Local Child Safeguarding Practice Review regarding Emily

Executive Summary – for Emily

Dear Emily

I met you at your home on 25.10.2023 and we talked about why I have written this report for professionals who work with children, so everyone can do their best to keep children safe. Now I know you, I think I know how to explain this to you. When I use the word 'professionals' I mean your social worker, residential care worker, headteacher, police officers, psychologists, nurses. I met with many of the professionals that work with you, and they all have worked hard to help you and were open and honest about their work.

Some of the things they told me are in this long report and I have also put some of the things you told me into the long report so that all the professionals know what you think. This part of the report is a short version. This report is in sections and included learning and ideas like this:

- How important it is to plan early for children's futures – thinking about what the child might need when they get older when they are still young.
- When children move to different homes it is important to have a clear plan about this. Moving home can be upsetting and so it is important to help children when they begin to get upset.
- That there are lots of ways to help keep you safe but one of the best ways is that you learn how to keep yourself safe.
- Professionals had to use the law to keep you safe and that meant doing things like locking the doors or you having to live in the mental health hospital. This was hard for you and sometimes hard for the professionals who wanted you to be happy.
- When children are taken into custody by the police this can be frightening. What can be done to make sure you and other children who are upset are not arrested. You told me that although the police were nice, being arrested and kept in the police station was not nice!
- The professionals worked really well together to make a good plan for you, and they found you the home you live in now.
- The report talks about what that good work looks like and what helped the professionals to help you be safe. These are things like talking together with each other a lot; listening to you and understand what you wanted; being committed and making sure things change for children soon and the big managers listening to all of the professionals who know you best!
- You talked to me about your safety online and also about you running away. The report says it might be better if the adults understood the games children are playing online and how the games can have good and bad chats in them.
- The report also talks about planning for you now and planning for your future when you grow up. It talks about how you understand and chose about some parts of your life, but some parts of life are more complicated! So, the report talks about how professionals try to make decisions for you when they are difficult that they think you will like and that are best for you.
- Then there are some recommendations to help professionals keep children safe.
- Thank you for deciding to rename yourself in this report as Emily so that your identity can be protected. The published version will note you as Emily throughout.

Background

1. Emily has been a 'looked-after' child to Enfield since she was 4 years old, due to chronic neglect and parental substance use. She is subject to a full Care Order (CA 1989). She is the youngest of a group of siblings who were also removed, as were several cousins to Emily, across three related families. Her mother passed away a few years ago. Emily has a diagnosis of autism, global developmental delay, and ADHD. Her long-term foster placement from aged 4 became unstable when she was 12 years old (leading to a psychiatric admission) and broke down completely when she was 15. Her behaviours became more complex and extreme during adolescence and the foster carers was not able to care for her in the way that Emily needed. There was a short stay in a hospital, followed by 6 weeks in Residential Placement One, followed by 11 weeks in a psychiatric unit. She then moved into Residential Placement Two. There is a timeline of key practice events at Appendix One.

2. Emily had been in Residential Placement Two at the time of the incident for 4 weeks, sharing this home with one other child. This placement had been established to meet her needs. There were Deprivation of Liberties Safeguards (DoLS)[1] in place for Emily and she had 2:1 support at all times. On the day after her 16th birthday, Emily went missing and was found at a central London underground station the next morning. She said that she had been raped and injected with cocaine by a person who she had met online in an interactive game. A criminal investigation has been undertaken and at the time of writing, the file has been passed to the Crown Prosecution Service for a charging decision.

3. There are Terms of Reference for this Local Child Safeguarding Practice Review (LCSPR), agreed by Enfield Safeguarding Partnership that set out the scope of this review (see Appendix Two). These were informed by the recommendations from the Rapid Review that took place in January 2023 and suggestions made by National Panel for Child Safeguarding Practice Reviews. The period under review is the year of 2022. Five learning themes were established as areas for exploration (Themes Two- Five). During the course of the review, participants in the LCSPR identified that there was some key learning arising from information shared around Emily's experience of care planning and placement prior to the period under review which are detailed at Theme One. Each section will consider the learning from and about this case and the wider relevance of this for the safeguarding of children with complex needs like Emily's.

4. The analysis in this review is based upon the following activities.
   - Review of information shared for the Rapid Review
   - Follow-up information template for this review completed by the following Enfield agencies Children's Social Care; BEHMHT CAMHS; Emily's GP; the care provider Residential Unit Two; the Metropolitan Police; NUMH.
   - A practitioner learning workshop (two sessions as more time was needed). This was a reflective conversation around the key themes.
   - Follow-up conversations with Head of Safeguarding, Head of Disability, Designated Nurse ICB NCL; Lead commissioner ICB NCL; the child's IRO; the fostering supervising social worker and fostering team manager.

[1] *Deprivation of Liberties: Legal Mechanisms.* Nuffield Family Justice Observatory Feb 2022

- Observations of the Joint Transitions Operations Group (26.06.2023); The Dynamic Support Register Meeting for Children (27.07.2023).
- Planning and visiting Emily at her home on 25.10.2023 follow-up by a letter to her. This was delayed due to a change in social worker and planning to consider how best to make this visit, which took place when Emily was on half term.

5. It is much appreciated that all practitioners involved in this review have been notably open and reflective upon their practice. Practitioners have been involved in offering written analyses as well as verbal contributions and demonstrate a clear willingness to identify good practice but also mistakes and shortfalls and reflect on them in order to seek improvement. Their reflections provide rich information and learning about the system around looked after children with complex needs.

Learning from practice: analysis

Theme One: Planning to prevent the escalation of risk.

6. This theme describes the learning from Emily's case regarding the prevention of the escalation of complexity of a child's needs and the risks to the child through effective care planning and placement sufficiency.

7. Emily's early years were adverse – she is known to have survived chronic neglect in the care of parents who misused substances. Emily has a diagnosis of autism and global developmental delay and ADHD. It is suspected now that she may also have suffered intra-familial CSA, however this does not seem to have been a clearly understood aspect of her experience as she grew-up in care, although one of her siblings had clearly disclosed sexual abuse and there were possible behaviour signs in Emily and in her siblings. A recent LAC review decided to revisit her possible diagnosis of a Foetal Alcohol Spectrum Disorder (FASD) in order to understand the impact upon her behaviour.

8. When Emily came into the care system, she was in the same foster placement for eight years, with other birth children in the family. Emily did spend a short period of time with her birth sister in the placement, but largely she was without her birth siblings. Emily called the foster carer 'mum' and there was love and commitment from the foster carer. The carers made efforts to involve Emily in community activities and to have contact with her siblings. When Emily was younger, the foster carers had had her sister placed there as well as Emily. The foster carers had been able to manage some risks in Emily's life, for example her safer use of her iPad.

9. However, at this time, Emily's behaviour became more dysregulated and at the same time, the foster carer and another family member had health concerns. The IRO and the fostering team recalled that there were mixed emotions within the foster family about the female foster carer's commitment to continue to care for Emily. This led to the carers having at least 3 changes of decision regarding continuing to offer Emily a placement. When she was aged

12/13 the foster carers (then working for an Independent Fostering Agency) intended to apply for a Special Guardianship Order for Emily, however, then they served notice when there was an escalation in Emily's distress. When she was subsequently sectioned (s3) under the Mental Health Act, aged 13, the foster carers changed their mind about the notice and applied to Enfield for a specific fostering approval. The foster carers underwent a successful viability assessment, and the fostering panel made the decision to approve the application, given the love that the carers demonstrated for Emily and because the length of her time with them.

10. A few practitioners recalled their ill-ease or dissent against this decision at the placement panel, feeling that Emily's return to the family was an optimistic plan. As the majority were in favour of proceeding to support the carers to continue to care for Emily with regular overnight respite. With hindsight, practitioners were able to reflect on the factors that have contributed to her placement breakdown. These included:
    - A lack of effective life-story work with Emily (this was reported as a more widespread system shortfall), which meant that Emily could not understand her position in the family. She saw the foster carer *"as her mum too"*. This led to instability and an inconsistency which Emily felt in comparison to foster siblings. She had been and was sent away from the family, the other children in the family (her foster siblings) were not.
    - Emily could not process the distorted stories about her early years that her sister shared with her, during their unmanaged contact at school. Emily had no alternative life-story with which to counter her sister's account.
    - A lack of support and perhaps challenge around the foster carers' ability to put in boundaries. Whilst the carers attended all of the training when approved as Enfield carers and the foster carer was keen to attend additional training (such as "Great Behaviour Breakdown"; training around impulsive behaviour and around Keeping Safe), her needs may have been beyond these carers who did not really know how to respond to her changing developmental needs as she moved into adolescence. A referral was made to HEART (LAC Therapeutic) Team in early 2022 to support the foster family, but this was rejected as below the then risk threshold.
    - The fostering team also noted that After the placement broke down the foster carers admitted that they had not been very good at asking for help or admitting they were struggling.

11. As reported to the foster placement disruption meeting, the LA was not able to find carers to offer alternative overnight respite care, which was part of the plan to support the placement at the point of their fostering approval. This was down to a lack of suitable respite carers being available at the time, but also to the restrictions arising from Covid-19. Emily's foster carers were reported as being very angry about this lack of parity: the foster carers of complex children should be afforded the same offer as parents of complex children; however, this was not the standard offer in Enfield at that time. The Local Authority is aware of this anomaly and working on to change. Where such arrangements have happened for other children this appears to be by luck e.g. another family member is also a foster carer, rather than design.

For Emily's foster carers they did not have the opportunity to reset over a weekend without her.

12. Whilst recognising Emily as a unique child, there were clear indicators in her past which may have suggested that her childhood trauma could compromise her emotional wellbeing into adolescence. It is not clear the extent to which the foster carers or the system caring for Emily were prepared for the changes to her behaviours as she matured. A practitioner observed that Emily's *"kind of 'up and down' regulation'"* and unpredictability posed a real challenge for her carers. Upon reflection, the practitioner suggested that Emily "*perhaps never quite 100% settled [in the placement]… something wasn't quite right".*

13. Senior managers noted that some of the challenges to local foster placements for complex children still exist across the system in Enfield:
    - It was identified that there is a shortage of respite placements although the Local Authority are aware of this and seeking solutions.
    - There is a lack of a clear therapeutic model for foster placements in the authority – i.e. offering therapeutic support to both child and the carers to encourage placement stability, especially where children have complex needs.
    - There is work to do around placement sufficiency and needs/ risk mapping to anticipate placements for the near future for children such as Emily who are at risk of becoming more distressed and dysregulated as a result of past trauma when they enter adolescence.

14. There are also challenges in the system around finding appropriate local residential placements for children and the lack of suitable specialist placements is a national issue[2]. There is a sufficiency strategy in place with local residential provision being developed for looked After children and plans are in place to develop a local respite centre pending DfE approval Emily's placement at Residential Placement. One placement had been made under pressure as Emily needed to be discharged from hospital, but the placement was not suited to Emily's complex needs. The professional network that worked with Emily reflected on not being rigorous enough in establishing a clear behaviour and crisis management plan, alongside the team caring for Emily at Residential Placement One. Instead, some practitioners suggested they may have been lulled into a sense of optimism due to the initial 'honeymoon period' when Emily first moved there.

15. Therefore, is recommended when any looked After child with known complex needs moves to a new placement a clear risk/crisis/behaviour support plan (including DoLS) is implemented and regularly reviewed. This forms part of a generic recommendation (Recommendation One at paragraph 96) and is relevant to all safeguarding partners.

16. Since Emily was admitted to the psychiatric hospital last August, in contrast to the placement plan at Residential Unit One, there is evidence of effective and dynamic multi-agency

[2] Josh McAllister (2022) The Independent Review of Children's Social Care, p112; Children's social care market study Competition and Markets Authority March 2022.

placement planning for her, driven by a sense of urgency. Alongside this is a more developed assessment of Emily and her presentation. Finding her an appropriate placement took a lot of time and commitment: there is evidence of robust leadership, with the ICB's lead children's commissioner chairing and attending weekly Dynamic Support Register (DSR) meetings -(see below) and the multi-agency professional network collaborating to seek solutions to the dilemmas that Emily's case posed. Emily's voice appears as absolutely central to care planning and the details of her plan reflecting her wishes. The current professional network demonstrated their support and comprehensive understanding of Emily's personality, with a real sense of regard for her as a child.

17. When the Independent Reviewer visited Emily in this current placement (Residential Placement Two), it was evident that the rigorous planning has made a significant difference to Emily. The nurturing and consistent style of care affording by committed carers, who describe "loving" their jobs, has provided Emily with a secure base from which to develop socially and emotionally; to learn more about what is safe and how to keep herself safe; and to be happy. The placement, although it was the home that she ran from having been groomed online, appears to have contributed significantly to her positive recovery from that incident and the care planning around her has supported mitigating the harm from that incident.

18. In summary there are some learning points around planning to prevent escalation of behaviours and risks in placements, some of which are specific to the LA, however, should also be the role of key partners to challenge and support on behalf of the child. These form Learning Point One: *In order to prevent such escalation and placement breakdown, good practice includes:*
    - *Ensuring that children understand their life stories.*
    - *Ensuring that the placement needs of children in long term fostering are anticipated as far as possible. This can be done using national research and local learning around complex development trajectories where neurodiversity, learning disabilities and childhood trauma are known.*
    - *That foster placements are offered learning and development opportunities and are reviewed regularly for their capacity to meet a child's ever-changing needs.*
    - *That foster carers are offered overnight and therapeutic support where the child's needs present challenges to the wellbeing of carers, in-line with the offer to birth families who have disabled children.*
    - *Moving to new placements should be recognised as a time of significant challenge for the child and risk management and care planning for children who are moving needs to be at its most comprehensive and based on past risk and vulnerability as well as current presentation.*

Theme Two: The effectiveness of multi-agency practice in risk assessing Emily's changing needs and risks alongside balancing the prevention of harm against Emily's Deprivation of Liberties.

a. The Use of Deprivation of Liberties Safeguards[3]

19. When Emily (aged 15 and 8 months) was in the psychiatric unit, a DoLS application was sought and granted by the Family Court for Emily. Section 2 of the Mental Health Act (1983) had expired and the treating clinical team felt Emily did not have a diagnosable mental illness that would mean she could be held in the psychiatric hospital (in another borough and ICB area) under section 3 of the Mental Health Act. The suitability of the hospital placement (an in-bed facility run by the mental health trust in the borough of her previous residential placement) had been queried by her treating clinicians and the professional network: it was felt possible that the placement itself would impact negatively on Emily's mental health. However, this setting was the only option whilst an appropriate therapeutic placement was sought. The DoLS order granted approval of providing a safety net to keep Emily safe which was effective and proportionate whilst she was in the care of the psychiatric hospital. Whilst there, Emily attempted to run away from carers whilst out on community visits on two occasions. Having DoLS in place allowed the practitioners to find and return her.

20. After the initial approval, the DoLS were reviewed on a fortnightly basis by the Family/ High court judge. Since Emily's 16th birthday and her increasing stability at Residential Unit Two, the Court of Protection reviews the DoLS every 3 months. Additionally, there is a clear and dynamic analysis of her ongoing need for the DoLS. The social worker's assessment is very much informed by Emily's perspective. Emily is aware of the risks and is able to express that she wants to run away but that she also wants to be kept safe by those caring for her. There was also good practice in working with Emily's new school to implement the same strategies as per the DoLS in place.

21. Partners involved in the Rapid Review had identified a missed opportunity to maximise Emily's safety through not updating the risk management strategy in the DoLS at the point of Emily moving to Residential Placement Two. However, this was not entirely accurate. The DoLS were updated but the placement had a clearly stated policy of not locking the doors and this was known during the planning for her move there. The psychiatric hospital locked the doors and staff there were able to physically restrain Emily. As the alternative risk management plan at Residential Placement Two, the court authorised DoLS that permitted a staffing ratio of 2:1 caring for Emily at all times. Physical restraint was not permitted and the emphasis was on de-escalation. Once she moved, there was –multi-agency planning regarding Emily's tendency to run away and around the management of crises e.g. when she became dysregulated, however the measures were not sufficiently targeted and appear as very different in terms of risk management strategies compared to the previous plan in the hospital.
22. Emily may have become used to physical restraint in the hospital but at Residential Placement Two, Emily was able to leave but would be followed by staff members, without physical contact. It was recognised that her desire to run was fuelled in part by wanting to go back to

[3] https://www.scie.org.uk/mca/DoLS/at-a-glance

see her foster carer and so measures to ensure tighter boundaries around that were also suggested, however only After some time in placement. After the incident on 20.12.2023, the DoLS was reviewed in order to ensure that staff caring for her in her residential unit were able to ensure her safety with more clearly stated measures around locking the doors and how she was supervised. Her carers described that now they are able to hold Emily physically whilst she has an over-riding impulse to run away. Staff reported at the practitioner event that this often "turns in to a hug" and de-escalates rapidly. When Emily was visiting at her home in October 2023, carers confirmed that she no longer wants or needs to run away. Although she still experienced impulsivity, Emily said that when the voice in her head says "run away!", she tells it "No! Think about safety". Emily is clear that she doesn't like being locked in however it appears that other interventions with her have made that a thing of the past.

23. **Learning Point Two**: *DoLS was and continues to be used effectively to safeguarding Emily. The nature of the DoLS was and is regularly reviewed. But DoLS must be reviewed in the light of patterns and changes of behaviours, but also in identifying any new or different risks inherent in the environment or different settings in which the child will be placed or educated which might undermine safety.*

24. It is recognised that working with DoLs and also Mental Capacity is a complex area of professional practice. The Head of Service identified that he wished to develop an 'expert' practitioner within his service for this however this had not yet come to fruition.

b. Operational risk management of Emily's case

25. Practitioners that know Emily offered a comprehensive description of Emily's very unique presentation. The professional network identified the significant complexity in managing the risks to Emily as well as the risks that she may pose to others thus: "there are *multiple risks or multiple points [to consider] so that you're always having to anticipate what might happen across so many different settings".* In each setting (school, residential, hospital), Emily has been understood to respond differently to different carers. The multi-agency network now have a better and shared understanding of Emily's strategy in each environment: she works out what somebody might want from her and 'offers' it to them. This was described as her 'survival mechanism'.

26. There is learning for the system as to how each practitioner working with a child might understand the nature, severity and likelihood of a risk at a particular moment and as a team make sense of or rationalise the different perspectives on that risk. An example of this is the incident leading to the foster placement breakdown when Emily was 15 and 6 months. There were very different responses to the risk of Emily as described as assaulting her carer and "*using a knife"* by the carers themselves, social care and the police. The supervising social worker recalled how the foster carer had described Emily punching at her, but other practitioners in the system understood that Emily, in her anger, was just trying to get to a butter knife and was successfully prevented from doing so by her foster mother. **Learning Point Three**: *That clarity is key and as much factual description as possible should be shared*

with other agencies around an incident. This will enhance the assessment of risk and immediate safety needs.

27. In the run up to this incident, The Head of Service for Disabled Children noted that while Amu was a new allocation to them, the failure and lack of urgency in the social worker's practice to respond to Emily's escalating dysregulation and the three telephone calls requesting help made by the foster carer, one of which received the response from the social worker that they couldn't come *'out of hours'*. Despite that social worker reportedly apologising to the carers, during the subsequent placement disruption meeting, the foster carers expressed that they had felt abandoned. The previous 24 hours had not prompted an urgent social care response to Emily's increasing dysregulation and so the foster carer escalated their concerns about the risk to the police who responded very differently and arrested Emily. Emily had been admitted to hospital twice in the previous 6 months due to extreme distress and dysregulation – her behaviours were familiar to those caring for her and should have been an indicator of the likelihood and severity of the consequences of her escalating distress.

28. Because of the complexity of managing Emily's case and the risks, even during periods of much more robust risk management, there were sometimes gaps in the multi-agency decision-making upon Emily's presentation and risk. For example, later one, there was a lack of joint consideration around a plan to significantly reduce the foster carer contact with Emily. This then led to Emily's increased attempts to run away. This decision was made despite frequent multi-agency meetings, perhaps indicating the complexity of planning and level of activity to meet her needs. At higher levels of risk, the duties upon all staff increase, but practitioners identified that the complexity in cases such as Emily's could be better responded to with the support of multi-agency tools e.g. a single operational risk management tool /multi agency risk protocol which covers all mental health risks as well as safeguarding aspects of risk around a child such as Emily. In Emily's case there were, and remain, several different risk assessments and risk management processes in each environment she spends time in, despite a need for a consistency in the response to her by all staff, in order to avoid escalating her distress. This is not just the case for Emily, but anecdotally for other children in Enfield. *It is recommended that the LSCP supports key partners in social care, health, education and police to develop a single risk assessment and tool for all children with complex needs* (This forms part of Recommendation One at paragraph 96).

29. There was also a particular challenge noted of offering a consistent response to emerging risks when so many people were involved in her daily care, i.e. in the psychiatric hospital setting. In order for that setting to be safe, those caring for Emily would have to rapidly develop a shared understanding of what the risks might be to Emily. Key practitioners suggested that this was compromised by high staff turnover and use of agency staff. This is a system challenge and should be emphasised as such: the country's most vulnerable children are being cared for, but with an unacceptable degree of inconsistency in who the carers are, further escalating the child's distress and the level of risk. This was wholly recognised at the time by lead

clinicians and the professional network, who should be commended for their tenacity in trying to keep Emily safe in an unsuitable but only possible placement.

30. Again, this stems from placement insufficiency. Therefore, the review makes this recommendation.

Recommendation Two: ***That the LSCP flag the lack of suitable placements for children like Emily to the National Panel as further evidence of a recognised national issue.***

31. However, despite the challenges that working with Emily presented, planning and intervention was and is carried out with Emily at the centre. Practitioners working with her recalled in-depth and ongoing conversations with Emily about some of the risks – particularly around her impulse to run away, and constantly reflected on this behaviour as a presenting symptom as Emily's deeper need to 'test' the system to understand the extent to which those looking after her genuinely cared for her.

32. The quality-of-care planning and risk management for Emily during the period under review was variable. There was some evidence, when Emily was 15 and 1 month, of effective responses to incidents in terms of the quality of the response to risk: there were two attendances and hospital admissions via the Emergency Department where critical risk information travelled well between all professionals. One admission had been brief and involved the use of s136 (MHA, 1983) due to her mental health – her foster carer accompanied her during this and Emily was discharged as a result of a multi-agency decision. During the second stay of 6 nights in a general hospital, there were two MDT meetings; the social worker visited regularly; there was input from a play therapist whilst she was on the ward; and there was good liaison between agencies. However, following the placement breakdown as discussed at Theme One, planning for Emily was carried out under pressure, which resulted in a placement which contributed to increasing risk and challenges for Emily for her emotional well-being and as Emily was able to articulate, she was not happy in. However, it appears as though planning became more effective when Enfield's Dynamic Support Register began.

c. Good practice in multi-agency systemic risk management: Enfield's Dynamic Support Register (DSR).

33. The complexity of her situation lead to Emily being the focus of planning via Enfield's Dynamic Support Register[4] (DSR), a NHSE local mechanism designed to keep children and adults with increasing or complex needs out of hospital. Enfield's DSR appears as key to the effectiveness of care planning and a significant contributory factor for greater success in achieving outcomes for Emily. More broadly, Enfield's DSR appears as an emerging example of an effective systemic approach to multi-agency planning. The DSR has supported the shift to make multi-agency work the norm and is co-chaired by the ICB's Children Services commissioner and the Head of Service of the Children Disability Service.

[4] National Guidance re Dynamic Support Registers

34. At the time of writing there are approximately 30 children known to the Enfield DSR, all of whom are known to Children's Services. There are 4 children in Enfield being managed at RAG level Red (as Emily was) at the time of writing. The health system, education and social care are represented at a weekly meeting by those who hold a suitable level of responsibility for decisions but also operational knowledge. A risk-informed strategic case discussion takes place, with more detailed case discussions taking place in regular MDT meetings. Evidence presented to the review regarding Emily's case shows how the DSR significantly improved planning and outcomes for Emily when she was at the highest level of risk and need through problem-solving and a commitment to moving obstacles. The level of urgency in seeking a suitable placement is demonstrated in the rapidity with which Residential Placement Two was found and Emily placed in a planned and child-centred way.

35. The DSR is still embedding in Enfield, supported using best practice tools [5]. Although it had been a long-established meeting, the current chair who took over a year ago described its previous version as somewhat ineffective due to an approach that was described as "single agency and silo-working". A new protocol was created, giving the DSR leads a mandate to put pressure on all agencies in the system to act before the crisis for the child happens, or to ameliorate existing risk to the child, such those in tier 4 mental health settings like Emily. The DSR is mandated to draw together and focus different systems upon the child's needs and desired outcomes.

36. Practitioners reflected on the benefits of the holistic DSR risk assessment in Emily's case. The risk assessment is clear in identifying indicators that inform a focus on specific aspects of a child's home life, school experience, and experiences in the community. Critical risk areas will lead to a specific score and priority areas of focus e.g. if a child is out of school, there are a range of pathways which can be followed and interventions offered. Emily is successfully back in school after a period of 6 months out, however the Chair of the DSR noted that increasingly some schools are refusing to take children with behavioural challenges or are requesting funding for 1:1 support in school. Most of the children known to the DSR are out of education or struggling significantly in their school placements.

37. The development and success of the DSR relies upon the commissioning of clear pathways and matched resource provisions tailored to the needs of children with Learning Disabilities or Autism at each level of risk. At red, there is the key worker scheme in place; at amber a TCAPs[6] project. There are other commissioned interventions including a 16-bed unit for young mental health patients. Recently, an outside agency has been commissioned to work with a cohort of high-risk children across the five North and Central London boroughs in a pilot that delivers Positive Behaviour Strategy (PBS) interventions. As well as ensuring appropriate operational responses for children, there is also evidence of strategic planning e.g. skills mapping by the DSR system to ensure that needs are met through local resource.

[5] https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/dynamic-support-register-and-care-education-and-treatment-review-policy-code-of-practice-and-toolkit/

[6] See pilot report for TCAPS

38. The strategic shift in the improvement to the DSR was described by the children's commissioner as moving from "*care management to risk management"*. As part of the review the author observed a DSR meeting demonstrated extremely challenging cases being managed in the community through professional skill in understanding the needs of children and their families. In a discussion with the chair, the importance of having the 'right' agency leads that are accountable for their actions and directions back to their teams is emphasised. The DSR is not simply a process. It represents a shift to becoming a systemic approach through changing culture, attitude and values. The chair reflected on the wider impact: the multi-agency workforce working with these children and families has also made some shifts their reflective practice and willingness to be open to suggestions or improvements in practice is key in holding risk and anxiety.

39. Practitioners reflected on the importance of direct access to the senior commissioner at the ICB who chairs the meeting. Her availability offers support and direction to their case management. A year ago, there were few or no operational Multi-Disciplinary Team meetings (MDTs) and the chair recalls that key statutory services were 'not onboard' whilst under previous leadership. Currently, in all cases, the DSR ensures there are regular meetings that offer the detailed planning for children that sit below the DSR, which will recommend a CIN meeting or a Care and Treatment Review (CTR) as an action for agencies.

40. It is also important to highlight how Enfield's risk management and planning process is underpinned by the partners' values. The DSR focusses on working around challenges through keeping the child's experience at the centre as the priority. An example given was of a disabled child living in their family home. The DSR activity ensured the heating in the family home was fixed with urgency, through putting appropriate requests and challenges to the key agencies involved.

41. As mentioned earlier, the aspiration to keeping children with complex needs at home or close to home appears as an important condition in planning for Emily but also for other children with complex needs. The complexity of some of these cases was palpable when the author observed a DSR meeting. It should be emphasised that these cases evidence the emerging narrative in the borough around the nature of the current cohort: "*the complexity is through the roof".* But positively, there is a shared vision about what is best for these children that is child-centred, and risk informed. During this review, there have been concerns aired at the context of multi-agency practice as one of poverty, deprivation and homelessness against a backdrop of significant budget deficit amongst agencies. Practitioners have shared their concerns that there will be more crises and even more complexity without more comprehensive preventative support for families.

42. Going forward there is clear ambition for the DSR approach in Enfield. The same ICB commissioner has just taken commissioning for adults into her role and is now chairing Adults DSR meetings. Currently the DSR for children focusses only on children with diagnosed

Learning Disabilities and Autism (LDA). However, the approach works and there is some real learning, either in extending the approach within the borough to include not just LDA but those children whose presentation suggests such extreme trauma because of abuse and neglect that they pose a challenge to existing multi-agency resources and responses.

43. In summary, the DSR is an example of a really promising approach. Therefore, it is useful to be explicit around what helps the DSR have a positive impact upon outcomes. **Learning point four**: *the key contributory factors to the emerging effectiveness of the DSR are:*

- *Engaged and available leadership.*
- *A shared vision of responses to need and risk that prioritise the child's welfare with the key agencies' commitment to implementing that vision.*
- *A culture of positive communication and of 'can-do' attitude, with a willingness to challenge and be challenged.*
- *Responses that are proportionately urgent to the level of assessed risk to the child.*
- *Truly multi-agency risk assessment and management, supported by a clear multi-agency process.*
- *Clear pathways to specifically commissioned services meeting need and managing risk at specific levels.*

44. Other related multi-agency strategic developments in the borough are also going live at the time of writing. These give a sense of the system making real impact on some of the operational challenges faced. The NCL ICB has published its new Complex Discharge Policy and alongside it, Enfield are hosting a 5-borough Children and Young People's Complex Discharge Project to support cohesive management of complex discharges from the acute trusts. Again, this demonstrates the system's commitment to risk management and problem solving.

45. As a side note: the good practice of the DSR and other developments are directed at a specific cohort of children with diagnosed conditions. The challenge will be to replicate the drive and urgency of the DSR to support meeting the needs to all children who have complex presentations, particularly adolescents who may have a range of undiagnosed conditions and unmet health needs. This may include children with behavioural difficulties who have not been effectively 'gripped' by the system or are 'labelled' in a way that prevents a comprehensive judgement on their experience, for example, unaccompanied asylum-seeking children or children in refugee families who are new to the system in Enfield.

Theme Three: The quality of the approach to the risk management of, including assessment and care planning, Emily's online safety and use of social media of children with additional needs.

46. All the professionals working with Emily expressed their shock and distress at the incident and alleged rape. Some identified how unlucky it was that the incident had happened, given that Emily was subject to DoLS and a comprehensive care and risk management plan. This event might have been preventable, but only if the risk management plan had been for Emily to have no access at all to the internet, or that she had been locked into Residential Unit Two.

However, for such measures to be in place at the time would have been extreme and not proportionate for the assessed risk to and from Emily. The professional network was managing risk well but as far as understanding the online risk to Emily, they were operating in a space where there were too many unknowns, without the requisite knowledge to understand this.

47. The centrality of her iPad to Emily's life was acknowledged by the professional network. When she was in her foster placement, Emily was also known to have sought people out online and was also known to want a boyfriend. On occasions Emily told professionals that she had a boyfriend although those caring for her suggested that this was not the case. This may be due to different perspectives of adults regarding what sort of relationship constitutes a boyfriend online. Emily had always struggled to integrate into the community, despite the efforts of her foster carers, due to her not being able to manage peer relationships. She had no real friendships throughout her journey through several placements and this will have been exacerbated by her placement moves through hospital wards and a residential placement that had not meet her needs. She also lacked an educational placement. The isolation from social networks can not be underestimated as an influence on any child, nor can the influence upon Emily of depictions online of what 'normal' teenagers should be doing.

48. This centrality and importance to Emily was not reflected proportionately or consistently in the risk management of Emily's online use. Practitioners had worked with her around Emily's behaviours online and understood her lack of understanding of the online risk and her impulsivity. They were aware of her drive to test boundaries of her carers. But in summary, the risk management of her online use was only partially effective because of shortcomings in each of these dimensions:
    - Professional understanding of what sites Emily was accessing and their functions and how her use of virtual communication tools might be unsafe.
    - A full understanding of Emily's adeptness in working around parental controls and other measures to prevent full access.
    - What the possible unwanted behaviours of other people and potential perpetrators online were and hence the risk that they posed.
    - A comprehensive enough risk response and management plan in each setting.

49. A key reflection from the professional network was that practice was too reactive and not pro-active enough, however given Emily's situation and instability in placement this might be expected. Emily's use of the internet had been easier to manage in her foster carer placement. However, when she was admitted to the psychiatric unit, the professional network had actively encouraged Emily's access to her new iPad as there was so little to do on the ward.

50. The iPad was also Emily's route to contact her former foster carers. That relationship was not yet managed in terms of any boundaries between Emily and the foster family. The occupational therapist and the social worker put suitable controls on her access. But staff numbers and turnover agency meant that a consistent approach to monitoring this had not been possible. Emily persuaded some staff members to give her the password to their

personal phone and one carer allowed Emily to use their phone occasionally and download an app. It was described to the review that there were "*numerous incidents"* like this during her time on the ward and evidence of some risk responses resulting from her use of her iPad.

51. When she moved to Residential Placement Two, Emily had managed to turn off the parental controls on her iPad. The incident and alleged sexual offence that led to this review came to pass as the perpetrator was able to access Emily and groom her using the chat facility in an online game. Practitioners' understanding of how Emily was using the internet was not robust enough: i.e. that the game was interactive, with a chat feature that allowed access to strangers[7]. At the point of her move to her new placement, Emily did not have a phone and her iPad was utilised by the staff team as a 'soother' and as a positive behaviour re-enforcer. Staff in the residential unit were trying not to be overly intrusive or keep Emily under constant surveillance, in order to build positive relationships with her during her transition to her new home. There were some efforts to put things in place to manage her time on the iPad, due to her 'fixation' with it and it did impact her ability to settle initially as all she wanted to do was be on the iPad. It was thought by staff that Emily was very keen on her iPad as she could contact her previous foster carers.

52. There had been a pre-cursor event two days before she was assaulted, whereby Emily had asked staff to take a picture of her bottom to send to someone. This had been reported appropriately to the police. Emily shared that she had been in contact with someone, and the police took the iPad for further inquiry because at that point, it was discovered that she had taken and sent explicit photographs of herself to an unknown person. However, there were still too many unknowns about the contact that Emily had already had with the perpetrator – somehow, she knew where to find him or he knew where to find her on the evening of the assault.

53. At the point of the practitioner event in June 2023, Emily had no access to an iPad. Since she was assaulted, staff worked with her to reframe her use of social media and the internet. For example, Emily is offered new ways of using the internet by using it to learn to crochet. However, the observation of some practitioners was that her use of social media and online games needs a positive, risk management approach in order to prepare her for the reality of the virtual world when she reaches adulthood. It was agreed that this type of intervention is skilled and needs in-depth current knowledge. There was an additional reflection in that the impact of this event upon Emily and on those working with her had perhaps stifled the appetite for positive risk-taking in the professional network need for this type of intervention.

54. When Emily was visited in October 2023, she recalled that she had been "addicted" to the iPad and had had it in her room in the hospital at night. Progress has been made within a clear plan, Emily has her iPad for one hour each day and hands it back without prompting. She plays online games, but with chat-friendly codes. She knows who her friends are and can recognise

[7] Children and Parents: Media attitudes Survey 2022 OFCOM p 36

"good" and "bad" chat. She uses a boy's name as her online name, so that "bad people" won't think she is a girl.

55. But there are some challenges to effective practice in the system:
    - Some practitioners openly acknowledge their lack knowledge and understanding of social media sites and how to apply of parental controls.
    - Some services do not have sufficient focus on online risk amongst the range of more tangible and obvious risks. Really grasping the importance of digital devices as enabling and internet use as both a risk but a resource should underpin all safeguarding practice with children.
    - A perspective was shared that the responsibility for risk managing this is often fielded to social care or placement practitioners but should be a focus of multi-agency planning.
    - This also leads to perhaps a fairly risk -averse or 'blunt' risk response such as sticking to apps considered to be 'safe.' It was suggested at the practitioner event that those working with children needed to be more curious about the child's understanding of possible 'consequences' of a specific online safeguarding risk.

56. It was also acknowledged that possible opportunities exist to progress safety planning with children around this theme, such as the Looked-After Children reviews. However, feedback from the system is that the online safety of children might not be given enough of a focus for the same reason: some adults do not fully understand the virtual world that children inhabit.

57. Some of the risks come from outside and risk assessing the unknowns outside of Emily's control is sometimes not possible, e.g. other people's intentions. Other elements of risk will stem from facets of Emily's development – ie that she would like a boyfriend, but also that some aspects will prevent her from really being able to anticipate risk, despite her being clear that she wants to be safe.

58. Learning around how children can stay safe online is relevant not just to children such as Emily but more broadly across all vulnerable children that access services in Enfield, whether they are disabled or at risk of criminal or sexual exploitation. It is a context that adult professionals may feel the least competent in, yet which pose the most significant risks for some children.

59. Emily's current school acknowledge that their safeguarding training touches upon online risks but would welcome more input. Practitioners reflected that there could be more done to really understand the different apps that children use and perhaps what the implications might be – for example understanding if there is an interactive facility, ie a chat room etc. It was agreed that there could be more information shared around what apps children use. The police have a list of these to share, however, there are also a range of resources to utilise with[8] Emily's age group and with children and adults with disabilities [9]. There is more to be done to

[8] https://www.thinkuknow.co.uk/globalassets/professional/guidance/ceop-education-programme-resource-booklet-2022.pdf
[9] https://www.pinpoint-cambs.org.uk/wp-content/uploads/2022/05/Tech-it-Out-Accessing-the-internet.pdf

prepare Emily for adulthood. Emily's complex developmental presentation means that in some but not all aspects of her safety, she is functioning at a lower 'age' level. Utilising the key principles of transitional safeguarding[10] in seeing the virtual world as a key context for Emily, understanding her developmental 'fluidity' and working with her relationally to support her understanding and enabling her positive choices will prepare her to be able to navigate the virtual world more safely.

60. The key learning is that the internet, social media and gaming platforms should be regarded as another context where extra-familial harm can occur to children, and this can take different shapes and forms[11]. The challenge is to equip practitioners who are already managing risk for children in several more tangible contexts to consider the virtual world as a place where the child's vulnerability meets an exploiter's harmful motives e.g. in schools, the park, the shopping centre, or a residential unit.

61. In order to strengthen practice in this complicated area, there needs to be a strategic focus on the online safety of children.

Recommendation Three: ***That Enfield LSCP provides professionals from all partner agencies working with all children in Enfield access to developmental opportunities and effective tools and resources to support risk management of online risks for vulnerable children.***

Theme Four: The use of police custody during 2022 to prevent the risk from and the risk to EMILY, a child with additional needs.

62. During the period under review, Emily had contact with the police seven times, five of these were because she had run away from her placement. On two occasions during the period under review, the police were called to Emily's home: once to the foster placement and once to the short-term residential placement at times that Emily was displaying 'dysregulated' behaviour which were perceived as posing a risk to her and/or to others. Both incidents marked the ending of these placements.

63. On the first occasion the foster carers called the police as Emily's behaviour had been dysregulated since she had returned from school the previous days. Phone calls made to Children's Services for help had not been responded to effectively (see Theme One). During this attendance, Emily was handcuffed as she had been said to be witnessed attacking and threatening to kill the foster carer with a knife. However, this response to a child of Emily's known vulnerability raises questions regarding the depth of detail of the information upon which the police response was based. On this occasion, Emily was taken to hospital on the advice of Children's Social Care, to be sectioned. Professional carers were arranged by Children's Social Care to attend hospital with her. However, once at the hospital Emily was arrested for continuing to make threats to kill her foster carers (despite them no longer being with her) and common assault. She was taken to into police custody.

[10] Bridging the Gap 2022: Transitional SEmilyeguarding and the role of social work with adults
[11] Classifying and responding to online risk to children: Good practice guide LSE (2023)

64. Police officers doing their duty were required to take this approach on the information they had been given. Some alleged behaviours e.g. a threat to kill must lead to that response. However, her detention in police custody was refused and s136 (MHA 1983) was used to secure Emily in order to prevent further risks. She was supported by a skilled police practitioner who remained with her throughout her ordeal and whose practice demonstrated their recognition of Emily's extreme vulnerability. Again, this was by luck rather than design – the review heard from police colleagues that such a sensitive response was more likely to have stemmed from that police officer's personal experience rather than from a systemically embedded response to vulnerable children and adults who are at risk of arrest. The practitioner group reflected on the need to ensure that all of those involved in the response to such vulnerable children to be trauma-informed in their practice. This would support their consideration of past trauma as a vulnerability and the presenting behaviour as the child's way of communicating about that trauma.

65. Six weeks after the first arrest, Emily was arrested by police from Residential Placement One. Emily did not like it there, she did not like being in her room all the time and she did not want to be with other children. She was taken to police custody, where an out of hours duty social worker attended. During this period, she was also taken to the Emergency Department as she was unwell due to dehydration. She returned to police custody overnight as she had been arrested for common assault. However Emily was not charged and the matter was NFA-ed.

66. Emily was then returned to the unit at 3am. She immediately threatened to leave, kicked out at care staff and was arrested again. She then spent a total of two days in police custody. There were some appropriate responses: there was timely contact with the mental health nurse in custody who was able, with the custody doctor, to medicate and support the de-escalation of Emily's distress. The social worker visited her in custody and shared social stories to help explain to Emily what was happening to her. Due to her ongoing distress and dysregulation, she was placed under s136 (MHA 1983) and taken to hospital. Regrettably from this event, Emily has a caution on file and thus a criminal record.

67. When the Independent Reviewer met with Emily in October 2023, she talked about being arrested from Placement One which she said was "horrible". She said that although the police had been nice to her, she had been very upset and restraining her had hurt her a bit. When asked if there was anything she would like to say for the report Emily said: "I was upset! Next time, don't bring me there [the police station]".

68. The professional network reflected on the impact of this episode upon Emily. Actions such as this serve to traumatise further a child such as Emily. Practitioners identified that having successful moved Emily to Residential Placement 6 weeks previously, there was a sense of relief and too much optimism for the stability of the placement. There was a 'honeymoon' period, but the transfer from hospital to Residential Placement One had been rapid and pressured in terms of getting out of hospital. The change in placement was overwhelming for

Emily who was distressed at having to move from her foster carers and this was compounded by the mismatch in Emily's needs and the suitability of the placement. Additionally, the placement was felt not to have had a suitable crisis management plan for when Emily became dysregulated. *It is recommended that all placements should have a risk escalation/ crisis management plan, especially for children already known to exhibit behaviours when experiencing dysregulation* (this is included as part of Recommendation One at paragraph 96).

69. It is acknowledged that staff should not have to experience violence at work, although again, there was a useful reflection around what the word 'assault' described when shared over the phone to a police call centre. The context was not shared. The police did arrive to an active situation and on their observation the assessment of risk should have led to arrest. However, because there was no alternative de-escalation strategy utilised within the placement and little evidence of information sharing by the residential unit: she was arrested and taken to custody. At that point, the police sergeant contacted children's social care to ask exactly who they had arrested, suggesting that there had been poor communication and /or understanding of Emily's vulnerability at the point of arrest from Residential Placement One.

70. In both situations, Emily's situation did not sit comfortably with any of the practitioners and the practice of calling the police that should be always reviewed and immediate consideration given to the learning in each incident, with the decision of a placement to call the police scrutinised through a multi-agency process. The response to call the police should be used as an absolute last resort. Practitioners felt that arrest and custody was not helpful for Emily, it dysregulated her further and was felt to have added another layer of trauma upon her.

71. It was also acknowledged that the practice of calling the police to manage behaviour by a child that might pose a risk was and is different in different contexts. Police and school practitioners agreed that it is an absolutely last resort for police to arrest a child on school premises. A perspective was offered that a residential setting might be safeguarding other children in the unit, however this is also the case for schools. However, it is a much more frequent experience for children in residential care than children living at home with families. Emily has a police record now; this does not reflect the extent of her vulnerability and is something that she may not understand. She also has professed in subsequent interactions with police and other practitioners that she does not like or trust the police, which will not support her safety in the future. The practice of calling the police and having arresting children from their (residential) homes displays a system bias against children simply because they are looked after and serves to compound the existing sense of rejection for a child such as Emily.[12] Therefore when this does occur, the multi-agency network should ensure that the causes and the events preceding such an arrest are understood.

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Recommendation Four: ***Where there are children who are discussed at the dynamic risk register meeting it should be considered to share relevant risks with the police.***

72. Key reflections were made by practitioners on how situations like this could be averted in the future through preventative information sharing. For example, ensuring that more details are understood at the point of decision making and response is made possible by a passport designed and promoted by the National Policing Autism Association.[13] Emily now has one of these in place at her current placement. But it is not clear that this is the same for all children, therefore the review makes a further recommendation that is aimed at ensuring that key information regarding a child's pre-existing vulnerabilities is communicated in order to prevent any potentially traumatic experiences for the child.

Theme Five: How Emily's capacity to make decisions and give informed consent was understood and influenced care planning and decisions.

73. A highly positive aspect of this case is that from the point of her fostering placement breakdown, most practice with Emily recognised her complicated presentation and unique profile, which influenced the decisions and behaviours she made arising from her disabilities. This included:
    - the excellent practice of the social worker and CAMHs clinician in the latter part of 2022 in ensuring Emily's voice is heard in all decision making and
    - the way in which Emily was supported as a victim, with the police using a specialist from the NCA in order to support the investigation which has led to the file being passed to the CPS for the charging decision.
    - the GPs working with Emily demonstrated a 'compassionate and tailored' approach when interacting with Emily. The good knowledge around her presentation was judged to allow for better communication through giving extra time for appointments.
    - There was good information sharing between LAC nursing around health needs including sexual health, education and the social worker.

74. The Rapid Review in January 2023 had recommended that this area of Emily's mental capacity to consent to sexual activity should be assessed. In reality, this task is not a simple one-off process and is an aspect of practice with Emily that continues to challenge practitioners. The conversations during the review process regarding how professionals understood and applied the legislative framework around mental capacity to make specific decisions at specific times with Emily provided some of the most thoughtful but self-challenging reflections. There is relevant learning from Emily's case that can be more widely applied to children in this cohort i.e. those with diagnosed learning disabilities but also with similarly complex developmental profiles arising from childhood abuse and neglect.

[13] https://www.npaa.org.uk/alert-card-schemes/

75. Practitioners were asked about the area of having to make very personal decisions around the capacity of children e.g. consenting to a sexual relationship, especially as the child approached adulthood. When decisions require a consideration of risk that is also underpinned by complex beliefs and different values or morals, one practitioner described it as *"tricky"*; another described being *"scared, worried about getting it wrong"*. One worker reflected that the professional network was still working with the aftermath of the serious sexual assault and within the context of ongoing DoLS where the professional network had still not taken the move to step the staff ratio of those caring for Emily from 2:1 to 1:1.

76. Practitioners reflected that Emily's capacity to make the decision to give informed consent cannot be considered without considering what the nature of the relationship would be, who her partner would be and what risks they might pose i.e. understand whether the relationship was based on a power imbalance or even possible exploitation? Given the very clear direction of the MCA (2005) for a single issue around a decision to be very *specific and time-limited*, until Emily has a proposed partner, an MCA assessment cannot make a generalised judgement about Emily's capacity to consent to a sexual relationship.

77. Even if the professional network were to consider positive risk-taking around consent as part of an ongoing risk assessment on Emily's understanding of sexual relationships, other considerations come in to play around her vulnerability. Practitioners observed that Emily's capacity is different in different areas and can fluctuate depending on her emotional or mental wellbeing, the environment she is in or other stressors. It is also true to say that the shared understanding of Emily and "what is going on in her head" is still developing. For example, the Independent Reviewing Officer shared that at the last LAC review, Emily's capacity to develop new skills was not fully understood: her ability to self-care had been somewhat hidden due to the nature of caregiving by the foster carer which might be described as 'cosseting' rather enabling of her. Emily's plan now has a focus on enabling her to make up for the lost time of learning about the basics of self-care. CAMHs are doing more work around certain aspects of her behaviours and also conducting a full assessment of possible FASD which has never been fully considered in order to understand further her presentation. It was also observed that her history of possible sexual abuse has never been fully understood, and so an exploration of that should precede any MCA around a sexual relationship.

78. Within the professional network, some practitioners work regularly with each other and have a good understanding of the MCA, understanding that Emily meets the first part of the 'functional' two-part test of the Mental Capacity Ac, i.e. that Emily is able to make a decision. This would lead to consideration of the second part of the test, essentially around whether she could understand retain information about the decision and communicate her decision[14]. Practitioners suggested that it was fairly easy to demonstrate that Emily doesn't have full capacity e.g. in areas around finance, managing her accommodation and care. It is not so easy to demonstrate that she is has diminished capacity most of the time. Added to this is Emily's impending adulthood, when she turns 18, which will be when the thresholds applied will be

[14] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance#key-messages

different. One aspect has been simpler: the Local Authority hold Parental Responsibility and take the lead on capacity assessments and the court process has significant influence now. The professional network was clear that is it a priority to equip Emily to be able to manage as best she can in terms of making choices about safety, however practitioners working with her now will not know if they have been successful in that task. For some children who live with their families, parental responsibility and the child's right and capacity to consent can be an additional complicating dimension to this area of work. For Emily, there are many unknowns as organisational knowledge and memory about her will change over time.

79. Practitioners have demonstrated proficient and responsive work around Emily's understanding of key decisions. The police needed a statement regarding Emily's capacity and level of understanding of the information being given to her in order to deploy an intermediary from the National Crime Agency during their investigation of the sexual assault. This was provided and the intermediary enhanced a successful investigation. At the time of writing the file is with the CPS for a charging decision.

80. The response to the sexual assault she experienced had to explore Emily's capacity to consent to emergency contraception after the assault was assessed. Although Emily did not understand some of the technical aspects of contraception, she was clear that she did not want a baby. A later decision around ongoing contraception was also informed around Emily's wish to prevent pregnancy and help with her periods meant a best interests meeting was called to ensure that the administration of the most suitable contraception was agreed. In these circumstances, the Head of Service for Disabled Children supported the decision-making as practitioner-led given the positive nature of the relationship between Emily and her social workers. Other practice with capacity and understanding has included everyday living arrangements and support needs; regarding DoLS and Emily's understanding of this, including the use of a Best Interests meeting. Emily is said to not want restrictions on her life but recognises the restrictions in place keep her safe.

81. This complicated area of work is value-laden and recognised as bearing some significant responsibility. It is closely linked to transitional safeguarding as it necessitates the children's professional network to try to bridge the gap between protection (and sometimes being overly protective) and to consider her rights and move to a model of safeguarding and care what are all about enabling and empowerment. Some of the values that might apply as the norm in children's safeguarding practice are disrupted at the point of transition to adults' services and so as within the children's workforce there needs to be some critical reflection and thinking around shifting the conceptual basis from safeguarding at all costs to enabling the adult. There is a need to reconcile differences in values and beliefs and align thinking more generally before applying values to some of the specific issues.

82. The practitioners noted that there is a developing 'maturity' in their professional network which could support, to an extent, the reflective conversations around the values each practitioner might hold and how values could influence their decision-making. At the time of

writing some of the more complex decisions for Emily's future are beginning to be tackled. It is vital that multi-agency conversations are held regularly. The Looked-After Children's Review process offers the opportunity to have an ongoing dialogue about what is best for Emily and how her needs could be met into adulthood. However, there are challenges to this, for example, staff turnover and confidence and competence in this area of practice.

83. More strategically, practice and decision making in this complex area must be supported by supervision, including informal and peer support as well as joint supervision. The Head of Joint Disabled Children's Services prioritises his availability and that of his managers to practitioners in order to support practice but as mentioned earlier, there is a need to develop more skill around this complex area of work. There are opportunities for protected practice reflection time and regular discussion with the service. The service has created a reflective style where mistakes are considered and reflected on. However, it was suggested that the workforce need to be trained to think more reflectively and to complete MCA assessments, as it was observed by a senior manager that the application of the MCA in practice is not fully embedded. There was a plan to create a specialist social work role around making applications to courts for DoLS and mental capacity assessment practice with children, however, that has not yet been actioned due to staff changes in the service.

84. With the recognised increasing complexity of children this area of practice must be supported.

Recommendation Five: ***That training, and development opportunities are offered to develop local expertise in working with the Mental Capacity Act and Deprivation of Liberties Safeguarding with children are supported and prioritised by partners.***

85. The key observation around working with the mental capacity of children into young adulthood is that this is complicated, especially where the focus is upon the most intimate and intricate part of a child's life. Good practice needs time, resources and particularly skilled practitioners. Although practitioners working with looked-after children are often making decisions which will affect the rest of their lives, some practitioners felt that this is not always articulated – planning often is focussed on the present and does not anticipate the child's future. And as the complexity in some children's presentations grow and transitional safeguarding embeds there is a need to think ahead.

86. There was also another related area for Emily identified by practitioners and the Rapid Review. The professional network has worked hard to prevent and discourage Emily from having inappropriate relationships without offering intervention around the alternative i.e. how Emily might be supported to have a positive heterosexual (if that is her choice) peer relationship. Again, consideration of this within a transitional safeguarding framework may support to clarify in planning and inform a positive risk management approach.

Theme 6: Assessment and planning for Emily's transition for adulthood and to adult services.

87. This theme was added to the Terms of Reference due to a useful prompt by the National Panel. The multi-agency safeguarding network around Emily has been focussed on what had been and what is now for Emily, but her rapidly approaching adulthood has been evidenced as at the front of the minds of those in operational and strategic safeguarding practice. Working with Emily beyond the age of 16 already necessitates a different response from practitioners in terms of new dilemmas as per the previous theme. It requires an awareness of the different legislative structures on the part of managers who must find pathways and navigate children along them to adulthood with minimum disruption.

88. Feedback from an experienced mental health practitioner is that that the infrastructure for transitions of children to adult service does work, however, a 'good' transition relies upon adept risk assessments and a commitment to multi-agency work. It was observed that Emily's package is intensive and highly funded, and it was reflected that adults' services offer very different types of care packages to adults than to those in children's services, driven by different legal imperatives and pathways.

89. Feedback from those in the system is that multi-agency work in supporting transitions is improving. The oversight of the DSR process can and will help significantly to assist in ensuring that Emily's transition is as comprehensively planned as possible. The chair of the children's DSR also chairs the Enfield DSR for adults and at a recent meeting that focussed upon other older children who were close to transition, the multi-agency network identified gaps in the information shared between the two multi-agency systems regarding children approaching adulthood.

90. There are also some processes being developed and put in place to assist transition planning. It is recognised that the legislation prompts local authorities to begin to consider transitions when the child is 14. There are some cases where social workers take the initiative and begin to plan early alongside adults' workers. There are acknowledged pathways within agencies and to join up the borough's different services there is a Transitions Operations Group: (TOG) a panel attended by the Integrated Learning Disability Service, the SEND service, and the Joint Children's Disability Service. The practitioners of all children known to the latter complete an and Early Notification Form (ENF) at aged 16, however other workers can complete the ENF – from education and employment settings and from health services. Emily already has an allocated adults' services worker as it is recognised that joint decision making is critical to best meet her needs into adulthood. Despite improvements it was not obvious that the children's practitioners that were part of the review discussion were able to identify what the different adult offers were or where specific workers relevant to the child's transition to adulthood sit.

Recommendation Six: ***It is recommended that there is further guidance and resources provided on transition planning offered to all children's practitioners in partner agencies so that they are clear what the choices and pathways are for children who are approaching adulthood.***

91. The TOG discusses which service a child might need into adulthood. The review process included an observation of a TOG meeting. Again, the complexity of some cases is clear, however the initial information shared via the Early Notification system was a useful start point and where the information shared is of poor quality that is challenged. The premises and key decision is about presenting need and the appropriate available service pathway (learning disability, autism, physical, mental health), although again, the complexity of some cases was explicitly recognised as not fitting in to the existing service design or legislative frameworks and so that was identified and escalated as an issue for the strategic Transitions Implementation group. This TOG meeting was also clearly providing a safety net for some cases – it is not yet clear if there is a systematic assurance that all cases will be picked up by adults.

92. The TOG is also an opportunity to advise on best practice in preparing cases for transition. An example would be around maximising use of Educational Psychologists to evidence IQ within the Leaving Care Service in order to inform a smooth transition to the ILDS. It was acknowledged that there can be some lengthy debates around eligibility. There is a joint funded (health and adult and children social care) transitions worker in the children's disability service who leads on reviewing packages to ensure readiness for transition. They also ensure the service has developed resources for families to help them understand and prepare for transition (housing, employment, healthy relationships, sex education with this cohort). The ToG also sets the tone for a more supportive culture for transitions work which continues to develop. Children's services will continue to pay for a child's care package if it has not yet been set up by adult services. This commitment provides a framework for most cases and strong partnership working is supported by a shared aspiration to make a difference.

93. However, the transition process within the other agencies involved is not always congruent with the LA. It would be hoped that Emily's next placement will be identified by the time she is 17 and a half. However, more generally it was observed that a shift in thinking is needed about the nature of provision for 16- and 17-year-olds and to consider commissioning local placements that are dual registered (OFSTED and CQC) to support a child into adulthood. There were observations made by practitioners that current structure do not always capture all elements of a child/ young adult's life. Some conversations around eligibility in some services happen too late. Services in different agencies appear as slightly patchwork rather than comprehensive e.g. there is an 18+ therapist from CAMHS offering a service to young adults in the Leaving Care Service, however this worker may not be entirely suited to Emily's presentation. There is also a transitions nurse in the LAC nursing team – who addresses physical health needs, but there is no other 16-25 service apart from Leaving Care, despite children / young adults such as Emily requiring that wrap around care.

94. Concerns were aired about some previous cases of a similar complexity whereby 'receiving' adults' services had not quite managed to *"catch the young person",* even when they are subject to the DSR. This has led to some cases coming to a cliff edge. Some cases were cited where there has been a significant gap in health services not being provided until after the

child/young adult's 18th birthday – there seemed to be a lack of synchronicity in when the case moved over. The 'blunt' cut off point of aged 18 does not always contribute to continuity in care or in safety, or indeed fully reflect the developmental stage of the young adult.

95. Practice is developing, ie adults service are becoming more risk and safeguarding-informed, but 'the practical application' of significant strategic decisions is not always ensured. Gaps remain in a shared understanding or appreciation of decisions made around planning for a child across children's and adults services, e.g. why an expensive placement was made or an out of borough residential school thought to be the best idea. Additionally, in some cases, it is not always apparent to parents where children are not looked after that early decision making by adults' services is focussed on the welfare as priority – having settled a child at a residential placement, the plan it then to move them back. However, there are scarce resources and limited sources of funding (s117 Mental Health Act[15] or NHS Continuing Health Care[16]) for adults with complex needs, although locally there are some provisions which may be a source of support. Key stakeholders are more than aware of the challenges that exist and are actively engaged in planning to improve the system.

96. Emily is preparing for becoming an adult and moving on to a more independent resource. There is a holistic plan being implemented in Placement Two to give Emily practical and emotional skills with an awareness that a future move when she is 18 will look very different from the current care plan she has. Whilst she is learning a lot of new skills fast, Emily will need some levels of support and most importantly consistency in some of the very positive relationships that she has had over the past year.

Summary and Learning Points from practice:

97. There is no evidence to suggest that any practitioner caring for Emily over the past year has done anything less than their best to ensure her wellbeing and keep her safe. Where shortfalls in practice led to harmful but unintended consequences for Emily, the professional network has demonstrated reflection and learning. The incident of 20.12.2022 had an impact on Emily and also upon those caring for her and it is to the credit of the multi-agency network that they have been so reflective and supportive of one another as well as to Emily. The developing culture between health and social care demonstrated in this case is of real note in that in this case, it is from the top-down and the bottom-up. Two essentially traditional organisations have worked through many of the recognised barriers around approach and language and are developing excellent joint working practice based upon a shared vision for children. .

98. There are some learning points to be highlighted and some suggested recommendations to be agreed by Enfield SCP

[15] https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-Emilytercare/
[16] https://www.england.nhs.uk/healthcare/

- **Learning Point One:** *around good practice to prevent escalation of risk in placements (see para 17)*

- **Learning Point Two:** *DoLS was and continues to be used effectively to safeguard Emily. This is regularly reviewed. DoLS must be reviewed in the light of patterns and changes of behaviours, but also in identifying any new or different risks inherent in the environment or different settings. Risks that might undermine safety.*

- **Learning Point Three:** *That clarity is key and as much factual description as possible should be shared with other agencies around an incident. This will enhance the multi-agency assessment of risk and immediate safety needs.*

- **Learning point Four:** *There is much to learn from the good practice of the Enfield Dynamic Support Register. The contributory factors to this success are transferable to all multi-agency work with children and vulnerable adults (see para 42).*

- **Learning point Five:** *Once a risk tool is developed, this should be used by the multi-agency network when any looked after child with known complex needs moves to a new placement to ensure a clear risk/crisis/behaviour support plan (including utilising DoLS) is implemented. That includes a risk escalation/ crisis management plan, especially for children in placement already known to exhibit behaviours when experiencing dysregulation.*

Recommendations

There are seven recommendations and to support action planning, some indication of the intended outcome from making this recommendation. The theme of risk management, i.e. activity to assess, plan and intervene to reduce risks or mitigate the impact of harm to a child runs through Emily's story.

> **Recommendation One:** *Enfield Safeguarding Children Partnership SCP should support key partners in social care, health, education and police to develop a partnership dynamic risk assessment and tools for planning, extending the improvements made by the Dynamic Support Register system in to practice.*

Outcome evidence: A tool used by key partner agencies that supports more consistent and effective risk assessment and planning for children with complex needs.

> **Recommendation Two:** *That the LSCP flag the lack of suitable placements for children like Emily to the National Panel as further evidence of a recognised national issue.*[17]

Outcome evidence: A specific communication around this to re-emphasise this and national improvements to local placement sufficiency.

[17] Children's social care market study Competition and Markets Authority March 2022.

Recommendation Three: *That Enfield LSCP provides professionals from all partner agencies working with all children in Enfield access to developmental opportunities and effective tools and resources to support risk management of online risks for vulnerable children.*

Outcome evidence: Engagement with the professional system around good practice and the development of practice resources.

Recommendation Four: *Where there are children who are discussed at the dynamic risk register meeting it should be considered to share relevant risks with the police.*

Outcome evidence: Police are aware of risks to high-risk and complex children.

Recommendation Five: *That training, and development opportunities are offered to develop local expertise in working with the Mental Capacity Act and Deprivation of Liberties Safeguarding with children are supported and prioritised by partners.*

Outcome evidence: Existence of practice evidence around impact for relevant children who are subject to DoLs and where the MCA is utilised.

Recommendation Six: *It is recommended that there is further guidance and resources provided on transition planning offered to all children's practitioners in partner agencies so that they are clear what the choices and pathways are for children who are approaching adulthood.*

Outcome evidence: Clear accessible information on ESCP website (which hosts both adult safeguarding and children MASA) and other relevant resources to support practice.

Appendix One: Timeline of Emily's story

Before the period under review:	
Aged 4	Emily was placed with A and K – long term IFA fostering placement
Aged 12	The foster placement became unstable– Emily moved to one then another temporary foster placement, then to a residential and was then assessed and held under the MHA s2, then s3 for 3 months.
Aged 13	Discharged and returned to former carers on a specific fostering approval by Enfield, remained for another two years, however her behaviours began to escalate and her needs exceeded what the foster carers were able to offer. Through this time she was at the same school – however one of her siblings is also there and the information she shares about their family with Emily unsettled Emily
Period under review – commenced just after her 15th birthday until two days After her 16th birthday:	
15 & 1 month	Emily ran away but was then brought to the ED and had a MH assessment. There is no MH illness, but remained in ED as s136 is in place. Returned home the next day. 10 days later, Emily is admitted to NUMH, distressed and dysregulated. She remains there for 6 nights and is discharged to the foster carers

15 & 6 months	Emily was removed from foster carers by police and taken to hospital (NUMH, under s136) after physically threatening them (with punches and a knife), threatening to kill them and attempting self-harming . She remained there for 18 days then was placed at Residential Unit One, in another London borough and CCG/ICB area
15 & 7 months	Emily physically attacked staff at Residential Unit One and was arrested, taken to back to the unit, attempted to attack staff again, was taken to custody which was refused, then taken under s136 and moved to Whipps Cross. This takes place over 48 hours.
15 & 7.5 months	After 4 days in hospital, Emily was detained under s2 of MHA and moved to a psychiatric unit in another part of London.
15 & 8.5 months	DoLS approval was granted as an alternative, to 'hold' her after s2 of MHA ends. Emily was in a psychiatric unit for 11 weeks whilst a placement was identified and prepared for her to move in to.
15 & 11 months	Emily was moved to Residential Unit Two after much planning and preparation for the move
16 years & 1 day	Emily went missing from the unit and was found the next day. Emily said she had been raped and injected with drugs.
Period after review:	
16 & 1 month	Emily was managed well as a victim, an intermediary from the NCA allowed her to make a statement. The police passed her file to the CPS for a charging decision. Emily's immediate sexual health needs were addressed well through MCA and best interest decisions. Emily remained is currently very settled at Residential Unit Two. She is successfully engaging in hobbies, developing new skills and achieving at school.

Appendix 2

Local Child Safeguarding Practice Review (LCSPR) child EMILY.
Terms of Reference for the review
DOB: 19.12.2006
Date of Incident: 20.12.2022-21.12.2022

1. Introduction

1.1 EMILY was the subject of a Rapid Review meeting on 25.01.2023. The meeting was made up of key professionals representing the statutory partners of Enfield Safeguarding Children Partnership. The meeting recommended that ESCP conduct a LCSPR and on 01.03.2023, the National Child Safeguarding Review Panel confirmed this decision.

2. Context

2.1 LCSPRs are undertaken for the purpose of safeguarding and promoting the welfare of children, in line with the requirements of the Children Act 2004 (as amended by the Children and Social Work Act 2017) and, the statutory requirements set out in Chapter Four 'Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote welfare of children, 2018'.

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

Safeguarding partners must make arrangements to:

- identify serious child safeguarding cases which raise issues of importance in relation to the area and
- commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

2.2 When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a LCSPR. Safeguarding partners must consider the criteria and guidance in Working Together 2018 and the Regulations when determining whether to carry out a LCSPR. In this case the Rapid Review meeting established that this case met these criteria for a LSPCR as

- Highlights or may highlight that there are improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- May have been one that the National Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

2.3 This was on the grounds that the LSCPR could expand on the learning points in the Rapid Review regarding:

- The practice involved in risk assessing changing needs and risks and balancing the prevention of harm against Deprivation of Liberties.
- Risk management, including assessment and care planning regarding the online safety and use of social media of children with additional needs
- Use of police custody to prevent the risk from and the risk to a child with additional needs
- Understanding capacity to make decisions and give informed consent

2.4 The National Panel also advised reviewing practice in transitions (including transitional safeguarding) in this case.

2.5 Therefore there are 5 themes to consider which as set out at 5.3.

3. Case summary

3.1 EMILY has been looked after since she was 4 years old due to neglect. She is the youngest of 6 siblings. Her mother passed away a few years ago. EMILY has a diagnosis of autism and global developmental delay from FAS and ADHD. Her long-term foster placement broke down as her behaviours escalated during adolescence and the year prior to the incident leading to the review saw a deterioration in placement stability for EMILY. EMILY had been in the placement at the time of the incident for 4 weeks, sharing it with one other child. The placement had been established to meet her needs. There was a DoLs in place and EMILY had 2:1 support at all times

3.2 On 20.12.2022, EMILY went missing and was found at a central London underground station the next morning. She alleged she had been raped and injected with cocaine. As a child that is looked after on a full Care Order (s31. Children Act 1989), this was a notifiable incident. A criminal investigation is underway and involves a specialist advocate from the National Crime Agency support EMILY as a witness and victim.

4. Methodology, Engagement and principles

4.1 This LCSPR will be undertaken utilising an Appreciative Inquiry methodology, consistent with the principles in Chapter 4 of Working Together 2018. Appreciative Inquiry helps us to understand, define and celebrate good multi-agency safeguarding practice; it rebalanced the focus on to what is good, what works and what we'd like to do more of. This is different to traditional approaches of reviewing practice where the primary focus is often on what went wrong and what should be done differently. As an approach, Appreciative Inquiry does not apportion blame; instead it seeks to understand what has happened, within the principles below.

4.2 Key principles for the review process

- To always remember that the main purpose for undertaking a LCSPR is to learn and improve.
- Recognition that the practice involved safeguarding children is complex.
- It is important to understand the facts as well as the underlying factors that led individuals and organisations to act as they did.
- That the review process should seek practice-based evidence from the viewpoint of practitioners and the analysis should based on what was known and what was knowable at the time rather than using hindsight to form findings.
- The review should be underpinned by the current evidence base and that this will inform findings and recommendations.
- That the child's lived experience should be at the heart of the review
- Collaboration, curiosity and honesty and reflection are key.

4.3 Agencies will provide further information and analysis of their agency's intervention, responding to the key themes and questions identified by the Rapid Review in January 2023 (see section 5). This is in addition to the Rapid Review themes and there will be a further themed template for each agency to complete. In complete this task, agency authors should seek out the views of professionals that were involved with EMILY. A summary of emerging themes will be developed to share with practitioners.

4.4 Agencies (see section 7) will return the themed template to ESCP and these will be shared with the Independent Reviewer in order that emerging learning is analysed.

4.5 **Practitioner Engagement:** There will then be a face-to-face **practitioner learning workshop** to reflect further on the themes, identify further learning and allow practitioners to contribute to the analysis of multi-agency practice. It is vital that as many practitioners that have worked with EMILY are able to attend as well as strategic partnership leads.

4.6 However, Appreciative Inquiry is also a methodology use to design for the future. Therefore, this workshop will also be about reflecting more widely across the 5 themes, in order to be able to begin to produce practice resources for all safeguarding practitioners in Enfield. An example of this might be the design of a toolkit for online safety with children with additional needs.

4.7 **Engagement with EMILY and family:** The views of EMILY (perhaps using an advocate) and key family and carers will also be sought in order to inform the review findings. However, this will

be done at a point where engagement would not compromise any other processes, such as the current criminal investigation. Again, the focus on this will be regarding what went well and why, in order to inform future practice.

4.8 This LCSPR will aim to reach recommendations that are SMART, deliverable, and measurable. They will be focused on actions that are most likely to prevent or reduce the risk or recurrence of a similar incident and on improving outcomes for children.

4.9 The Independent Reviewer will write a report regarding multi-agency learning which also supports the development of learning tools.

5.0 Scope: period under review and themes for consideration.

5.1 This review will focus on practice from her 15th birthday onward – ie from 19.12.2021 and will cover the 12-month period until 21.12.2022 **(date of incident)**.

5.2 In addition to that period, agencies have provided relevant background information to the Rapid Review that was considered important and may be asked to expand on that information where it helps set the context for the themes in this review.

5.3 This LSCPR will analyse, for further learning, the multi-agency safeguarding practice around

a. The effectiveness of multi-agency practice in risk assessing Emily's changing needs and risks alongside balancing the prevention of harm against Emily's Deprivation of Liberties.
b. The quality of the approach to the risk management of, including assessment and care planning, Emily's online safety and use of social media of children with additional needs.
c. The use of police or EMILY attending the police station during 2022 (28.06.2022; 02.08.2022) to prevent the risk from and the risk to EMILY, a child with additional needs.
d. How Emily's capacity to make decisions and give informed consent was understood and influenced care planning and decisions.
e. Assessment and planning for Emily's transition for adulthood and to adult services

5.4 The following key questions should be addressed to each theme (below at section 6):

- **What are the key facts/ evidence around this theme?**
- **What are the areas of good practice in this case and strengths in the system that can be identified and built upon?** *(E.g. effective liaison between professionals to develop the care plan)*
- **What are the contributory factors to good practice or these strengths?** *(E.g. professional 1 had an existing good relationship with professional 2 as they had worked together on another case.)*
- **What might be done differently in order to improve or enhance practice or the effectiveness of the safeguarding system?**

6.0 LCSPR (Overview) Independent Reviewer

6.1 Josie Collier, a qualified social worker and independent safeguarding consultant, has been commissioned as a reviewer to undertake this LCSPR.

7. Agencies and their practitioners to be involved with the review.

7.1 All agencies below should complete the themed template with these ToR as well as

- Enfield Children's Social Care
- Enfield Adult Services.
- Turning Point - commissioned placement provider
- NELFT Brookside Hospital
- Integrated Care Board including safeguarding lead and those involved in placement planning, as well as the GP's input.
- BEHMHT – Safeguarding. CAMHS, Community services, LAC nursing
- Speech and Language Therapy
- Schools – Oaktree, Five Rivers
- Police

8 Timeline for Review

The LCSPR will follow this timeline:

Rapid Review Meeting	25.01.2023
National Panel Confirmation	01.03.2023
TOR for LCSPR agreed by PI panel (virtually), distributed along with themed template for agencies	By 25.03.2023
Themed template to be returned	By 21.04.2023
Practitioner learning workshop	25/26/04.2023 or 3 / 4.05.2023
Engagement with EMILY and or representative, engagement with any key family and carers, plus outstanding fact checking.	w/c 08.05
First drEmilyt of report for PI meeting 05.06.2023	By 31.05.2023
PI meeting	05.06.2023
Amendments and report re-circulated by	15.06.2023
Final report completed signed off by ESCP Executive, ready for National Panel.	25.07.2023