case for Change: The independent review of children's social care. June 2021 DfE
[60] The Case for Change: The independent review of children's social care. June 2021 DfE

It is important to highlight an important exception to what was said to be *senior management avoidance of risk sensible decision making.* This relates to the period of time Chloe was in semi-independent accommodation. At this time, the risks faced by Chloe were high; on many occasions she assaulted staff, destroyed property, and her mental health was of significant concern. There was a view that she should be placed in secure accommodation, but it was concluded that another period of confinement would do little to mitigate risks in the medium - long term. Instead, enabling Chloe to have as much autonomy and freedom as possible to enjoy and achieve in the community, whilst attempting to mitigate risk, was felt to be in her best interests. It is commendable that every effort was made to achieve this - this required risk to be held at a senior level within CSC and this was done. It is unclear how the senior manager was supported in taking this sensible position and it would be of interest to know how far inspectorates (such as Ofsted) would support this kind of sensible and realistic approach to deal with the inherent limitations of the system.

Conclusion: Once again, the issues identified in the review of children's services mirrors Chloe's experiences and mirrors the experience of multi-agency practitioners. In terms of addressing these issues in real time, the most consistent request from multi-agency practitioners was to have the opportunity to come together as a multi-agency team, to pause and reflect and think together. It was suggested that the advantages realised during the pandemic of using virtual platforms should be built upon. It was strongly argued that unless this is set out as an absolute requirement it simply would not happen as, once again, the urgent drives out the important and *performance indicators and bureaucratic tasks are prized higher* in the organisations within which they work.

It could be argued that Child Looked After Reviews provide a statutory forum for multi-agency meetings. However, whilst some changes in Child Looked after Reviews are needed (these are discussed in the next section) they are not the forum that would enable this kind of multi-agency reflection and decision making. Examples [61] of these kind of multi-agency forums were discussed by panel; these examples of best practice should be used to inform future developments in Croydon.

Recommendation 13

CSCP to set as a requirement of all partner agencies that children with complex needs are the subject of regular multi-agency group discussion and planning. This requirement should feature in multi-agency policies and procedures and a suitable approach should be set up and embedded with support provided by CSCP.

ii. Working together as corporate parents within Children's Services

As this report draws to an end, it is important to return to a central issue of how CSC can be supported to fulfil their responsibilities as corporate parents. Chloe's experiences reveal how the system we call 'corporate parenting' is made up of multiple practitioners, teams, systems and processes across Children's Social Care. It is clear that moving beyond this to a system of care that achieves what children need simply cannot happen without the care of children being shared across the multi-agency network. That said, there are some aspects of work within CSC that require attention.

[61] Such as: London Borough of Merton CAMHS in Social Care Team. Community in Practice: Reflective Space

Despite all the good intentions of practitioners within CSC, there was a strong sense that responsibility was left in the hands of front-line social workers. The absence of ownership of risks at a senior level and the lack of a multi-agency approach would have been contributory factors but it also seemed that the wider CSC workforce did not share equal ownership. It is clear that a lack of resources plays a key part but there was also a sense that teams/services, who had an important role to play, stepped back. In part this was about a lack of investment in building capacity but there was also a sense that the front-line social work team did not see or trust the wider system to support them in their work. Of particular note was the work of the Independent Reviewing Service/IROs.

iii. The importance of IROs in a child's life

IROs hold a central position of responsibility, and it was clear that a number of Chloe's IROs had a significant place in her life – and held a composite memory of Chloe across the multiple changes of Social Workers and placements. Whilst it was apparent that they attended several important meetings in-between Child Looked After reviews, when they advocated for her needs, it was also clear that several recommendations made in reviews were repeatedly left unaddressed from one review to the next. It is understood that there have been significant improvements in the relationship between IROs and Child Looked After Teams with an improvement in the speed at which recommendations are completed, these changes are a welcomed development. However, in learning from Chloe's experiences there are additional areas that require attention which include the need to:

- Promote a greater appreciation of the relationship that can exist between a child and an IRO within CSC.
- Consider the meaning they may hold for a child as a trusted adult and how this might be enacted in a child's life.
- Continue to pay attention to how IROs/Child Looked After reviews can move further away from process checking to achieve more nuanced consideration of the important issues in a child's life.
- Consider how the mental health needs of children can be better reflected in Child Looked After reviews and how the outcomes of intervention are evaluated and recorded.
- Promote an understanding across multi-agency partners about the role of IROs and the position they occupy in children's lives.
- Consider how Child Looked After reviews can be better aligned with other planning forums/processes.
- Routinely review safety planning as part of Child Looked After reviews

Author: Bridget Griffin – Independent Reviewer

Post Inquest Amendments: Donna Świrski – CSCP Business Manager

Conclusion

Chloe's story is a tragic picture of a child in the care of the state who suffered early trauma, who was repeatedly exploited and traumatised, who had no adult she could consistently rely on, whose sense of self was fragmented, who did not belong and had no place to call home. The resilience of the workforce, in providing compassionate care in a system that at every turn has few good options, is a testament to the skill, courage and bravery of the workforce.

Whilst the inquest found (and indeed agencies admitted) some factors which contributed to her death, these were reflective of the challenges of working in a system stretched thin, and on the whole are factors visible with the benefit of hindsight. No prevention of future deaths report was issued. Notwithstanding the above, learning with the intention of changing practice has occurred and will be continued.

This CSPR has made a number of recommendations however, the changes that are needed are beyond the gift of multi-agency practitioners and beyond the gift of the CSCP. National wholescale change is needed. Without this, it is an immutable tragedy that Chloe's life story is currently the lived experience of other children, and these lived experiences will be mirrored across the country for some time to come.

'Chloe' - Post Inquest Addendum (v5)

Chloe was a 17-year-old Child Looked After who took her own life when in a state of mental crisis. She was subject to a Care Order and was living in semi-independent accommodation in another London Borough. She was open to the Croydon Looked After & Care Leavers Team. As the CSPR and recommendations were concluded long before the inquest finished (and we were in a position to publish), the following addendum gives some clarity about the action taken to progress the recommendations, between the original review being completed and the publication date.

No. Key - **Complete**, **In Progress**, **Outstanding**

No.	Recommendation	Status / Evidence of completion
1	Multi- agency partners to consider how identity will be promoted within the current system by using existing processes (such as care plans, Children Looked After (CLA) reviews, Personal Education Plans (PEPs, CLA health assessments and Pathway Plans (PPs) and other multi-agency processes/points of contact with a child. IROs to lead on scoping opportunities within the child's network for building a positive identity. CSCP to maintain on overview of progress and provide support and challenge.	▪ Pilot training event for practitioners, in collaboration LBSC, took place in February with a focus on self-harm/suicide/LGBTQ2+ (unique training content) ▪ This training was positively received and has led to more sessions being planned for 2023/24. ▪ Successful funding applications will develop the training model so it will become a sustainable social enterprise business product, with the aim to roll out to other local authorities. ▪ The CSCP has commissioned an online training program 'Trauma Informed Approach' to support practitioners' awareness and influence how they respond to young people who have experienced trauma. ▪ Team Managers within the Children Looked After Service have received 15 days training on systemic practice and now deliver systemic group supervision periodically with social workers. Within any group supervision a young persons' identity is a central theme. Considering their GRACES (Geography, Race, Age, Culture, Ethnicity, Sexuality etc) and people who are important to them are identified using a cultural genogram. ▪ There has also been training provided on direct work tools that help young people to establish their identity, such as the 'Tree of Life' that helps young people reflect on where they have come from and develop positive narrative about their foundations. ▪ For continuity and oversight of health needs, Croydon Child Looked After (CLA) health team now allocate a specific nurse to each CLA including those placed out of area. Part of the health assessment focuses on identity and offers referral pathways to relevant agencies.
2	CSCP to review what progress has been made following the recommendation made in the Vulnerable Adolescent Thematic Review, (VAR60) with a particular focus on identifying evidence to demonstrate how trauma - informed practices are being enacted in services provided to children (including commissioned services/homes) and how trauma - informed organisational approaches are supporting the multi-agency workforce.	• Training event took place in Sept-2022: Young People at harm of suicide. • Oct 2022 Exec reviewed the VA60 Recommendations • '7-minute briefings' about the learning have been disseminated across the partnership. • CSCP have commissioned from the local substance misuse provider to provide Substance Misuse Awareness, Harm Reduction Training as well as a discussion of their safeguarding procedures and how they work in partnership with agencies regarding Safeguarding. • Staff the in children in care service have received a 2-day training course on 'narrative approaches to why am I in care'. The course

		is delivered by a care experienced and well-respected trainer who provides social workers with the tools to help young people explore their history and why they are in care. • There has also been training for staff and managers on trauma informed practice and writing. This is about understanding the impact of trauma on the developing brain and on behaviour. Case summaries are being written in the first person and visits are now being written directly to young people, promoting a child-centred approach to case recording as part of a broader cultural shift to a more trauma informed culture within the practice system. This programme is ongoing. • The virtual school has commissioned training on suicide and self-harm, supporting practitioners to understand the relationship between suicide and self-harm and how to develop safety plans with young people experiencing suicidal thoughts. • Since the training a number of social workers have gone forward to use safety planning their work with young people and networks with greater confidence.
3	CSCP to be guided by the national reviews and embed relevant learning in the future service provision of mental health and wellbeing services for survivors of CSA. This should include the services provided by the voluntary sector and commissioned services that are provided to Children Looked After who are living out of area.	• Croydon has signup for CSA (Centre of expertise for Sexual Abuse) training with the CSA Centre, accessible via Croydon Learning. • CSCP supported the coordination of CSA training that took place in March 2023. • VAWG strategy being written by FJC, scope of this piece of work was shared at the January (2023) LIG meeting. • The CSCP established a Priority Group looking at mental health because of this and other SPRs. Commissioners are involved and we have influenced the Public Health Schools Survey to understand the cohort who do not access support for mental health issues as well as supporting the next Joint Strategic Needs Assessment for mental health provision. • At a London level the CSCP has asked its counterparts to share learning involving children who have taken their own lives. Redacted facts about this case will be part of a case study as well as other learning and resources on reducing self-harm and suicide.
4	The therapeutic work a child needs should be detailed in a child's care plan. Child Looked After Reviews to monitor what therapy is being provided, evaluate outcomes, and determine what future services are needed. Criminal compensation should be pursued for all children who have been the victim of sexual abuse – Looked After Reviews to maintain oversight.	• The social work teams are aware of this requirement and have a system that managers through supervision or the IROs should ensure it is applied for. • There is a renewed focus on ensuring that therapeutic goals are identified in young people's care plans. At the point of commissioning a therapeutic resource, there is an agreement about the how therapeutic goals will be reviewed and what level of reporting will be provided by the therapist. • Children receive therapeutic support through schools and the goals are named within their personal education plan (PEP) which are then assumed into their wider care plan. • There are currently two dedicated psychotherapists within the Children Looked After Service who support staff
5	CSCP to identify opportunities within the current system to provide multi-agency support to carers in the local area (informed by	• CSCP L&D attended a Foster Service business meeting to discuss risk assessments this is included a Q&A session to discuss the training that is on offer to support their practice.

	initiatives in other areas) and for this scaffold of care to be detailed in a child's care plan and reviewed in LAR's and multi-agency planning meetings.	• The development of the local authority permanence strategy includes review of the data around stability of placement for children in care and consideration of the support provided to carers, to promote the stability of young people's placements as a key aspect of their permanence.
6	Multi-agency partners to consider how false transition points within agencies (including the private and voluntary sector) might be reduced to maximise the opportunities for practitioners to build consistent relationships with children. CSCP to maintain overview and provide support and challenge.	• The Croydon Adult Safeguarding Board (CSAB) and CSCP are due to carry out a joint activity to audit and review transition. This has also been discussed in learning and Practitioners have shared best practice. • A working group has held two meetings to discuss the transition of children to adult services. They have agreed on points of transition, role clarity and responsibility, referral points, and a pathway for facilitating helpful transitions. The pathway will be presented to the Croydon Senior Leadership Team for approval and establishment within the governance process. This process supports young people with complex physical and learning needs. • Future work will focus on developing a shared pathway for referral to adult mental health services. This pathway will be agreed upon by both organisations' governance structures and implemented jointly to ensure smoother transitions for young people experiencing mental health crises. • There is now a recently formed adolescent team within the Children Looked After Service, comprised of support workers who are capable of providing direct assistance to vulnerable teenagers. • Two care experienced adults (CEA) nurse specialist have recently commenced and are co-located with 16 plus local Authority team. They will provide CEA in the borough with a universal and targeted health offer, to ensure there are no sudden gaps in services for young people leaving care once they turn 18 years of age.
7	Multi-agency services to review how changes in the current system can be achieved to provide consistent intervention and oversight of children placed in secure accommodation, and robust discharge planning at the point of admission. CSCP to maintain oversight and provide support and challenge	• When a young person is leaving a welfare secure placement, a mobility plan is agreed upon during the secure accommodation review (SAR) and the children CLA review to ensure a smooth transition. • The local authority is clear about best practice in supporting young people to exit secure and a joint risk assessment has been created that is shared between the Youth Justice Service and the child's social work team. • The Croydon Adult Safeguarding Adult Board (CSAB) and CSCP are due to carry out a joint activity to audit and review transition.
8	CSCP to strongly request that the local Integrated Care Board (ICB) and/or local commissioners, take steps to commission a ringfenced CAMHS team for Looked after Children which provides a flexible approach to meeting the needs of looked after children in the local area and across borough boundaries.	• This links with National issues raised in SPR Jake. The CSCP will link with SW London and national (TASP) work to join up challenges in the system and articulate to Government. • The ICB members are prominent and proactive partners in every subgroup in the CSCP. This recommendation is aspirational and unlikely in the present climate to become a reality at this stage. This has been signed off at the CSCP Executive who include the DCS and the Chief Nurse for the ICB (Croydon Place) & CUH. • Children's Social Care has a dedicated in-house team of clinicians and dedicated staff who provide training, support practitioners, and work directly with children and their families and carers. • All permanent social workers have had access to a full 15-day training course in systemic practice that is accredited training. This training enables staff to use a range of systemic skills and

		idea to understand and work with looked after children and their families. • There are two dedicated systemic psychotherapists who provide direct and indirect support to the children in care and care experienced young people and they are ring-fenced to the Children Looked After Service.
9	On behalf of looked after children living across the UK, CSCP to make representation to NHS England about this variable provision and ascertain how this might be addressed.	• Linked to recommendation above. • This has been raised at TASP (The Association of Safeguarding Partners) to gain an understanding of the national position and use their influence to jointly approach NHS England and Government. It is recognised that there is variable provision in respect of children's mental health and a lack of secure placements, and this needs to be addressed at a national level.
10	A child's mental health needs should be prioritised in all planning meetings and care plans and should include an accurate recording of these needs and an informed approach to meet these needs. Failure to gain relevant mental health services should be escalated. CSCP to maintain an overview of implementation and provide support and challenge.	• At service level, service managers in the children looked after service and IRO service have held service meetings with front line staff considering how young peoples' emotional wellbeing can be better understood and referred to in their care plans. • An operational health and wellbeing group has been established. This consists of health champions in each service has enabled oversight of the plan to address the child's health and wellbeing. This group that reports to the clinical commissioning group and the Croydon Senior Leadership Team. • A Health Needs Assessment (HNA) was carried out by Public Health Croydon between December 2019 and February 2021. In order to improve local understanding of the health needs of children looked after in Croydon and to inform the future direction, priorities, and commissioning of the services. • In October 2021 Croydon refreshed its Health and Social Care Plan in consultation with key stakeholders. Children looked after's health has been identified as one the key priorities, under our 'Best Start to Life' outcome. • The CSCP's Multi-agency Mental Health Priority Group provided oversight and scrutiny of the single agency and multi-agency arrangements to ensure planning takes in to account a child's mental health needs. • The bi-monthly audit carried out by all managers has been developed to include a section about children looked after and specifically monitors how young people's emotional needs are being met. The findings from the audit are shared at CSLT meetings and with the CSCP. • This is also part of the CSCP audit plan for 2023/24
11	CSCP to ascertain how improved integrated work between drug and alcohol services and mental health services will be achieved and how the recommendation made above will be taken forward.	• The CSCP have met with Public Health and substance misuse commissioners. The substance misuse commissioners and Public Health are working with Youth Justice Service, CAMHS and CGL (substance misuse provider) to develop an integrated pathway so that young people can have a clear pathway on how to access/move through the services. • The service will be asked to provide a Safeguarding Standards Report to the partnership in quarter 2 of 2022/23. This will provide assurance of what the provider is offering, how they are

		meeting their safeguarding duties and what difference the service hopes to make.
12	The CSCP should promote the briefing by the NSPCC on findings from young people who complete suicide, in particular the advice that suicide threats should be routinely assessed for motivation and level of intent.	• This has featured in our briefings and learning events and is a resource on the CSCP website.
13	CSCP to set as a requirement of all partner agencies that children with complex needs are the subject of regular multi-agency forums that facilitate group discussion and reflection. This requirement should feature in multi-agency policies and procedures and a suitable approach should be set up and embedded with support provided by CSCP.	• CSCP have regular multi-agency learning events that are focused on themes affecting children with complex needs. Part of those meetings include group discussion and reflection. This would be an aspiration and, actively promoted as for the purpose of good practice. • As part of its continuous improvement plan the IRO service is focussing on the multi-agency contribution to CLA reviews. • The CSCP has requested audit activity to examine the quality and attendance of multi-agency professionals at Child Protection Conferences which is currently underway. • The CSCP Project Officer attended the Complex Adolescent Panel, where there was evidence of good practice relating to information sharing. • Young Croydon Service has been established and includes a multi-agency provision for young people at risk of extrafamilial harm and vulnerable adolescents.