



# **SERIOUS CASE REVIEW**

**“Yasmine”**

**Jane Wiffin**

**March 2017**

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The independent lead reviewer and all those who have been involved in the Serious Case Review extend their deepest condolences to Carol's family for their loss. The extreme nature of Carol's murder had a significant impact upon those professionals who worked closely with her over many years and knew her well.

While this review seeks to capture as much learning as possible it should be acknowledged at the outset that no professional or agency could have foreseen that Carol would be murdered in the manner that she was or predicted the actions of the young people.

The murder of Carol was shocking to all in the professional community. The SCR's have been an opportunity to explore the role of professionals in both girls' lives and to consider whether this incident could have been foreseen and therefore prevented. We have found that neither girl had any history of violent offences; they were angry, abusive and hostile to those around them and there is considerable evidence that they experienced abuse and neglect which had an impact on their well being and behaviour. We have tried to understand the detail of the professional response to that abuse and neglect, and how trauma manifests itself in young people's lives. We have emphasised the non linear nature of this story; although we have learnt lessons about how we understand adolescent neglect more broadly, and the likely trauma it creates, we cannot predict how this will manifest itself on a daily basis or how it might interact negatively with other factors. These issues are beyond professional control.

It is important to highlight that those involved with both girls took their circumstances and obvious distress and hostility seriously, and sadly there were plans in place to address these issues at the same time as the murder took place. In talking about these factors in the girls lives, we do not intend to take away from the fact that both girls have been found guilty of Carol's murder and are serving custodial sentences as a result. This is why we have concluded that this serious incident was not predictable and therefore not preventable, but we can focus positively on all ways that trauma manifest in young people lives and address these effectively.

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# INTRODUCTION

## Why this case is being reviewed

- 1.1 This Serious Case Review (SCR) was commissioned by Hartlepool LSCB because Yasmine (aged 13 at the time) and another young person Olivia (who is subject to a separate review) were arrested and subsequently found guilty of the murder of a vulnerable adult (who is subject of a concurrent Safeguarding Adults Review). Yasmine is now subject to a significant custodial sentence. Although these circumstances do not fit the existing regulations<sup>1</sup> for undertaking a Serious Case Review the LSCB took the decision that because of the serious nature of the incident a Serious Case Review would be undertaken to provide the best framework to capture professional learning, improving systems and professional practice for the future.
- 1.2 Serious Case Reviews play an important part in the broader efforts of the LSCB to achieve a safer Child Protection system and ensure all children and young people are effectively safeguarded. Consequently, it is important to consider what happened and try and discover why in a particular case, but then to go further and reflect on what this might reveal about underlying gaps and strengths in the child welfare system that may reappear in other cases. In this case, the purpose is to reflect on the services provided to Yasmine, and her family, and what this can tell us about services to vulnerable adolescents with complex needs in the future.
- 1.3 There was some delay in the review proceedings because of criminal processes which took 16 months to complete. This did not prevent early data collection or key agencies reviewing their existing services to see what immediate action might be needed to be taken. Each agency involved with Yasmine developed an action plan from this early analysis and these plans have been regularly reviewed.

## Summary of the case

- 1.4 This review is about Yasmine<sup>2</sup> who is an only child. She lived with her mother but not her father as the parents were reported to be separated. The family's ethnicity is White/British. Early on in the review process mother reported that father had returned to live with them. Yasmine had recently started at secondary school. She had been noted as a child who might find the transition process difficult and was provided with support.

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<sup>1</sup> Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely: 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. (2) For the purposes of paragraph (1) (e) a serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

<sup>2</sup> All names are anonymised

- 1.5 Yasmine exhibited early and significant difficulties in her first term following transition to secondary school with disruption, aggression and bullying. The family was provided with support, which they did not engage with. There was an escalation of concerns and Yasmine became subject to a Child Protection Plan for neglect.
- 1.6 There were continued concerns about aggression and some physical abuse from father to Yasmine, as well as allegations of aggression and hostility from Yasmine to her parents at the family home and bullying and disruptive behaviour at school. She was also known to drink alcohol and use drugs, and there were escalating concerns regarding possible underage sexual activity. Services and support were provided, but neither the parents nor Yasmine engaged and the circumstances deteriorated. In October 2014, Yasmine's parents asked that she be placed with a foster family.
- 1.7 This placement lasted two and a half weeks before breaking down, and she was placed in a new foster placement just at the time the murder took place.

### **Summary of the Review Methodology**

- 1.8 The expectations of a Serious Case Review as contained in Working Together 2013<sup>i</sup> is that they are conducted using a systems approach but no specific methodology is prescribed. This review has been undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence (SCIE) and more details about this can be found at <http://www.scie.org.uk/publications/guides/guide24/index.asp>. SCIE provided quality assurance supervision at key points in the data analysis process and at the end when the final report was in draft form.
- 1.9 Information is provided in Appendix 4.1 about the methodology and process of this review.
- 1.10 The review was also assisted by a case group of frontline professionals across all the relevant agencies who mainly had direct involvement with Yasmine. This also extended to professionals who were managing or supervising those professional's involved and the foster carers. They provided data and sensitive critical reflections to the review to best understand the professional response to Yasmine at the time but also the current systems of work. This has not been an easy thing to do given the circumstances and the independent reviewers are genuinely grateful to them for their honesty and openness.
- 1.11 Interviews were held with all professionals who had contact with Yasmine and her family. From this early data gathering, all reports and a substantial quantity of case records from across the agencies were accessed and reviewed. This data was analysed by the Review Team and formed the basis of this report. The Case group were involved in subsequent discussions about emerging findings and agreed with the subsequent analysis.

## The Review Team

Job Title	Agency
Named GP for Safeguarding Children	Hartlepool and Stockton-on-Tees (HAST) Clinical Commissioning Group (CCG)
LSCB Business Manager	Hartlepool LSCB
Detective Chief Inspector	Cleveland Police
Service Manager Child and Adolescent Mental Health Services (CAMHS)	Tees Esk & Wear Valleys NHS Foundation Trust
Assistant Director Children's Services	Hartlepool Borough Council
Designated Nurse Safeguarding Children and Looked After Children (LAC)	Hartlepool and Stockton-on-Tees (HAST) Clinical Commissioning Group (CCG)
Named Nurse - Out of Hospital Care	North Tees and Hartlepool NHS Foundation Trust
Head of Commissioning and Clinical Quality	Commissioning and Clinical Quality Section Hartlepool Borough Council Public Health
Named Nurse	Safeguarding Children Team - Tees Esk & Wear Valleys NHS Foundation Trust
Community Safety & Engagement Manager	Hartlepool Borough Council
Head of Safeguarding and Review, Children's Services	Hartlepool Borough Council
Principal Educational Psychologist	Hartlepool Borough Council
Senior Service Manager	The Children and Family Court Advisory and Support Service (CAFCASS)

## Family Involvement

- 1.12 Yasmine was asked if she wanted to contribute knowledge to the review process and she agreed to do so. She was visited by the reviewer where she is held in custody. Yasmine provided many key insights to her view of services she received and these are woven into the fabric of the report.
- 1.13 Yasmine's parents agreed to meet with the lead reviewer. Their perspective is woven into the fabric of the report.

## **Independence and Expertise**

- 1.14 The lead reviewer, Jane Wiffin, is accredited in systems learning and the SCIE “Learning Together” model, and is an experienced independent investigator and safeguarding lead who has undertaken many Serious Case Reviews nationally over the last 15 years. Jane has a professional background in social work, training and policy development. She has never worked for any agency in Hartlepool and is completely independent.
  
- 1.15 Medical expertise was facilitated by NHS England (NHSE) under Appendices 1 and 3 of the NHS Serious Incident Framework 2015. Under this Framework, the North NHSE region had begun collaboratively to commission single investigations in joint cases which meet all of the statutory requirements of Mental Health Homicide investigations, Domestic Homicide Reviews, SCRs and SARs.

## THE FINDINGS

- 2.1 This section contains six findings that have emerged from the review. Each finding lays out the evidence identified by the Review Team that indicates that these are not simply quirks of the case.
- 2.2 An overview is provided of what happened in this case, looking at professional responses and system learning. This sets out the view of the review team about how effective the professional response was to Yasmine and her family during the time under review. Where possible, it provides explanations for this practice, or indicates where this will be discussed more fully in the detailed findings that have emerged from this Serious Case Review.
- 2.3 This review covers just under a two-year period from when Yasmine was aged 11 to 13. During this time, Yasmine and her parents received a great deal of support from a consistent, caring and hard working group of professionals. These professionals met regularly, provided reports to the many multi-agency meetings that were held to consider the growing concerns about Yasmine and communicated often and in a detailed way. Professionals consistently escalated concerns appropriately over time. There is considerable evidence that all acted in a professional manner throughout and the appraisal and findings that follow are not meant to be seen as a linear story linking the unfolding events with the end outcome which triggered this review, but a reflection of the professional response up until this unforeseeable and completely unexpected event.
- 2.4 There was no indication to professionals that Yasmine would be involved in a serious violent crime. It was known she was often hostile, aggressive, and verbally abusive to professionals and other adults known to her. She was also known to bully other children and young people. She also experienced physical abuse from her father. There was no evidence that she had ever seriously physically assaulted another individual. This review is clear that hostility, abusive behaviour and aggression to others is unacceptable and must always be addressed in an empathetic but authoritative way.
- 2.5 Working with vulnerable adolescents who are experiencing huge changes in their lives, and whose difficulties and early traumatic experiences are manifest in behaviours such as anger and aggression, experimentation with drugs and alcohol, and early sexual behaviours and exploitation is complex, difficult and challenging. It is clear that all the professionals who had regular contact with Yasmine made exhaustive efforts to address her needs and improve her circumstances. These efforts were commendable and made the discussions about rethinking how we meet the needs of this group of young people difficult. This issue of how the multi-agency safeguarding network provides an effective response to vulnerable and troubled adolescents is discussed in Finding 1.

## Request for help and consecutive assessments: January 2013

- 2.6 The review period begins in January 2013 when Yasmine was 11 years old. The family had had no recent involvement with specialist services, although Yasmine had been flagged as requiring additional support to manage the transition to secondary school and this support had been put in place. Yasmine, however, exhibited behavioural difficulties from the start of the school year, with reported concerns regarding her being rude and aggressive to staff, fighting and physical aggression with other pupils, and persistently disrupting the class. The school addressed this through detentions, time out of the classroom and at the beginning of January support was sought from the early help service and a Common Assessment (CAF)<sup>3</sup> was initiated. Work has been undertaken in Hartlepool to increase support around transitions and this continues to evolve.
- 2.7 At this time, Yasmine's father made contact with the police to ask that Yasmine be removed from the family home because of what he described as her aggressive and disruptive behaviour. The police attended and Yasmine reported that she had been sent out of the home after an argument with her father. The police concluded that the parents were struggling to parent Yasmine and suggested professional help.
- 2.8 Mother went to the GP who made a referral to CAMHS<sup>4</sup>. CAMHS offered Yasmine and her parents an appointment which Yasmine and mother attended. An assessment was undertaken which concluded that Yasmine did not have mental health difficulties and they were signposted to other support services such as the Children's Hub in Hartlepool<sup>5</sup>.
- 2.9 Two weeks later Yasmine made an allegation to school that her father had physically assaulted her and a referral was made to Child and Adult Services. This resulted in an initial assessment.

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<sup>3</sup> The **Common Assessment Framework (CAF)** is a process for gathering and recording information about a child for whom a practitioner has concerns in a standard format, identifying the needs of the child and how the needs can be met.

<sup>4</sup> CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

<sup>5</sup> The Children's Hub provide information, advice and guidance on services and support for children, young people and families.

- 2.10 Three assessment processes took place over a four week period without there being any cross referencing between them. This meant that there were contradictions in the information collected. For example, in the CAF mother denied any issues regarding domestic abuse, but historic concerns of this nature were raised within the initial assessment. All three assessments were overly reliant on mother's stated view of the current difficulties, which were perceived to be the parents' struggles to manage Yasmine's unreasonable behaviour, some differences in parenting styles and the belief that they had "spoilt" Yasmine when she was young, that she struggled with boundaries and was therefore aggressive and hostile. This was accepted uncritically by professionals and this thinking would pervade practice across much of the period of review.
- 2.11 There was insufficient reflection across the three assessments about what might be causing the serious difficulties for a child of 11 about whom there had been few previous concerns. Yasmine's hostility and aggression were noted and CAMHS recommended work to address this, without being specific regarding what this would be. Overall there was no analysis of the meaning for Yasmine of the early signs of anger, hostility and aggression nor an holistic plan to address it and this is discussed in Finding 1.
- 2.12 The conclusion of the CAF/Initial Assessment was that there would be early help support focused on improving parenting, and school would continue to manage behaviour.

### **Early Help: February to September 2013 Yasmine turned 12**

- 2.13 An early help response was provided through a Team Around the School process and the lead professional was a Family Support Worker (FSW). Although the Team Around the School group met on a number of occasions to consider the progress of the services to be offered, there was no formal written plan with agreed goals or reviewing processes. These were early days of the early help process and it is now routine practice that early help plans have goals, objectives, and a focus on outcomes. Services were provided in the form of individual support to mother from the FSW to enhance boundary setting, parenting classes, and sessions on internet safety and sexual exploitation for Yasmine. These were all put in place, but the proposal for family attendance at a group for young people who are violent to their parents could not be organised as no group had been convened to coincide with the referral.
- 2.14 Overall the engagement of mother in individual support was sporadic, father would not attend parenting classes, and although mother and Yasmine did attend, their ongoing conflict was disruptive to others. Yasmine was dismissive and disruptive in the individual support provided regarding internet safety and was asked to leave the group sessions because of her poor behaviour and aggressiveness to her mother. Support from the substance misuse service was also provided, but Yasmine did not engage, and mother/child conflict made progress difficult.

- 2.15 There was a lack of acknowledgement of the limited progress of the early help response and this appears to be in part caused by the lack of a formal plan, but also because there were a number of further crises at this time, none of which led to a review or rethink. This early fixed thinking which was to pervade the professional understanding of Yasmine and her circumstances, and how fixed thinking more generally can be noticed and addressed in a multi-agency context, is discussed in Finding 6.
- 2.16 In April/May 2013, the police were called twice by neighbours because mother and Yasmine were fighting. Yasmine was excluded from school for smoking cannabis, which mother disputed, and there remained concerns from school about Yasmine bullying others and being verbally aggressive to staff. Yasmine confided to the FSW that she had spent a weekend with friends drinking and smoking cannabis and was with a boy overnight, but denied any sexual activity. When this was discussed with mother she was again dismissive, suggesting Yasmine was lying.
- 2.17 In July 2013, a Police Community Support Officer (PCSO)<sup>6</sup> found Yasmine drinking alcohol in the cemetery with other young people. A referral was made to the Anti-social Behaviour Unit<sup>7</sup>. Yasmine signed an Acceptable Behavior Contract<sup>8</sup>, which she complied with completely over the next 6 months. This highlights the importance of clear links between the Community Safety Partnership and child safeguarding processes which is discussed in Finding 5.
- 2.18 These were all early signs of the significant difficulties that Yasmine was experiencing and which were suggestive that this was more than as a result of a lack of boundaries or being spoilt at an early age. At this time a negative view of Yasmine emerged amongst the professional group promoted by the views of mother and father and reinforced by her bravado. This issue of parents placing the blame disproportionately on young people for family problems, the likely consequences for the adults use of the services offered, and the negative impact on the young person is discussed further in Finding 3.

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<sup>6</sup> Police Community Support Officers are members of support staff employed, directed and managed by their Police Force. They will work to complement and support regular police officers, providing a visible and accessible uniformed presence to improve the quality of life in the community and offer greater public reassurance.

<sup>7</sup> The Antisocial Behaviour Unit (ASBU) is a team of experts who work with the police and other agencies deal with cases of antisocial behaviour.

<sup>8</sup> The Acceptable Behaviour Contract is a formal written agreement where a young person agrees that they will not display or act in an antisocial manner in future circumstances and ABC's are important in encouraging children and young people/adults to take on more ownership and responsibility of their own actions

## Further Assessment September to November 2013

- 2.19 In mid-September, mother reported Yasmine missing to the police. Initially, mother said that Yasmine had gone to her maternal grandmother's overnight and when mother had phoned in the morning found she was not there. The police took this seriously as a possible child abduction, and radio and newspaper adverts were produced. Yasmine returned home the same afternoon and refused to say where she had been. Yasmine reported that there had been an argument at home and she had left. Mother believed that she had gone to maternal grandmothers but did not check her whereabouts until the following morning. The police were concerned about this behaviour, which was indicative of neglectful care, and appropriately made a referral to Child and Adult Services. At this time Yasmine also reported to her parents that she had spent the night at a friend's house in the bedroom of the brother who was in the same room. This was shared with the FSW and Yasmine denied this had happened. This was investigated, but no evidence that this had happened emerged. Yasmine did not engage in any discussion about this, but the FSW ensured that this information was shared as part of the subsequent referral to Child and Adult services.
- 2.20 The social worker who received the referral from the police contacted the FSW who said that she had already organised a meeting to discuss current concerns and had invited social work representation. It was agreed that this was an appropriate way forward. However, there was a lack of clarification about what type of meeting was necessary. The FSW was holding an emergency review of the early help response in the context of current concerns. This was appropriate, but there was additionally a need for a strategy meeting/discussion<sup>9</sup> with a specific focus on whether child protection enquiries were required and whether any criminal investigation was necessary regarding the concerns about possible underage sexual activity (the second concern in a few months) with a child under 13, for which Yasmine was not prepared to provide any further information.
- 2.21 The meeting that actually took place was attended by all involved agencies except a social worker - caused by the lack of clarity about the purpose of the meeting. Significant concerns were shared, including Yasmine's drug and alcohol use, her reported aggression and disruption at home and school, physical abuse by father and both parents' minimisation of these concerns. This all added up to significant concerns about adolescent neglect and possible emotional abuse, but this was not articulated. Although it was agreed that an immediate referral to Child and Adult Services was required, the lack of analysis of the available information meant that these signs of neglect were lost in the subsequent crises that occurred. This issue of the lack of articulation of concerns regarding adolescent neglect is discussed further in Finding 1. The referral was accepted and it was agreed that an

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<sup>9</sup> A **Strategy Meeting** (sometimes referred to as a **Strategy Discussion**) is normally held when there is an indication that a child has suffered or is likely to suffer Significant Harm. The purpose of a **Strategy Meeting** is to determine whether there are grounds for a Section 47 Child Protection Enquiry.

Initial Assessment<sup>10</sup> would be undertaken and that there would subsequently be a Core Assessment<sup>11</sup>.

2.22 At this time, father called the police to report Yasmine being aggressive and causing damage at home. She was arrested and taken to the police station. The youth offending service allocated a worker at this time under its prevention service, which responds to young people at risk of entering the criminal justice system, and an assessment was started. This happened separately from all the other work, and there was little liaison between the youth offending worker and other agencies. This separation of potential action to address destruction of property and hostility from a more holistic approach is explored in Finding 1.

### **Further Assessment: September to November 2013**

2.23 As with the provision of early help services, the progress of the assessment was hampered by a number of crises:

- There was significant reported conflict and aggression from father to Yasmine – she reported him dragging her off the toilet by her hair.
- Father reported aggression and destruction of property by Yasmine and as a result of him calling the police she was arrested for breach of the peace but father refused to press charges.
- Yasmine was reported missing overnight (she was 12 years old) and attending parties where alcohol was being consumed.

2.24 Support was put in place by the specialist edge of care team (see Finding 4 for a description of this work) whose remit was to prevent family breakdown; the work of the early help FSW ended at this point.

2.25 The Core Assessment was completed in November and identified significant concerns regarding the parents not policing Yasmine's Facebook use and ensuring safety, not addressing Yasmine's weight and ensuring her well-being, using physical force/physical abuse and possible parental alcohol misuse; however, the conclusion was that the parents needed support under the auspices of a child in need process rather than that there was significant evidence of adolescent neglect, with attendant emotional abuse and physical abuse which required a child protection response. This issue of the lack of articulation of adolescent neglect is discussed in Finding 1.

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<sup>10</sup> The **initial assessment** was a short **assessment** of a child referred to Children's **Services** focusing on establishing whether the child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm and further, more comprehensive (a Core Assessment) is needed. Practice has now changed and there is now a single assessment in place nationally.

<sup>11</sup> A **core assessment** is a structured, in-depth **assessment** of a child or young person's needs where their circumstances are complex. Practice has now changed and there is now a single assessment in place nationally

- 2.26 The subsequent plan was focused disproportionately on action to be taken by Yasmine rather than her parents, and it did not make clear that the expectation was that the parents would support her to address some of the difficulties she was experiencing. This lack of clarity made it difficult to challenge the lack of support they actually provided, and reinforced their sense that they had no need of any services. The focus was on school support to address her behavioural difficulties, continued work with the substance misuse worker, continued engagement with youth offending service, a referral to an eating programme and referral to a specialist agency to address the impact of sexually harmful behaviours on her.
- 2.27 The issue of the cause of Yasmine’s aggression and hostility was not addressed and was not contextualised alongside father’s aggression and possible physical abuse of Yasmine. The importance of a holistic approach to adolescent behaviour that is likely to be a manifestation of harm or trauma is discussed in Finding 1.
- 2.28 The analysis remained that the core issue here was one of the parents struggling with boundaries, providing inconsistent parenting and intensive parenting support was to be provided. There was a lack of reflection that this analysis was not supported by the evidence of escalating conflict and coercive parenting. This pattern of fixed thinking and its influence on practice is discussed further in Finding 6.

### **Escalating Concerns leading to Strategy meeting: November – December 2013**

- 2.29 A few days after the core assessment had been completed and the child in need plan<sup>12</sup> put in place, there were further escalating concerns. Evidence emerged that Yasmine might have been coerced into underage sexual activity; she would provide no information except that it had not happened, and police inquiries were inconclusive. Yasmine was also reported missing on a number of occasions, and there was continued conflict between Yasmine and her father. Appropriately a Strategy meeting was convened, child protection inquiries initiated and an Initial Child Protection Conference (ICPC) planned.
- 2.30 The parents told professionals at this time that they could no longer cope with Yasmine’s behaviour. A plan was put in place for Yasmine to spend time during the week (usually two days) with a support foster carer and to be taken out twice a week by a caring support mentor. Although this was a practical solution at this time to the threat of family breakdown, it appears to have caused the parents’ views about Yasmine as “*the problem that needed fixing*” to be further entrenched. The lack of a placement agreement for this type of placement meant that the parents perceived the purpose to be to “*show Yasmine how to behave*”. The focus and purpose from the perspective of professionals was not clear, beyond providing all involved with

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<sup>12</sup> A child in need plan should be clear about what the assessment (Initial or Core) has identified as needing addressing, which agencies will provide services and what is expected of the parents/caregivers and the child or young person. <http://www.legislation.gov.uk/ukpga/1989/41/section/17>

a break and to ease high levels of tension. The issue of professionals not challenging parents when they ask for young people to come into care, when those parents have not engaged in services designed to support and improve family relationships, is discussed in Finding 4.

- 2.31 The child protection enquiries<sup>13</sup> made use of the information collected as part of the Core Assessment and also historical issues emerging from the police information regarding historic domestic disputes between mother and father and mother's past arrest for being drunk and disorderly. It was sensible to use existing information, but what was required was a new analysis, focused on the risk of significant harm to Yasmine and an exploration of the causal factors underpinning this. This did not happen, and the issue of father's aggression towards Yasmine, and the previous historic domestic disputes, were not connected with Yasmine's own difficulties with managing her own anger and aggression or early sexual behaviour in the community – alleged and unproven, but worth exploring in the context of her wellbeing. There was a lack of a holistic analysis of the connections between these difficulties.

#### **Initial Child Protection Case Conference and protection plan: January 2014**

- 2.32 It was appropriate that an Initial Child Protection Case Conference<sup>14</sup> was convened and this took place in January 2014. Professional attendance was good, and many reports provided. This was an opportunity to take an holistic, multi-agency perspective regarding Yasmine's circumstances. However, the conference minutes state that the reason for the conference was said to be Yasmine's "risk taking behaviour", and concerns were expressed about her alcohol and drug use, being "sexually active" and her worrying use of Facebook. This meant that the major focus was again singly on Yasmine rather than her experience of adolescent neglect and this was reflected in the multi-agency outline child protection plan, which focused on Yasmine's responsibilities rather than balancing it with the need for support from, and change by, the parents.

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<sup>13</sup> Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of [significant harm](#). This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47 investigation" after the section of the Children Act 1989 which sets out this duty. The purpose of the enquiry is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

<sup>14</sup> An Initial Child Protection Case Conference is a multi-agency meeting often attended by family members which takes place within 15 days of the strategy discussion/meeting if as a result of the child protection enquiries a child or young person is considered to be at risk of significant harm. Those at the meeting (conference) discuss the risk to the child and decide what needs to happen to make sure they are kept safe.

- 2.33 There were additionally concerns regarding Yasmine being found with a group of youths causing damage in the community but this was not further discussed, nor was a plan formulated regarding what risks this might pose to her and others. This highlights the importance of clear links between the Community Safety Partnership and child safeguarding processes which is discussed in Finding 5.
- 2.34 Concerns about the parents' alcohol use was discussed, and disputed by mother who also questioned why the information regarding historical domestic disputes was relevant, or the recent conviction for being drunk and disorderly. These were relevant concerns as they are all issues that are known to have the potential to impact negatively on parenting capacity, and children's outcomes. The fact that mother focused on refuting these concerns, rather than addressing the many worries about Yasmine's safety and wellbeing, was not addressed at this point as further evidence of neglectful care which was not clearly enough articulated.
- 2.35 Overall these parenting capacity issues were not considered again in any depth again in a multi-agency context. The child protection plan required the parents to accept support to enable them to put in place clear boundaries and to engage in a process to explore family history and they were to be supported through the use of respite foster care; again the purpose of this was not made clear, and the parents continued to believe that it was to teach Yasmine to behave better, and to give them a break (from what is not made clear). At this point the exploration of Yasmine's significant difficulties remained focused on what was described as her own risk taking behaviours and lack of boundaries, without there being any discussion regarding whether these sufficiently accounted for the seriousness of the issues raised for a 12-year-old girl. There was no connecting up of historic evidence of domestic abuse and conflict between the parents, fathers physical abuse of Yasmine and her difficulties in managing her own anger and verbal aggression. This lack of a holistic and joined up approach is discussed in Finding 1.
- 2.36 Yasmine was made subject to a plan for neglect, without it being clear what this actually meant, what risks the neglect was causing, what change was required from the parents and what were the improved outcomes and safety the conference was looking for.

### **Initial Child Protection Plan: January – March 2014**

- 2.37 In the three months' period from the Initial Child Protection Conference to the review conference in March 2014, professionals worked hard to progress the child protection plan, with limited success because of poor engagement by the parents and Yasmine. The parents attended the first multi-agency Core Group and said they did not agree with the plan, and although mother engaged in part, father refused to engage at all. Yasmine continued to see the substance misuse worker, but did not take the sessions seriously. Yasmine started to see the sexual exploitation worker, but complained of being bored; she also attended the sexual exploitation group once and was

asked to leave because of her aggression and hostility. The school nurse tried to engage Yasmine in a healthy eating programme, but was unsuccessful. Yasmine's behaviour at school remained of concern and they described her as being aggressive, hostile, and verbally abusive.

- 2.38 Yasmine also was found again with alcohol in the community, and signed an anti-social behaviour agreement. She was reported missing by her parents on three occasions, and was returned home by the police. On one of these occasions she was away overnight. Yasmine did continue to spend time with the respite foster carer and the support worker and this was the only part of the plan that was working.

### **March 2014: First Review Child Protection Conference**

- 2.39 The review conference was held in March 2014. This was an opportunity to review the progress of the child protection plan, and the mixed progress was acknowledged without there being any plan of action to address it or mother being asked to explain her lack of agreement with the plan. Recent information shared by Yasmine about her parent's alcohol use and her views about its negative impact on family life were discussed; the parents continued to strongly deny that this was a concern and there was no plan made to address this. The information made no impact on the current analysis of the family difficulties or the child protection plan, and the emphasis remained on what was described as Yasmine's "risk taking behaviours" and being "spoilt" by her parents. This lack a refinement of the professional approach and multi-agency plan in the face of new and emerging information and lack of progress in addressing the concerns is discussed in Finding 6.

### **March 2014 –December 2014**

- 2.40 Over the next six months' professionals continued to take forward the child protection plan, hampered by a number of issues which suggested a continued deterioration in Yasmine and her family's circumstances. The parent's engagement with the proposed work remained variable; father continued not to engage at all, mother partially engaged, but both ceased to attend the multi-agency Core Groups<sup>15</sup>. The parents spent time out looking for her when she went missing at night, and expressed frustration and anger at having to do this.

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<sup>15</sup> This is a small group of professionals and family members who meet together after a child protection conference to decide how best to implement the outline child protection plan, drawn up at the child protection conference. Along with the social worker, the core group fills out the details of the plan, what exactly will be done, by whom and by when. It will also make sure that the plan is carried out.

- 2.41 Yasmine began to be inconsistent in staying with the respite foster carer and meeting with the support worker. She continued to be reported missing to the police from home and newly from the respite foster carer's home, and refused either to say where she was going or to take seriously professional concerns about her safety and wellbeing. The foster carer and the police followed the clear procedures in place regarding young people missing from home, but they also felt frustrated at not being able to prevent it.
- 2.42 There continued to be aggression and conflict; Yasmine reported to her social worker that her father had hit her; this was subject to a further strategy meeting and investigated. Father denied it and no further action was considered necessary because Yasmine was already subject to a Child Protection Plan. Mother reported to the police in May that she had been assaulted by Yasmine who had caused damage to the home; mother did not want any action taken. Yasmine continued to attend offsite school provision, and to be difficult and disruptive. A plan was formulated to enable her to return to mainstream school in September 2014.
- 2.43 In June 2014, Yasmine was reported missing by her father after they had an argument. When she was brought home by the police she told her father that she and a friend (not Olivia) had been at Carol's<sup>16</sup> house and there had been an argument. The police interviewed the friend who denied ever having been at the house and Yasmine said she had made the story up so as not to get into trouble with her father. Carol was not interviewed and so the potential risk posed by young people to a vulnerable adult were not assessed or considered and this is addressed in the concurrent Safeguarding Adult Review (SAR).
- 2.44 In early September, a further multi-agency Core Group meeting was held and the professionals present considered that things had been more settled over the summer and Yasmine had recently returned to school. Those present believed that progress had been made and it was agreed that at the next case conference Yasmine could be stepped down to a child in need plan. The Vulnerable, Exploited, Missing and Trafficked group<sup>17</sup> (VEMT) meeting was told that Yasmine was making progress and therefore she was removed from these discussions. This sense of progress was over-optimistic and influenced by the fixed thinking discussed in Finding 3.
- 2.45 A few days after the Core Group there were a number of familial crises. Yasmine reported to the police that she had been again assaulted by father, but she did not want to take any further action and professionals were concerned that she did not seem to be taking this incident seriously. Father dismissed the allegations and told the police that Yasmine had done this to get him into trouble. The professional response was to enable Yasmine to stay with the respite foster carer; this provided a short term solution to the

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<sup>16</sup> Carol was the woman who was subsequently murdered.

<sup>17</sup> VEMT stands for Vulnerable, Exploited, Missing, Trafficked and is a multi-agency meeting convened to understand and address the issues relating to children who are at risk due to going missing from home and care and / or are at risk of sexual exploitation and trafficking.

family tensions, but did not address the longer term issues regarding neglect and the blaming of Yasmine for family difficulties.

- 2.46 At this time, Yasmine was reported missing to the police by the respite foster carer and there were concerns that she might have been sexually abused in the community. Yasmine refuted this and she refused to say where she had been or who with. She was reported missing to the police on a number of occasions over the next four weeks and returned home.
- 2.47 Yasmine was also excluded from school and when she returned she was immediately escorted off the premises for disruptive behaviour. It was agreed she would permanently attend the offsite provision at the Learning Support Unit (LSU).
- 2.48 The second review child protection conference took place in September 2014. This could have been a further opportunity to consider current concerns and difficulties and review the progress of the child protection plan. The conference was well attended, and a number of comprehensive reports were provided; it was a brief meeting only lasting 30 minutes. The analysis did not change in the light of the escalating concerns and emerging information about family life from Yasmine.
- 2.49 The conference notes suggest that there was a sympathetic view taken to mother who is recorded as saying "*Yasmine has hurt me so much, it will be hard to forgive her*". The parents were described as passively helpless in the face of Yasmine behaviour, rather than failing in their duties to provide warm, consistent and authoritative parenting. There is a summary statement in the case conference minutes which suggests that "*Yasmine's parents feel powerless to parent and would like her looked after*". This was not challenged and reinforced the continued view that this was an issue regarding a problem adolescent who put herself at risk, rather than more deep seated issue connected to poor family relationships and neglect and the parents' failure to keep Yasmine safe. This is further discussed in Findings 1 and 2.
- 2.50 During the conference mother spoke about feeling unable to cope with Yasmine and that they wanted her to be placed in foster care. This was not challenged as an inappropriate response, the likely impact on Yasmine was not discussed and neither was the parents' lack of engagement in the extensive services designed to help them cope and improve their parenting addressed. This is discussed in Finding 5.
- 2.51 Over the next month Yasmine was reported missing on a number of occasions and her parents called the police reporting that she was assaulting them when she returned home. The parents spent time out looking for Yasmine – often late into the night. The offsite school provision found Yasmine to be difficult and disruptive and she often went to sleep because she was out all night. The edge of care worker spent a lot of time with Yasmine, whom she was supporting most afternoons.

- 2.52 On the 22 October 2014, mother said she could no longer cope and asked for Yasmine to come into care. Yasmine was extremely upset and emotional when she was told. The issue of addressing the responsibilities of parents and their requests for children to come into care, often abrogating their own responsibilities and not acknowledging the lack of effort made to create change is addressed in Finding 5.
- 2.53 A foster placement was agreed for four weeks whilst further assessments were undertaken. The placement lasted for just over two weeks and broke down due to Yasmine's difficult and disruptive behaviour. During this time, Yasmine began to open up about her parents' drug and alcohol use and she was supported during this time by the edge of care worker and the staff at the offsite education provision. It became clear that Yasmine felt she was in a difficult position suggesting that she should not share her parents' problems.
- 2.54 In November there was an incident where the police were called regarding an allegation that Yasmine and Olivia had stolen a mobile phone from a 15-year-old but she withdrew the allegation as she did not want to take any further action; this incident lacked sufficient evidence for action. This was the first occasion on which Yasmine and Olivia were known to have been together. Yasmine denied it had happened. Yasmine was discussed at VEMT (Vulnerable, Exploited, Missing and Trafficked) Group and was agreed to be high risk and the importance of a new placement and the planned work with the parents acknowledged.
- 2.55 Yasmine returned home for two weeks whilst another foster placement was sought. During this time she continued to be reported missing to the police on many occasions. There were high levels of concern regarding possible underage sexual activity which were investigated by the police, but a lack of evidence and the poor cooperation of Yasmine meant no police action could be taken.
- 2.56 Significant work went into finding an appropriate foster placement for Yasmine at this time, an extremely difficult task because of the needs of this group of vulnerable adolescents. At the beginning of December, a new foster family was found and they were made well aware of Yasmine circumstances, her vulnerability, poor family relationships and her difficult and disruptive behaviour. The foster parent was very positive and caring, put appropriately put boundaries in place which were initially successful. At the end of the first week Yasmine went missing, and both foster parents went to considerable lengths to find her and encourage her to return to the foster placement. They were ultimately unsuccessful and Yasmine was brought home in the middle of the night and the next day was arrested on suspicion of the murder of Carol and remanded into custody.

## THE FINDINGS IN DETAIL

- 3.1 The aim of a Learning Together case review is to use a single case as a 'window on the system', to uncover more general strengths and weaknesses in the safeguarding system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case specifics, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the reconstruction of the unfolding case, documentation and an examination of the key practice episodes.
- 3.2 The second step is to consider whether the issue observed in this case is 'underlying and that it is not simply a 'quirk' of the case. The third step is to consider how geographically widespread and prevalent the issue is within the national system. Sometimes it is not possible within the scope of a review to collect this data. The sources for these steps will be information from the review team and case group; any performance data; national research and other reviews in a variety of combinations.
- 3.3 The last step is to articulate why this issue matters and what are the risks to the safeguarding system. The findings reflect the wider national context and challenges for safeguarding children and questions are formulated for the SAB.
- 3.4 This review has prioritised six findings. They are related to the needs and circumstances of young people who have experienced harm either in their formative years or at the onset of adolescence and who present a range of complex behaviours, which often exacerbate existing harm. They are all interlinked, and point to the national challenge of providing an effective service and response to this critical group of young people – who will be the adults of the future.

Findings	Typology
<p><b>Finding 1: There is an insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 2: Professionals working within the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 3: Parents blaming young people is not sufficiently recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.</b></p>	<p><b>Family – Professional interaction</b></p>
<p><b>Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 5: There is a disjoint between both children’s and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.</b></p>	<p><b>Management system issue</b></p>
<p><b>Finding 6: Effective single agency and multi-agency supervision and effective processes to promote multi-agency reflection are necessary to pick up fixed thinking in a particular case. Although there has been action in a number of agencies to promote this approach to complex work it can be further strengthened, including by developing arrangements which enable multi-agency groups to come together.</b></p>	<p><b>Human reasoning: cognitive and emotional biases</b></p>

### **3.5 Finding 1: There is an insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm**

#### **What is the issue?**

- 3.5.1 At a national level there is significant recognition across practice, policy and research networks of the corrosive and negative impact of serious and significant neglect on children's wellbeing and outcomes across the developmental lifespan into their future as adults<sup>ii</sup>. This had led to an increased practice focus on the development of effective identification processes, assessment frameworks and tools and interventions that will address neglect and break the long cycle that is often seen from generation to generation. Much of this work has focused on young children because of their vulnerability and the need for sensitive and attuned parenting in the early years.
- 3.5.2 In comparison there has been limited research and policy development in the field of adolescent neglect (see Stein et al<sup>iii</sup> and the Children Society<sup>iv</sup> for exceptions to this). This lack of attention may be due to the perception that adolescents are less vulnerable and less reliant on good quality parental care. The evidence is clear that this is not the case.
- 3.5.3 Adolescence is a time of rapid development, including brain and cognitive development, physical growth and sexual maturity as well as the development of moral reasoning, pro-social behaviour and empathy for others. Adolescents need effective, warm and authoritative parenting to successfully complete these developmental milestones, and the consequences of not receiving good quality parenting is deficits in some or all of these areas. The ramifications and outcomes for adolescents who have been being neglected over the long term, or at the start of adolescence have been covered in Finding 1, but are far reaching and have consequences for the successful transition into adulthood. This group is over represented in adult mental health services prisons, unemployment and homelessness<sup>v</sup>.
- 3.5.4 It is essential that professionals are equipped to recognise, assess and intervene effectively. This requires a focus on the quality of care provided across the developmental domains of physical care, health education, supervision and safety as well as emotional care, including the development of a moral compass and pro-social behaviour.
- 3.5.5 Gaps in the care provided in all these areas should be considered as "global" neglect and requiring serious attention. Understanding which areas of a young person's life are most affected provides both a pathway to appropriate interventions and protective activities, but may also help to understand current complex and difficult behaviour. For example, if a young person is experiencing poor emotional care, they are unlikely to have well developed empathy skills or know how to engage in services. Young people whose needs for safety and supervision are not met are likely to be those who run

away, or engage in anti-social behaviour. Continued neglect will mean that they are not given the internal structures to enable them to address these behaviours.

- 3.5.6 Alongside a detailed understanding of the quality of care across the developmental domains, it is also essential that professionals assess parental attitude. Neglect is often assumed to be an act of omission, with parents /caregivers struggling to provide effective care because of their own impoverished and deprived circumstances. This is very often the case and this knowledge provides a pathway to appropriate support and intervention. However, for some parents or caregivers neglect is an act of commission; they take no responsibility for the quality of care they provide and are often hostile or dismissive to advice or interventions. These parents do not agree with professionals' concerns and do not engage in services designed to improve their children's circumstances. These render those services ineffective and require robust challenge.
- 3.5.7 The lack of responsibility on the part of parents often tips into blame. Children and young people are held responsible for the poor quality care they receive, with parents citing their young people as too difficult or too damaged to care for and this attitude has a powerful impact on young people's lives – something touched upon in Findings 3 and 4. This issue of the connectedness between what care is provided and the parental attitude towards it receives insufficient attention in current practice. It is clear that we are working across a continuum of parental attitude, where some parents know what is important and get on and meet their young people's needs; some parents know what is important, but their own personal and family circumstances can get in the way of providing this; some parents struggle to know what is important and how to provide it – but some parents are both dismissive of the needs of young people and are hostile to advice about it. In order to intervene effectively and address the emotional needs of vulnerable and troubled adolescents we need to know which type of parent we are dealing with and what action would support change.
- 3.5.8 Underlying all of this is the importance of trying to establish why parents and caregivers neglect their young people and, having established this, attention needs to focus on addressing those primal issues, rather than only dealing with the consequences such as addressing poor physical living standards. If the primary cause is not assessed and addressed, the pattern will continue.
- 3.5.9 Adolescent neglect is a complex area of practice which requires the workforce to be equipped to identify it, seek out the causes and address the quality of care and parental attitude towards the provision of that care – alongside linking that care to the presenting problems of young people in order to provide a holistic approach.

### **How did it manifest in this case?**

3.5.10 It remains unclear what level of care Yasmine received in her early years, and she had no contact with services until she was 11 years old. At this time, there was growing evidence of harsh and critical parenting, accompanied by conflict and physical abuse. Her parents talked of struggling to manage her behaviour, and yet would not engage fully with the services designed to help.

3.5.11 Yasmine was made subject to a Child Protection Plan for neglect, but the focus was disproportionately on her and the changes she needed to make, rather than a detailed look at what neglect looked like across her developmental needs (her health needs would have stood out – alongside education). What her parents needed to do to change their approach, what was causing the neglect in detail or how their attitude, which was one of blame, was likely to impact on the efficacy on any support offered.

### **How do you know it is underlying?**

3.5.12 The Review Team recognised that adolescent neglect was a significant issue in their work. Research and the Ofsted analysis of serious case reviews also suggest that adolescent neglect is a significant national issue.

### **How prevalent is the issue?**

3.5.13 Overall the national evidence suggests that neglect is a significant category of maltreatment both during childhood and adolescence.

### **Why does it matter?**

3.5.14 Adolescent neglect is a significant issue which has a profound effect on young people's lives. Recognising and responding to adolescent neglect is a critical part of addressing the many areas of harm that young people are vulnerable to, and an ineffective response leaves young people at risk of significant harm.

#### **Finding 1**

##### **Questions for the Board to consider**

- How will the Board seek assurance that adolescent neglect is recognised and addressed effectively by agencies?

- 3.6 Finding 2: Professionals working within the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.**
- 3.6.1 This finding concerns the extent to which current systems are sufficiently sensitive to the needs of vulnerable adolescents, able to recognise the impact of long and short term harm, abuse and neglect and to recognise that this harm and abuse is likely to cause a range of behaviours, often described as problematic, but which are in fact the manifestation of trauma and need treating in a holistic or trauma focused way.
- 3.6.2 There is considerable national evidence from research<sup>vi</sup>, inspections and serious case reviews<sup>vii</sup> that the multi-agency safeguarding system and the professionals that work within it struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs.
- 3.6.3 Adolescence is a time of considerable biological, psychological and social change which makes young people more likely to engage in experimentation, risk taking and impulsive behaviour. Recent neurological research<sup>viii</sup> suggests that this is a normal and important stage of development in preparation for adulthood. These behaviours can cause tensions and difficulties with parents, family, school and the community, but are usually successfully negotiated through support from friends, family, services and the community.
- 3.6.4 Adolescents who have been exposed to a range of risk factors in the long term, such as neglect and abuse, parental substance misuse, domestic abuse and poor parental mental health are likely to struggle to manage this transition<sup>ix</sup>. It is also clear that for some adolescents, abuse and neglect starts at this time, and the evidence is that this is equally damaging to the individual<sup>x</sup>. There is considerable evidence of the long term negative impact on outcomes and wellbeing of this harm in all areas of a young person's life. The impact of the abuse and adversity means that the personal tools required to cope with these changes, such as self-efficacy, good self-esteem, effective problems solving skills - in essence, resilience - are eroded in the context of poor, critical and harmful care.
- 3.6.5 It is therefore unsurprising that this harm is also connected to the risk of sexual exploitation; underage sexual activity; sexually harmful behaviours; peer abuse; substance misuse problems; self-harm; suicidal ideation and anti-social behaviour; aggression; violence and criminality.
- 3.6.6 Despite this evidence, adolescents may be considered as more robust and resilient than younger children and less dependent on parents and family, and therefore are less likely to be subject to formal safeguarding processes; although this is changing. They are also often viewed as independent from their caring relationships, parents and family and seen to be making their

own choices. This belief in total self-determinism can lead to professionals being overly judgmental or condemnatory of behaviour which adolescents often feel they have no control over, lacking processes to help them develop control, or an accurate moral compass. This is the impact of harsh, critical and neglectful care. There is a paradox here, covered in Finding 3, that young people can end up feeling blamed for the lack of care provided to them, responsible for being “difficult” and “damaged” and this can be unintentionally reinforced by professionals. This is a self-reinforcing negative cycle which needs addressing.

- 3.6.7 It is important for these vulnerable adolescents that their complex behaviours are understood as a consequence of harm, a manifestation of trauma, and the primary goal is to understand the root cause, to address it and rebuild the context of warm caring relationships and personal skills required to foster resilience. This is complex for professionals who are often presented with a series of crises, and adolescents who are reluctant to engage, and who are on the face of it dismissive of concerns. It is unsurprising that a fragmented response emerges, as professionals have to deal with the outcome of the abuse, and deal with the crisis.
- 3.6.8 This means that all professionals require good support to carry out this work, and effective supervision to be able to step back and consider the whole picture for an adolescent as well as processes which enable complex cases to be discussed in a multi-agency context.
- 3.6.9 Adolescents who have been harmed and abused unsurprisingly find it difficult to trust adults and need opportunities to build good quality relationships with a small group of professionals. They also need services which take a sophisticated approach to issues of engagement, recognising that providing a whole host of services at the same time is not helpful. In this context adolescents are often described as “not engaging” or “cannot engage”; when what is required is an approach that asks, “What have we (the professionals) done to enable them to engage and what could we do differently?”

#### **How did it manifest in this case?**

- 3.6.10 Yasmine was not known to any specialist services until she made the transition to secondary school. She became very quickly a cause for concern regarding her behaviour, attitude and hostility and aggression, alongside bullying behaviour. Processes were put in place to address these concerns but, as is addressed in Finding 6, there was little reflection on whether the explanation provided by mother that she was “spoilt” was sufficient.
- 3.6.11 Over time, it emerged that she had lived in a household where there were concerns about conflict requiring police attendance, and that there were underlying issues regarding alcohol use, which were denied by parents, but expressed as important by Yasmine. This indicated that she had been living in circumstances where her needs had not been of primary concern.

- 3.6.12 This growing recognition did not influence the response which remained the same. She was provided with a range of services to address the different problems she was to be experiencing, such as misusing drugs and alcohol, running away from home and allegations of early sexual experiences. Consequently, this brought her into contact with many different professionals, and there was no reflection on whether given her experiences of poor parental care she was likely to be able to engage with or trust a large group of adults.
- 3.6.13 Yasmine's difficulties were not seen in the context of parenting which was, at times, hostile, physically abusive and blaming.

#### **How do we know it is an underlying issue?**

- 3.6.14 Nationally<sup>xi</sup> it is reported that resources have been redirected and youth work services have been cut. This, alongside an assumption that adolescents have a greater resilience to the impact of abuse, has left a gap that leaves adolescents without a system that can adequately respond to their complex and differing needs.
- 3.6.15 The case group of professionals who provided services to Yasmine spoke of feeling like their work was crisis driven. They considered that in the pressure of dealing with crises such as running away, they had little time to step back and consider the bigger picture. Although the review found that most professionals received supervision, this did not overall serve to challenge the notion of "difficult adolescents" and there was also an acknowledgement that professionals needed more knowledge regarding trauma related care.

#### **How prevalent and widespread is the issue?**

- 3.6.16 This is not just problematic locally. The recent report by the NSPCC<sup>xii</sup> highlights that child protection processes and procedures tend to be designed for work with young children in the family context. Work by Research and Practice<sup>xiii</sup> and the Children Society<sup>xiv</sup> suggest that adolescents need a more sophisticated model of risk and prevention.

#### **What are the implications for the reliability of the safeguarding system?**

- 3.6.17 Whilst services continue to be fragmented responses to particular needs of the adolescent, as opposed to a service designed around their circumstances and emotional developments, it is likely that professionals will continue to experience difficulty in reaching out to adolescents at risk of significant harm. The consequence of this is that there will continue to be concern regarding sexual exploitation, substance misuse and poor mental health.

## **Finding 2**

### **Questions for the Board to consider**

- How will the Board support its partner agencies to develop the multi agency workforce to be able to respond to the holistic needs of adolescents rather than relying on presenting problems in decision making forums?

- 3.7 Finding 3: Parents blaming young people is not sufficient recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.**
- 3.7.1 If young people are to develop and grow successfully into adulthood they need and deserve sensitive caregiving, where secure and loving attachments are fostered, where love and care is provided and children are enabled to experience empathy and are treated fairly and justly. This is the springboard from which children learn these characteristics themselves and this should enable them to negotiate school life and adulthood. This does not mean that parents need to be perfect, but there needs to be recognition that some adult issues can impact negatively on children, and parents/carers need to be able to take advice or reflect on the impact of their behaviour or choices on their children. Most parents/carers do this.
- 3.7.2 Parental attitudes to young people which are about blame, harsh and critical care and scapegoating are recognised as a key indicator of emotional abuse<sup>xv</sup>. Emotional abuse has the capacity to impact negatively on children’s development in the short and long term<sup>xvi</sup>.
- 3.7.3 Parental blame, in the context of adolescent neglect has the potential to undermine helpful interventions because of parental denial of their own responsibility to change. It is a self-reinforcing process whereby young people who have already experienced harm and abuse, which has undermined their self-esteem and resilience, are now held responsible for that poor quality care. This is something like a cognitive “catch 22” or a “no win” situation which has the capacity to cause great emotional damage and impact on moral development. Ultimately the message here is that these young people do not warrant or deserve appropriate and loving care (see Finding 4).
- 3.7.4 The challenges of addressing the needs of adolescents who present difficulties as a manifestation of their hurt and pain/trauma is that they are not easy to work with or form relationships with. This can lead professionals to empathise with parents, unintentionally colluding with parental blame and reinforcing the young person’s sense of poor self-worth.
- 3.7.5 It is particularly striking that parental blame of children and young people means that the routine repair that goes on in family life when parents get things wrong does not happen. This is critical in the context of abuse, where it is necessary for children and young people to know that what happened to them was wrong (this shapes moral development), that there are consequences when someone harms you or anyone else (this shapes an understanding of right and wrong and a development of the moral compass) and that there is some form of repair, which might be an apology or regret (this shapes attachment relationships); and the absence of incremental reparation will mean that the damage is cumulative over time.

- 3.7.6 It is essential that professionals are equipped to recognise and address the blame of children and young people by parents as emotionally neglectful and abusive, and to recognise when blame of young people for the “risky” or “willful” behaviours becomes part of the professionals’ response. It is also important that professionals notice when young people are harmed where there is no acknowledgment that this is wrong, there are no consequences for those who harmed and no repair of the immediate harm.

#### **How did it manifest in this case?**

- 3.7.7 Yasmine’s parents were very clear that the problems they were experiencing were entirely to do with Yasmine and her difficulties. They accepted no responsibility and refused to engage with services, seeing them as irrelevant and unhelpful. They consistently blamed Yasmine in meetings, and were unable to accept that their parenting style, conflict and physical abuse at home, might have an impact on Yasmine. Parents need to provide warm and authoritative care to adolescents to enable them to negotiate this time successfully, with clear boundaries put in place. Yasmine’s parents said they struggled to impose boundaries but did not accept support for this, and they did not accept that their parenting style needed to change. They blamed Yasmine for their inability to be warm and caring to her.

#### **How prevalent and widespread is this issue?**

- 3.7.8 There is little available evidence regarding how widespread and prevalent an issue this is. It is not part of the processes of auditing cases and the Review Team considered that parents blaming children has been underestimated as a significant factor in assessing parental capacity, adolescent neglect and the extent of significant harm. It has also not been connected to adolescent complex behaviours or recognised as one part of a root cause.

#### **Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

- 3.7.9 Emotionally neglectful and abusive parenting is characterised by routine humiliation and criticism of a child, threatening, using sarcasm to hurt a young person and blaming the young person for the poor quality of care they receive or for deserving not to be protected because they are bad or they deserve to be harmed. In these circumstances, parents’/carers’ attitudes to children are characterised by extreme negativity, where they view children in hostile and rejecting ways, and where parents believe children to be wicked and unlikeable. This is a very serious and significant issue in the context of safeguarding children but is also an intolerable environment for children to grow up in.
- 3.7.10 This creates considerable challenges for safeguarding children and leads to negative outcomes for children. Adolescents who have been emotionally abused over a long period of time are more likely to self-harm and experience depression than children who are not emotionally abused<sup>xvii</sup>. Children and young people who grow up in homes where they are constantly

berated and belittled may experience self-confidence and anger problems. Children who don't get the love and care they need from their parents may find it difficult to develop and maintain healthy relationships with other people later in life. Adults who have been emotionally abused as children have higher levels of depression and health problems compared to those who have experienced a different form of child abuse<sup>xviii</sup>.

- 3.7.11 There are significant consequences for young people if this issue is not addressed. Professionals should be alert to the seriousness of blaming children.

### **Finding 3**

#### **Questions for the Board to consider**

- How will the Board assure itself that member agencies have processes in place to support staff to recognise and challenge inappropriate parental blaming of children and the subsequent emotional impact of this behaviour?

- 3.8 Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.**
- 3.8.1 This finding looks at the way in which parental non-engagement can undermine attempts to ensure that vulnerable young people with complex emotional needs are supported to remain living in their families and communities of origin and where they cannot, the process for bringing them into care does not feel like rejection.
- 3.8.2 One of the key principles highlighted by the Munro review of safeguarding<sup>xix</sup> is that a child and young person's family is usually the best place to be brought up where it is safe and appropriate to do so. This is endorsed by research<sup>xx</sup>, and underpinned by the UN Convention on the Rights of the Child 1989 (UNCRC)<sup>xxi</sup>, the Human Rights Act 2000<sup>xxii</sup> and the Children Act 1989<sup>xxiii</sup>. This emphasis has led to a policy focus on services to support families and prevent family breakdown. This is particularly important for young people who are the largest group in care; in 2015 almost half (45%) of the looked after population was aged 10- 17<sup>xxiv</sup>. Once in care, this age group tends to stay longer and have multiple placement breakdowns, and these young people can oscillate between home and care<sup>xxv</sup>. Unsurprisingly this leads to poor long term outcomes, which are characterised by the potential for sexual exploitation, involvement in crime, poor mental health, reduced life chances, poor health and wellbeing and a higher risk of experiencing difficulties in the parenting task and role<sup>xxvi</sup>.
- 3.8.3 This all points to the need for action to consider how best to meet the needs and improve the circumstances for these often troubled young people. Part of this action has been to try and improve family relationships with a specific focus on services to prevent family breakdown, often known as “edge of care” services. Nationally there is no one way of delivering these services, and there has been a proliferation of methodological and theoretical approaches<sup>xxvii</sup>.
- 3.8.4 The evidence suggests that adopting a holistic family approach is essential. Alongside this there needs to be a good quality assessment to understand in detail the nature of the problems to be addressed, a good analysis of the causal pathways, with a focus on past and present difficulties and clear aims and goals and areas of change for all members of the family. It is essential that services do not collude with parental conceptualisations that the young person is the only problem (see Finding 3), but also to be empathetic to the complexities of parenting troubled young people.
- 3.8.5 In a national themed review of “edge of care” services by Ofsted (2011)<sup>xxviii</sup>, family engagement was considered a critical factor and was found to be

difficult to achieve where there was a lack of warmth or empathy with children.

- 3.8.6 Where parents do not engage with those services designed to support them, it is almost inevitable that family breakdown will occur. It is essential that professionals are proactive in reviewing progress and do not wait to take appropriate action. Far too often it is parents who signal that they can no longer cope and ask for young people to come into care - the lack of professional action appears unintentionally to provide opportunities for parents to very publicly reject or abandon their young people, with attendant consequences for already complex attachment histories.
- 3.8.7 In this situation agencies are placed in a difficult position; they must take action to safeguard the young person. This risks colluding with the parental perception that the young person is unmanageable, and is the problem, and it can imply that it is acceptable to give up your responsibility as a parent. This requires careful thought about how these situations are to be managed, if we are to promote a young person centered process which minimises the potential for re-traumatising vulnerable young people.

#### **How did it manifest in this case?**

- 3.8.8 Extensive support was offered to Yasmine and her parents to help improve their circumstances. They refused to engage and were dismissive of attempts to help.
- 3.8.9 Although there was a Child Protection plan in place for a 12 month period, it was not made explicit that the services were part of a whole systems approach to prevent family breakdown. This was despite significant concerns about both parents and the care they provided to Yasmine, and particularly their ability to keep her safe.
- 3.8.10 In the case conference in September 2014, concerns were expressed about continued conflict at home, that the parents were unable to keep her safe and that concerns regarding alcohol remained. Mother focused the conference's attention on her struggles to parent Yasmine and how "she would never be able to forgive her". The conference minutes suggest there was a high level of sympathy for mother, who said she would be asking for Yasmine to come into care. This was not challenged.
- 3.8.11 Yasmine's parents brought her into the social work office and asked that she be brought into care. She was significantly distressed and expressed her feelings of rejection. Her parents were not able to comfort her and although the professionals that managed these circumstances were supportive of Yasmine, they were insufficiently challenging of the parents and their behaviour and attitude. This meant that Yasmine continued to believe that this rejection was her fault.

### **How do we know it is an underlying issue and not something unique to this case?**

3.8.12 The review team recognised that this was a routine and complex dilemma that they regularly faced when working with vulnerable adolescents with complex needs. The research evidence suggest that this age group is more likely to become subject to voluntary accommodation in a crisis and the Care Inquiry has highlighted the significance of managing these crises well for the future care needs of young people. This was an issue we saw in the lives of both girls subject to review.

### **How widespread and prevalent is it?**

3.8.13 Nationally young people are the largest group in care; in 2015 almost half (45%) of the looked after population was aged 10- 17<sup>xxx</sup>. Once in care, this age groups tends to stay longer, have multiple placement breakdowns and these young people can oscillate between home and care<sup>xxx</sup>.

### **Why does it matter?**

*“High-quality relationships matter more than anything else for children in or on the edge of care ... the quality and continuity of relationships, ... promotes and enhances.” (Care Inquiry<sup>xxxii</sup>).*

3.8.14 The Care Inquiry<sup>xxxii</sup> highlights the importance of all young people having a sense of security, continuity, commitment and identity through childhood and beyond. In this context family are important, relationships are important and attachments are important. The breakdown of family relationships is a critical moment for young people and if they are to be able to build resilience into their future as adults and to form new relationships they need to understand that they are not wholly responsible for family breakdown, and that services are prepared to challenge what is felt by the young person to be rejection and abandonment.

#### **Finding 4**

##### **Questions for the Board to consider**

- How will the Board seek assurance that interventions designed to enable children and young people to remain in their families are appropriately child centred and are planned, implemented and monitored to provide the best possible outcomes for those children and young people?

**3.9 FINDING 5: There is a disjoint between both children’s and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.**

3.9.1 This finding focuses on the importance of good working relationships and information sharing across the Community Safety Partnership (CSP) and services responsible for safeguarding children.

3.9.2 This is important because there are increasing concerns regarding the narrow focus of safeguarding nationally on young people being at risk of harm from their families or alternative caregivers. There is increasing recognition that young people as they develop, spend increasing amounts of time with their peers, their school, and the community and public environments, independently of adult supervision. For some young people, this leaves them at risk of abuse and exploitation and currently this is appropriately the focus of much policy and practice attention.

3.9.3 Less is known in research terms in the context of safeguarding about the risks that young people pose to others in the community, whether this is peer abuse, teenage relationship abuse, harmful sexual behaviours, serious youth violence, or involves sexual bullying and exploiting those who are vulnerable in the community. This is a significant safeguarding issue and clear systems and processes need to be in place to address these concerns, map young people and their connections and consider how existing fora can address these concerns. The University of Bedford has produced a recent toolkit that aims to support practitioners to recognise how social environments and extra-familial relationships are relevant to safeguarding adolescents.

**How did this manifest in the case?**

3.9.4 There were ongoing concerns regarding Yasmine’s vulnerability in the community when she was away from home. Yasmine was also known to the Anti-Social Behavior Unit. She signed an Acceptable Behaviour contact, and she complied with the requirements of this order. There were low level concerns held by the PCSO about single incidents beyond this. However, Yasmine was very often missing from home overnight, and it was not always clear where she had been or who she was with. There were also concerns raised in the Initial Child Protection Conference about Yasmine spending times with groups of youths in the community. There is no further information about the implications of this, but the child protection conference process did not make links with what community knowledge might have been known about her behaviour and the risks to her. This joined up approach would have enabled a broader picture to emerge.

## **How do we know it is an underlying issue?**

- 3.9.5 This is a national issue and there is much emerging research about the threats to vulnerable young people when they are unsupervised in the community with their peers. There is emerging evidence that these young people can also pose a risk to their peers and vulnerable members of the community. Locally, the Review Team confirmed that they were not always well informed about the role and range of community safety services and their work with vulnerable young people did not always make connections with this team. The Review Team also reflected on the focus in child welfare on the vulnerability of young people, particularly girls, without there always being a focus on risks they might pose to others. This risk could be harassment, bullying, stealing and anti-social behaviour more generally.
- 3.9.6 There has been work undertaken already locally to improve the two way communication between the agencies, and to make use of the community safety services. It is important that this progress continues if children and young people are to be protected from harm, and if we are to recognise the potential risks young people in the community might pose to their peers and vulnerable adults.

## **What are the implications for the reliability of the system?**

- 3.9.7 The intelligence shared by agencies such as the police and those leading wider safety initiatives within a community are key to identifying those who are anti-social. Sharing intelligence between frontline and at a strategic level will strengthen community safety and positively feed into safeguarding systems. This is particularly important to detect when a vulnerable individual may be being targeted by adults or young people.

### **Finding 5**

#### **Questions for the Board to consider**

- How can Hartlepool Safeguarding Children Board (HSCB) work in partnership with Teeswide Safeguarding Adults Board (TSAB) and the Community Safety Partnership to ensure that the development work currently being undertaken by the Community Safety Strategic Partnership strengthens the links for both adults and children?

**3.10 Finding 6: Effective single agency and multi-agency supervision and effective processes to promote multi-agency reflection are necessary to pick up fixed thinking in a particular case. Although there has been action in a number of agencies to promote this approach to complex work it can be further strengthened, including by developing arrangements which enable multi-agency groups to come together.**

*‘One of the most common, problematic tendencies in human cognition ... is our failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture.’ (Fish, Munro and Bairstow 2009: p9<sup>xxxiii</sup>)*

*Child protection inevitably involves working with uncertainties and making difficult decisions and complex judgements on the basis of incomplete information in rapidly evolving, often hostile and highly stressful contexts. Burton 2012<sup>xxxiv</sup>*

- 3.10.1 There is a substantial body of research evidence<sup>xxxv</sup> that has clearly identified the unconscious tendency for early evidence bias in human decision making; that is, an initial summing up of a situation strongly influences the analysis of subsequent or new information leading to fixed thinking and faulty conclusions.
- 3.10.2 Serious Case Reviews have repeatedly found that professionals were either unwilling or slow to revise their judgements in the face of new or contradictory evidence<sup>xxxvi</sup> and that this selective interpretation of information, only using that which confirmed their preferred view about a particular case, became a “pervasive belief” which influenced the professional response. These pervasive beliefs were found to remain, even where there was considerable evidence of lack of progress or success in interventions and services offered. As Munro notes, “*the single most important factor in minimising errors in safeguarding practice is for professionals to be enabled to admit that they might be wrong*”<sup>xxxvii</sup>.
- 3.10.3 Practitioners must be willing, encouraged and supported to challenge, and where necessary revise, their views throughout the period of any intervention. To achieve this, practitioners and their managers should routinely play their own ‘devil’s advocate’ in considering alternative actions, explanations or hypotheses. Supervision should provide a safe but challenging space to oversee and review cases with the help of a fresh, experienced, pair of eyes and to systematically guard against either rigid adherence to a particular view.

**How did the issue manifest in this case?**

- 3.10.4 When Yasmine was 11 years old she became known to a number of specialist services because of her parents’ and school’s concerns about her aggressive, hostile and disruptive behaviour. There were three assessments completed by different agencies, all of which relied too heavily on mother’s view that Yasmine’s difficulties were caused by being spoilt when young and

some inconsistencies in parenting style. This influenced the initial plan of intervention which was to provide parenting support. The services offered were not helpful because of the high level of conflict and hostility between mother and Yasmine through the sessions, but the initial hypothesis did not change and parenting classes continued.

- 3.10.5 Over the next six months, information became available regarding allegations that father was physically and verbally abusive to Yasmine, that there was a history of police being called to conflicts between mother and father, and that mother and Yasmine were involved in further fights. This new and emerging information should have caused there to be a rethink about what the problem was and what therefore would be a more suitable intervention.
- 3.10.6 There were several further assessments during this time, and professionals met together regularly through child protection case conferences and core groups. Despite the lack of progress and very poor engagement of mother, father and Yasmine, the thinking about the causal factors did not change and services focused on addressing each crisis as it arose. The influence of this fixed thinking meant that there was an overall lack of recognition that the services being offered were focusing on the presenting problems, rather than looking at underlying causes.

**How do we know it is an underlying issue and not something unique to this case?**

- 3.10.7 There is considerable evidence from the summary analysis of Serious Case Reviews which have taken place over the last 20 years<sup>xxxviii</sup> of the influence of fixed thinking on professional practice. The case group also reflected that they recognised that fixed thinking and bias had an unconscious impact on their work.

**Finding 6**

**Questions for the Board to consider**

- How will the Board be assured that the impact of 'fixed thinking' and 'unconscious bias' is understood by agencies and their staff and there are effective arrangements in place via reflective supervision to challenge these?

## 4. APPENDICES

### 4.1 Methodology and Process of the Review - Appendix 1

4.1.1 This review has used the SCIE Learning Together model – a ‘systems’ approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective support and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and child protection work (Munro, 2005; Fish et al, 2009).

1. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influences the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.
2. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.
3. The basic principles – the ‘methodological heart’ of the Learning Together model – are in line with the systems principles outlined in Working Together 2013:
  - Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the ‘view from the tunnel’). What was influencing and guiding their work?
  - Provide adequate explanations – appraise and explain decisions, action and inaction in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.
  - Move from individual instance to the general significance – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency safeguarding system.
  - Produce findings and questions for the Board to consider.
  - Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

4.1.2 Typology of underlying patterns: To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

4.1.3 Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

4.1.4 Anatomy of a finding: For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency local safeguarding children board?

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