LUTON
SAFEGUARDING CHILDREN PARTNERSHIP

CHILD SAFEGUARDING PRACTICE REVIEW

‘LENA’

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Finalised July 2022

Contents

1. BRIEF OUTLINE OF THE CIRCUMSTANCES LEADING TO THE REVIEW

1.1. In 2019, Luton Safeguarding Children's Partnership conducted a rapid review to consider the serious harm experienced by Lena through, sexual and criminal exploitation. Lena who is from a dual heritage background was at this time eighteen years old and had received a range of services over the preceding three years. During those three years, Lena had been missing on over sixty occasions. On two of these missing episodes, Lena had provided statements about being raped and sexually assaulted, as well as associating with others known to be victims of child sexual exploitation (CSE). Lena was believed to be involved with local gangs and groups associated with 'County Lines' drug trafficking.

1.2. The rapid review concluded that there was scope for system learning from Lena's experiences and in improving safeguarding and welfare of young people exposed to similar risks. This report provides a summary account of the Child Safeguarding Practice Review (CSPR) conducted by Luton Safeguarding Children Partnership in accordance with statutory guidance (*Working Together to Safeguard Children, HM Government, 2018*).

1.3. In examining the circumstances of agency and professional involvement with Lena this review has focused on exploring the multi-agency response in the Luton area to keeping young people safe from risks related to child sexual exploitation, criminal exploitation, and gang associations. Its intention is to promote learning, reflection and to improve the way the multi-agency partnership might respond to children in similar circumstances to Lena.

2. PURPOSE, SCOPE & TERMS OF REFERENCE

2.1. The purpose of this CSPR has been to:

- Establish whether there are lessons to be learnt about the way in which local professionals and organisations worked together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

2.2. For the period agreed (January 2017 to October 2019), the CSPR sought to:

- Ascertain whether previous relevant information or history about Lena and/or family members was known and taken into account in professionals' assessment, planning and decision-making
- Establish whether the respective statutory duties of agencies working with Lena and her family were fulfilled
- Evaluate how well agencies co-ordinated and established levels of risk

- Identify whether there were obstacles or difficulties preventing agencies fulfilling their duties (e.g. organisational ones such as caseloads or other contextual issues)
- Identify and describe relevant improvements in service design or delivery ahead of the dissemination of this report.

2.3. Case-specific issues explored were to:

- Responses to occasions on which it was understood Lena had reported to some professionals that she was pregnant
- Use and effectiveness of placements at a distance from Luton
- Impact of the use of secure accommodation
- Responses to criminal conduct attributed to Lena e.g. assaults on her mother.

SOURCE MATERIAL & CONDUCT OF REVIEW

2.4. This CSPR has been based upon information derived from:

- Individual agency chronologies and significant quantities of further material provided on request by Luton's Safeguarding Children Partnership
- Bedfordshire Police Service, Luton Children's Social Care (including its Independent Reviewing Officer (IRO) Service, Housing Service, Missing Person Co-ordinator / Provider of 'return home interviews', Secure Accommodation Provider, and relevant health information (GP and hospital).

Involvement of Lena and her family

2.5. Lena was informed of this case review and had limited direct involvement via a remote meeting that was facilitated by her current Personal Adviser (PA). A reported deterioration in her emotional well-being during 2021 prompted the indefinite postponement of a further discussion with Lena's following her review of her case records. At the time of concluding the report in July 2022, Lena had advised through her Personal Adviser that she was not in a position consider the report findings and to talk about her views, therefore this position has been respected. Further attempts were made to meet with Lena by her 18+ Independent Reviewing Officer (IRO) but without success as while Lena said she wanted to contribute and review the report's findings she did not attend planned appointments to do so.

2.6. This final draft incorporates the views Lena was able to express in her initial meeting with the author and the separate meetings with her PA and IRO. Lena's parents were informed of the review and were invited to contribute any views they might have, although they did not respond during or after the conduct of the review.

Limitations of the review

2.7. It is recognised that the report process and style followed a more traditional and less systems led model of review. There is limited consideration of the voice of Lena, how she viewed her culture and identity, her lived experience and trauma responses. The

review therefore would have benefitted from further input from those who knew Lena well and from holding further professional focussed conversations.

2.8. Subsequently views were sought from those who had been involved with Lena more latterly. They spoke of Lena being conflicted in terms of where she fitted in and that during the period under review Lena was seen as finding more about herself and exploring her sexuality and identity. Lena has continued to have support from a PA and an 18+ IRO (an innovation following this review) and her IRO has spoken about Lena still searching for meaningful relationships, being at risk of domestic abuse and of falling back into past associations especially where they are offering her monetary rewards.

2.9. Section 3 describes Lena's recorded experiences during the period of review. It is interspersed with italicised comments that highlight either good or sub-optimal professional systems or practice.

2.10. Development of the narrative was significantly constrained by difficulties and delays within Children's Social Care in locating:

- Aside from the July 2018 s.26 Children Act 1989 case review, a record of any others (though eight were actually completed during the period covered by this CSPR)
- Accounts of all completed 'return home interviews'
- An accurate list of all relevant addresses

Comment: such key information is required for routine inspections such as those conducted by regulator Ofsted and needs to be readily accessible; the late submission of (in themselves well-completed) reviews in in November 2020, served to complicate completion of this draft report. ***March 2022 update - experience to date of Luton's new IT system and clear local procedures – rooted in national guidance - provides reassurance that such information is now readily accessible and routinely monitored.***

2.11. Limited educational material relating to Lena's times with either parent or in local placements has been provided by the Education Service, though some social work records indicate liaison in early 2017 during attempts by Children's Social Care to complete an assessment.

Comment: References exist in LAC review records to the planned completion of a Personal Education Plan (PEP) (attributed to SW2 and 'Virtual School') but no written confirmation of completion was provided. ***March 2022 update: PEPS are now updated and monitored termly and audited as needed.*** *It is though clear that substantial and effective efforts were made by the Secure Unit staff to offer Lena relevant education whilst she was resident there.*

2.12. Given Lena's vulnerability to sexual and criminal exploitation, a very limited number of health-related contacts inevitably served to exacerbate her level of risk e.g. she made very little use of local GP Services and consistently failed to co-operate with formal health assessment appointments offered following her entry to Care.

2.13. Constrained by the fact that material available to this CSPR was less than a complete account of events and practice, section 4 seeks to respond to the elements within the terms of reference and encapsulate what can be learned from a retrospective evaluation of recorded case management. Sections 5 and 6 respectively, summarise overall conclusions and offer recommendations for improving planning and/or delivery of services to vulnerable young people such as Lena (and for facilitating more effectively, reviews such as this one). ***March 2022 update: responses made during 2021/22 are reported to have sufficiently resolved the recommendation of para. 6.3.***

Summary of what needed to change during the period under review

- Practitioners need to ensure that relevant family history and dynamics, pressures, and challenges such as or parental capacity to manage competing demands such as from mental health and disability are identified, assessed, and addressed as early as possible.
- Intense individual support needs to be available to young people at risk of child criminal and sexual exploitation by those specialising in CSE support work to include engagement with young people with adverse childhood experience and experience of trauma and those missing from education.
- Strategy discussions and meetings need to include all practitioners with relevant information and expertise and be compliant with Working Together 2018 expectations.
- Where there is a need for alternative care (by means of s.20 or s.31 Care Order) this should be assessed and planned for as soon as possible as the child cannot wait.
- There is a need for a robust Children's Social Care practice framework that identifies the need for robust case supervision and management oversight that provides a clear rationale and analysis in assessment, plans, interventions, and decision-making.
- There needs to be robust 'return home interviews' which reflect the views of children and young people, and which fully articulate the risks and consider the need for Edge of Care process where parental support for young people is likely to be withdrawn.
- Information sharing processes within local hospital emergency departments and sexual health clinics need to be strengthened and clarified to ensure appropriate and timely referrals are made to CSC.
- The LSCP needs to ensure the learning from this review is shared at a large-scale practice event on the theme of contextual safeguarding and extra-familial harm
- CSPR processes need to be strengthened to ensure that terms of reference are robust and build on the learning from the rapid review and that the expectations on panel members and single agency report writers are clear from the outset.

Actions taken since the review

- As highlighted throughout the report significant practice improvements were made since this review was undertaken. In addition to the activity referenced in the report and within the action plan there have been a number of new processes and structures related to child sexual exploitation put in place. These include a weekly *Missing and Child Exploitation* (MACE) multi-agency coordination meeting, *MAGpan* to support those identified as being at risk from gang or group association and a *Youth Partnership Service* to address those young people at risk of coming into the criminal justice system.

3. EVALUATION OF SERVICE DELIVERY

INITIAL CONTACTS WITH INVOLVED AGENCIES

Support of residence with mother

3.1. The material provided by Children's Social Care confirms that on 03.01.17 (Lena 15), her school made a referral of her report of a row with mother, being slapped around the face and told she would need to go and live with her father if her misbehaviour, which included truanting, continued. The information initially provided to this CSPR suggested the case had been closed next day without assessment of need / risk. Later provision of a 'single assessment' completed by 10.01.17 confirms that the response was more proportionate to the described circumstances. The author is advised that this apparent contradiction may reflect a manager over-riding (though without capturing the rationale for so doing) an initial practitioner recommendation.

3.2. The anyway poorly completed assessment revealed that the case had been closed less than a month earlier to the same worker (SW1) and contains a very extensive list of historical contacts with one or more family members i.e. records offer clear evidence of a family struggling to cope. The fragmented and incomplete document confirmed that Lena was seen on three occasions and that a phone discussion with an un-identified police officer and a named teacher from her High School had been completed.

3.3. A brief reference exists to Lena's previous contact with, and ongoing need for, advice from the Brook Sexual Health Service. Mother is recorded as being aware of her daughter's termination and planning [sic] to bring her to the GP for a follow up consultation. No such action is captured in GP records of 2017 though it *might* be a poorly expressed reference to a seemingly comparable event on 26.10.16 when an otherwise unelaborated reference exists to a termination in June or July that year.
Comment: it cannot be in the interest of the individual for there to be no reliable record of a procedure as significant as a termination. (Assuming such a procedure has been completed, where was it undertaken and why was the GP Practice not informed in a timely manner so that its clinicians could factor Lena's experience into any future consultations?)

3.4. The recorded output of the assessment, which was authorised by an unnamed manager, was both '*Child in Need Plan* required' and '*no further action*' (NFA).
Comment: it is not possible to reconcile these two outputs – in the event, the constituent elements of the sensible actions contemplated e.g. convening a family group conference (FGC) and engaging a youth worker appear to have been set aside. Feedback received suggests that this reflected parental opposition to those plans.

3.5. Police records capture her mother's report that Lena had been suspended from school for five days for fighting and was engaging in sexual intercourse. An unused condom

was found in Lena's bag. According to mother, Lena's father was having little contact with her.

3.6. On 09.04.17 Lena was the victim of actual bodily harm when assaulted by two unidentified females. Police records offer a picture of a mother unable to cope with her children and included a report that Lena had (and reportedly *unknown* to her mother) undergone a termination in 2016. Lena claimed that '*various support workers, teachers and Children's Social Care*' were aware of her pregnancy which she reported had followed after she had intercourse with a 15-year-old.
Comment: the accuracy of Lena's assertions is reinforced only by a reference to them in GP records (and they indicate that her mother had been aware of a termination). Although the procedure might have taken place elsewhere, the author has been assured that Lena did not undergo a termination at the local Luton and Dunstable Hospital. In her conversation with the author, Lena felt unable to comment on this sensitive issue about which there therefore remains unhelpful uncertainty.

3.7. Lena's case was consequently opened to the then relatively new Police '*Child Sexual Exploitation (CSE) Team'* and (from November 2017 to July 2018) her name appeared episodically at the Police Strategic '*CSE Management Meeting'*. Lena consulted a senior nurse health advisor on 25.04.17 where a safeguarding proforma is understood to have been completed. Lena made no disclosures, and the consultation prompted no further action.

3.8. Lena had received routine treatment at the local hospital on 07.06.17 when she presented with a self-inflicted injury to her foot as a result of kicking a door. School Nursing was informed, and they invited the parents to make contact if there remained about her health.
Comment: as far as the incident seems to have been a result of a loss of temper, there may have been some scope for further exploration and/or involvement of the hospital's safeguarding nurse.

Rape Allegation

3.9. An agreed joint agency response was made in June 2017 when, following Lena's report in school of being thrown out of the maternal home, she described smoking 'weed', consuming alcohol, and sleeping with a named male aged 26 (Lena was then a month short of her 16th birthday). Lena reported that she was unable to recall whether she had been sexually assaulted. In spite of significant efforts to identify evidence, its insufficiency later prevented prosecution.

Strategy Discussion (Police & Children's Social Care)

3.10. A strategy discussion on 08.06.17 (04.06.17 in Police records) shared the report of Lena's 2016 termination including a reference to an (unnamed) member of staff accompanying Lena. Agreement was reached about the need for a 'single assessment'.

Temporary Move to father's home

3.12. The strategy discussion concluded that upon completion of a medical examination and an 'Achieving Best Evidence' (ABE) interview, there would be a need for further discussion e.g. to ascertain whether father could protect her and whether Police would be taking any action against the adult alleged to have assaulted Lena. It was thought that *until* these actions were completed, an initial child protection conference was unjustified lest it emerge that concerns had been substantiated yet Lena no longer be at risk of significant harm.

Comment: without regard to the result of the criminal investigation of her rape allegation, what was already known about Lena's circumstances could have justified an initial child protection conference; this was a missed opportunity.

3.13. Having apparently stayed at a number of locations, Lena was collected by police officers on 09.06.17, taken her to her father's home (address 2) where she stayed for only two days. Meanwhile, her 13-year-old half-sister had been accommodated under s.20 Children Act 1989 from 02.06.17 to 12.06.17 as a result of being at home alone while her mother travelled to a location in the North of the country.

3.14. Police records suggest that mother briefly resumed care of that daughter on 11.06.17 before she again ran away. Prior to the completion in August of the Social Care assessment, that agency's records include Lena revealing that she had been thrown out of home by her mother on at least three occasions.

Strategy Review Discussion (Police & Children's Social Care)

3.15. Records supplied by the Police (and only Police) confirm that a review discussion was completed on 20.06.17 when it was agreed that Children's Social Care would continue to support Lena as a 'child in need' and it was hoped that she would co-operate in terms of an ABE interview and provision of a DNA swab. The possibility of residence with an unnamed aunt is also captured in Police records.

Comment: Children's Social Care and Police accounts of this period are hard to reconcile; the latter are generally more complete (though it became clearer during the CSPR that not all relevant Social Care records had been traced and made available); the level of risk apparent in the examined records at this time suggests that alternative care would be necessary.

3.16. During July 2017 Police records indicate that Lena was spending time with other missing young people at risk of sexual exploitation as well as male members of the Travelling Community.

3.17. An allegation from Lena's father was made on 09.08.17 that his daughter (though unaware at the time) could be seen in a social media video having consensual sexual intercourse with a named 15-year-old Following extensive enquiries, the result was 'no further action'.

3.18. The risk of CSE was recognised and the Social Care assessment completed on 17.08.17 noted Lena to be 'a *very vulnerable young person in need of the stability of a placement which will meet her emotional, physical and social needs…she needs to have a positive role model to break dependency on her close friend and build positive relationships with peers*'. An 'Action Plan' cited remains untraced.

3.19. On 01.09.17 Lena's father reported her as missing, and Police evaluated the risk to which she was exposed as 'medium risk'.
Comment: as far as father thought Lena would be with a friend, that she had run away before and that there was no indication of any medical issue or risk of self-harm, this evaluation appears reasonable.

3.20. A fortnight later on 14.09.17 Lena reported to a support worker at the Homeless Unit that she had been raped by a male aged fifteen. Police records confirm an allocated crime number for that allegation.
Comment: this was a further intimate encounter with the same individual; it remains unclear (though might reflect Lena's reluctance to offer evidence) why the young man was never interviewed.

3.21. Lena was reported missing on ten occasions in the latter half of September, from Address 3 and Address 4 (apparently funded via s.17 Children Act in consequence of her 'child in need' status). It was deduced from return interviews that Lena may have been staying at a named local hotel and/or with local individuals known to be sex offenders or targeting 'looked after' children. The author of these interviews appropriately relayed relevant Intelligence about Lena's associates to Police.

3.22. A second presentation to that hospital occurred on 27.09.17 when Lena (then 16) described a minor injury received during an altercation. The Safeguarding Children & Young Persons Service was not informed.

Strategy Discussion (Police & Children's Social Care)

3.23. Police confirm completion of a further strategy discussion on 05.10.17. It was acknowledged that Lena who had been regularly missing, was an 'incredibly vulnerable young person' and was associating with other older individuals also vulnerable to sexual exploitation and substance misuse. A CSE assessment was to be updated by SW2 and the possibility of a placement for the then missing Lena investigated.
Comment: the existence of a CSE assessment emerged only from Police records latterly supplied – it has not been located [March 2022 update – both agencies currently report a high level of confidence about respective and joint responses to CSE, including formal minuting of all such liaison].

3.24. Though not in material supplied by Children's Social Care, Police records indicate a meeting on 20.10.17 involving SW2 and the allocated workers for two other females,

all at risk of CSE. SW2 confirmed his manager's agreement to accommodation under s.20 Children Act 1989.

Comment: this was an important turning point prompting more decisive action.

ENTRY TO THE CARE SYSTEM

Strategy Discussion / Meeting

3.25. On 01.11.17 a third strategy discussion (Police describe this as a meeting) addressed the reportedly growing level of risk associated with Lena's 'reckless behaviour'. The possibility of an application under s.31 Children Act 1989 was considered and legal advice was to be sought about the possibility of obtaining 'Harbouring Orders'. The 'Missing Person Co-ordinator was tasked with completion of a return home interview as/when Lena re-appeared.

3.26. In the event Lena was voluntarily accommodated under s.20 and placed in a Children's Home (address 5). In accordance with Care Planning regulations, a request for an 'initial health assessment' was formulated.

3.27. Lena herself recalls her opposition at this time to entering the Care system. During October and November Lena was reported missing twenty-four more times. Records of comprehensively completed 'return home interviews' have latterly been located and indicate a sensitivity toward Lena coupled with a demonstrable willingness to share relevant information with Police and Social Care. How the outputs from each completed interview were linked to the casework planning is less clear.

3.28. In her (remote) conversation with the author, Lena recalled and identified as one of her more positive experiences of the Care system, the support she felt was offered by the Missing Persons' Co-ordinator.

Comment: Police records indicate that the first time Lena was reported as missing from her then placement was on 17.11.17 and that there were only four more such reports (each handled in a standardised manner); it may be that the majority of such episodes were managed internally.

3.29. Supported by a key worker from her then accommodation provider, Lena consulted a doctor from the Sexual Health Service. She referred during that consultation to a termination of pregnancy in 2016.

Comment: the circumstances surrounding the termination to which Lena referred were unfortunately not captured – suggesting scope for more professional curiosity and/or improved record keeping.

3.30. S.47 enquiries were completed on 21.11.17 and the description of nature and level of concern at that time and a month later just prior to Christmas were unchanged. Lena failed to attend her initial health assessment on 22.11.17.

3.31. Police records confirm that a strategy meeting was held on 22.12.17 during one of Lena's increasingly frequent missing episodes. This one extended from 19.12.17 to

24.12.17 when she made herself known to staff at an East London railway station and reported that she was a missing person with no money. British Transport Police reported that she had been in possession of a knife and cannabis. Records indicate that a Youth Offending Team (but not which one) was notified.

3.32. Lena described to police officers at her 'safe and well interview' that she had also been to London, Newport in Wales, and Exeter with a friend and unknown (or anyway un-named) males.
Comment: establishing the identities of those companions would have been of real assistance; the nature and level of risk of CSE was this time all too clear.

LAC Review 1

3.33. The first, of what is now known to have been eight s.26 reviews during the period of the CSPR, was completed on 11.12.17 soon after the 20-working day requirement. The meeting involved all relevant parties, including Lena and was comprehensively recorded. It noted (as did several successor events) the need for a personal education plan (PEP) to be completed.

3.34. A planned fourth strategy discussion was held on 27.12.17 coinciding with a further missing episode. Following 2 (01.01.18 and 02.01.18) further episodes of being reported as missing and Lena's admission of dealing drugs, a 'Complex Strategy Meeting' was completed on 05.01.18.
Comment: Children's Social Care make no reference to this event in material supplied and the Police Service has confirmed that it was not provided with a copy of any output record that may have been made. ***March 2022 update – a 'performance framework' now exists and its use should inform and facilitate the monitoring of those at risk****.*

3.35. A follow-up strategy discussion / meeting (records of both agencies are unclear on this occasion) on 08.01.18, agreed that Lena was at risk of significant harm and Care Proceedings justified.

3.36. Having been reported missing again from her placement in what appears to have been a pre-arranged episode, Lena was sexually exploited by two men known to Police and later returned to her accommodation by officers. Within the Police Service, evidence was accumulating of Lena's exploitation on several occasions for criminal as well as sexual purposes by named and known criminals e.g. for selling cocaine.

CONSIDERATION OF SECURE CARE / APPLICATION FOR CARE ORDER

3.37. On 10.01.18 a legal planning meeting explored the need for and justification of secure accommodation. Several more missing episodes occurred during the remainder of January and February. On one of the latter occasions, the friend with whom she was found reported use of heroin and crack cocaine provided by a man they had met by chance.

3.38. Further attempts were made in January and February to complete an initial health assessment (25.01.18 and 07.02.18) though both failed.
Comment: Lena's chronic asthma, with a potentially associated though unquantified risk of an episode, is apparent only from the Secure Unit records.

PLACEMENT CHANGES

3.39. On 11.01.18 Lena was transferred to address six. Within days she had, with others, burgled and committed extensive damage to a foster home. She later explained this was revenge for a grievance with another looked after child. The incident was dealt with by means of a 'Community Resolution' and the Youth Offending Service in the relevant area (Shropshire) notified via email. Whether connected to the above burglary is uncertain but on 21.01.18 Lena self-presented again at the local hospital complaining of a self-inflicted accidental injury (she reported having punched a glass).
Comment: according to hospital policy, the Safeguarding Children and Young Persons' Team should have been notified.

3.40. Police (and only Police) records confirm a further strategy meeting on 31.01.18 at which there was a useful exchange of information and a commitment by SW2 to seek legal advice about a secure accommodation application. On 01.02.18 Police records indicate that Lena (again missing) wished to leave the area so as to escape the man who was forcing her to deal drugs. Children's Social Care was notified.

Use of Secure Accommodation

3.41. On 07.02.18 the local authority initiated a successful application for a Care Order (s.31) and a Secure Order (s.25) under Children Act 1989. Records supplied indicate that Lena was placed two days later at a Secure Unit in Northumberland (address 7).

3.42. Lena's memory of these events as relayed to the author differ. She recalls that *immediately* after the Court Hearing and granting of Care and Secure Accommodation Orders, she was (in spite of her resisting) bundled into a waiting car by two men whom she had seen at the Hearing and driven for several hours to Northumbria.
Comment: the need for secure care had been proven (and would later be accepted by Lena), it is unfortunate that the 'no preparation' execution of the plan was experienced as traumatic.

3.43. Records generated by the Unit provide reassurance that Lena's developmental, educational, and health-related needs were recognised and a comprehensive response to them provided. That impression has been reinforced latterly by the provision of the reports of the s.26 reviews completed during Lena's placement in the Secure Unit.

3.44. In spite of reported positive progress, well conducted 'Secure Accommodation Reviews' on 28.02.18, 30.04.18 and 08.05.18 confirmed (justifiably on the basis of reported behaviours / responses) the need for the Order to be extended. SW2's report compiled on 21.02.18 and signed off by team manager TM1, contained a convincing argument for

the continuation of secure accommodation. It has several obvious spelling errors and cannot have offered a favourable impression to the Court. Some material supplied by Bedfordshire Police and dated March 2018 evidences ongoing liaison whilst Lena remained at the Secure Unit.

3.45. Records supplied to the CSPR confirm Lena's attendance at a Sexual Health Service on 22.03.18 where she referred to (unspecified) unsafe sexual encounters though declined contraception because she was not planning to be sexually active after discharge. Also, during her placement at the Secure Unit Lena was on 11.04.18, sentenced at Stratford Youth Court in Newham to a 'Conditional Discharge' and a fine for the offence committed before Xmas 2017 (possession of a knife).

Address eight

3.46. On 28.06.18 Lena was transferred to her new non-secure placement (address 8). Within days, a routine Ofsted inspection rated it 'inadequate'. Following discussion between senior managers of Luton and the provider an agreement was made that she would remain.

Comment: given the limited choice for young persons in Lena's circumstances and what turned out to be a successful challenge of Ofsted's evaluation, this decision was appropriately 'child-centred'.

Further s.26 Statutory Review

3.47. Lena's 5th s.26 review was chaired by IRO1 on 19.07.18 (others had been held on 26.02.18, 30.04.18 and 14.06.18). Lena was present and contributed well to the majority of it. The outputs of the meeting captured well her positive progress whilst in secure accommodation.

3.48. During her stay at address eight, Lena revealed details of her exploitation as a seller of drugs. There seems to have been limited liaison between Children's Social Care and Police, though on 26.10.18 the former agency was contacted by Police who wished to speak with Lena in connection with an investigation of a burglary.

Formal Complaint from Lena

3.49. A formal complaint was initiated by Lena on 13.11.18 asserting that:

- 'I am not being listened to by Luton Social Care. I have asked my advocate to email my social worker, but I still have not heard anything from her since my LAC review
- There are several outstanding actions from my LAC review that I would like these resolving as soon as possible because I am due to go to semi-independence next year.
- I am worried that I will not be prepared for semi-independence as I do not have a transition plan in place.
- I want to be able to have my friends adding to my phone contact list because this will help me to build positive relationships with them before I leave here'.

RETURN TO LOCAL AREA

3.50. A response was sent about a month later and offered a general reassurance about wishing to work in partnership whilst acknowledging (justifiably) that it was not always possible to comply with her every wish. The response lacks any direct confirmation or rebuttal of the quantifiable aspects of Lena's complaint e.g. had the social worker made no contact since the review on 19.07.18 (*visits should have been at intervals not exceeding 6 weeks*). The response also includes references to issues that are not cited in Lena's complaint. Nothing further is known with respect to Lena's response.
Comment: in her conversation with the author, Lena recalled being assisted to formulate her complaint and receiving a response. She was unable to add detail though did think that frequency of contact with her allocated worker increased.

3.51. On 04.04.19 and contrary to its earlier prohibition, Lena was found to have renewed a relationship with another resident. Her placement provider issued 1 weeks' notice and she was transferred to address nine. Lena continued to run away frequently (there were eleven episodes between 18.04.19 and 22.06.19).

3.52. Police records confirm that 'safe and well' checks were completed on all occasions. 'Return home' interviews on behalf of Children's Social Care were completed on three occasions during this period. It remains unclear why (there having been numerous such exercises completed well in late 2017) there are no records of return home interviews in this period.

Strategy Meeting

3.53. The local hospital was helpfully alerted on 23.05.19 to Lena as vulnerable. This ensured that any future presentation could factor that in when assessing the nature and implications of presenting issues.

3.54. On 21.07.19 Lena described witnessing the rape of a friend and of being the victim of several sexual offences committed by the same male in the previous months. In response, a further strategy meeting was convened on 25.07.19 and SW3 tasked to complete a referral to the 'National Referral Mechanism'. It remains uncertain whether this task was completed. It appears that Children's Social Care was not notified of or involved in any subsequent Achieving Best Evidence (ABE) interview. **March 2022 update – reassurance has been provided by Police and Children's Social Care that, following training and procedural improvements, such referrals and ABE related liaison are now reliable and effective.**

Address 10 & Transfer to 18+ Team

3.55. On 30.07.19 Lena was moved to the Bedford YMCA (address 10) and her case transferred to the 18+ Team. A 'Link to Change'[1] referral was initiated with the aim of supporting her to avoid further exploitation.

[1] 'Link to Change' is a registered charity specialising in supporting children at risk of exploitation.

Comment: it remains unclear why such a referral to this specialist source of help had not been made much earlier.

3.56. Lena was arrested on 18.08.19 for possession of an offensive weapon having been seen on a CCTV using a large bike chain to attack a man.

Strategy Discussion / 'High Risk Panel'

3.57. Possibly in response to the latest incident, a 'complex strategy discussion' was held on 28.08.19 at which it was recognised that Lena represented a risk to others as well as being at risk of exploitation. No minutes of this meeting have been located by Children's Social Care (nor by Police who should have been supplied with a copy, though they have recently been located on the Children's Social Care record). ***March 2022 update – Police have provided assurance that such liaison now involves child-centred as opposed to 'offender-led' officers.***

3.58. Lena's stay at the YMCA ended on 04.09.19 because she failed to make proper use of it and had rent arrears. On 12.09.19 Lena alleged that she had been victim of a sexual assault whilst staying at the address of a known sex offender.

3.59. Her case was (very appropriately) discussed at the borough's 'High Risk Panel'[2] which noted the imminent court appearance, ongoing risk of CSE, Lena's potential grooming of others and rent arrears. It concluded that she needed 'settled accommodation'. On 14.10.19 Children's Social Care (not Police) records indicate that Lena was brought before the Crown Court in relation to the alleged possession of an offensive weapon. No evidence was brought and the case against Lena was discharged. As Lena was now an adult the outcome was not shared with services supporting her within Children's Social Care.

3.60. Luton Housing Service responded to an application made about a 'homeless' Lena and on 14.11.19 she moved into self-contained accommodation at address eleven.

[2] In Luton a 'High Risk Panel' consisting of senior managers meets regularly to consider those at greatest risk

4. RESPONSES TO TERMS OF REFERENCE & EMERGING LEARNING

RESPONSES TO TERMS OF REFERENCE

CONTEXTUALISING EVENTS

4.1. The assessment completed by Children's Social Care in January 2017 refers to, but fails to evaluate, the significance of the family's long-term struggle to cope - described and summarised only a month earlier by the same social worker.

4.2. This apparent reluctance to recognise the severity of the family's difficulties served to delay a clear recognition of Lena's significant ongoing vulnerability. Poor record keeping renders it difficult to be certain, but it would appear that grounds for the more decisive responses that followed toward Christmas 2017 had already existed for at least six months. Whilst clearly it is only a limited individual perspective, Lena's response when asked about the months at home with her mother and (briefly) her father was that she recalled a student social worker visiting her in school and little else.

FULFILMENT OF STATUTORY DUTIES?

Educational Input

4.3. Based upon the records shared with the panel, it seems that local educational input ceased at an unknown point during 2017– there being no further record of any alternative provision or dialogue about the career-related options for this young woman. No PEP has been traced (though a reference to a PEP meeting in March 2018 exists) and the only evidence of support from educational sources is that described by the Secure Unit.

Children's Social Care

4.4. Nothing within the material provided offers an explanation as to *why* there had been such an optimistic view of the potential to maintain Lena within her family and community i.e. few strengths were identified.

4.5. The decision to initiate Care Proceedings was entirely justified albeit tardy and the challenges that Lena represented to the various providers of residential care were a function of her level of disturbance and her continuing exploitation for sexual and other criminal purposes.

4.6. The location of the various Homes / Units at distance reflected the justifiable need to remove Lena from real and present threats from young men known to be capable of violence and the scarcity of placements willing to accept the challenges associated with such individuals. It has become clear that Lena was at least initially, actively opposed to being moved out of Luton.

4.7. Though little detail of most of her placements has been seen, it does appear that the Secure Unit especially, provided a period of stability and offered some invaluable education and health-related support. That finding was reinforced by Lena in her

conversation with the author. She recalled that whilst she had at first hated and resented the placement, she had come to like it and to view the staff as amongst the most caring she had met.

4.8. A significant amount of Police Service resource was deployed in investigating alleged and actual crimes from which Lena suffered or for which she was accountable.

CO-ORDINATION OF AGENCIES' WORK & EVALUATION OF RISK

4.9. Though there was more debate during the early part of the review period than was first apparent in material supplied to the CSPR, there was untapped potential for involvement of both Health and Education Services in those strategy discussions / meetings.

4.10. There exist some discrepancies / inconsistencies within and between and Police and Social Care references and records of discussions / meetings. These suggest scope for reviewing how such inter-agency liaison works in practice.

OBSTACLES TO EFFECTIVE SERVICE DELIVERY

4.11. The panel has not been provided with any evidence of organisational constraints though it is self-evident that providing a service at a distance (and requiring liaison with unfamiliar agencies) must represent an additional challenge. Informal feedback has also suggested that high turnover of staff at all levels in Luton Children's Social Care during the period of this CSPR represented a challenge, though the team involved in the early planning for Lena has been reported as relatively stable.

IMPROVEMENTS ALREADY IN PLACE?

4.12. In response to the provisional findings of this CSPR, the Senior Management Team of Children's Social Care provided the following response…*'There is recognition that there has in the past been some reluctance in recognising the family's difficulties. That said, because of this recognition, a contextual safeguarding panel has been set up. This is a multi-agency panel which sits every week, chaired by the police, and supported by the team manager with responsibility for missing children*'.

4.13. The further plan of action following the draft report is as follows:

- The department will develop an operational model to strengthen our work in contextual safeguarding and our decision making around thresholds; 2 Service Managers are leading on this and will be linking up with another person in Central Bedfordshire
- We will look at training and development work with the teams around contextual safeguarding'.

4.14. A virtual meeting with the current jointly funded 'Exploitation Lead' in Bedfordshire's Violence and Exploitation Reduction Unit (VERU) offered a view that the need for improvements in County-wide agencies' responses to CSE had been recognised during

2016 and prompted more strategic and better co-ordinated operational responses in 2017 onwards.

4.15. Whilst structures and systems are in place for responses to CSE (and Child Criminal Exploitation – CCE) there remains an ongoing need for further training and overcoming recruitment / retention challenges within Children's Social Care.

CASE SPECIFIC ISSUES

4.16. The remaining 'case-specific issues' identified in the terms of reference in section 2.3 have either been addressed at relevant points throughout the report i.e. (inevitable) distant placements, (justified and effective) use of secure care, or in the absence of any records, cannot be commented upon i.e. responses to reports of (a still unconfirmed) pregnancy and (unevidenced) 'assaults' by Lena on her mother.

EMERGING LEARNING

4.17. Though not apparent from the records supplied by Children's Social Care or other agencies, during 2017 and thereafter, Lena's mother was struggling to manage the persistently low mood state and self-harming of Lena's half- sister (aged thirteen at the point of her referral to CAMHS by her GP).

4.18. The (unusual) use of s.31(1) ii [i.e. the 'beyond control' criterion] and later the successful application for use of secure accommodation were both justified, albeit belated responses to the high level of CSE which Lena was experiencing.

4.19. If there were missed opportunities or 'reachable moments', it seems more likely than not that they arose in the period prior to the review period of 2017-2019.

4.20. A Child Protection Conference would have been justified in June 2017. In early to mid-2017 when the (optimistic) hope that Lena might be sufficiently managed by her mother was formed. Such an objective was undermined by:

- An absence of a coherent written multi-agency plan
- To the extent that a plan was agreed in Summer 2017, a failure (reportedly a result of parental opposition) to convene a Family Group Conference

4.21. It would appear that involved professionals were preoccupied with reacting to Lena's behaviours initially in the community and later in her various placements. To some extent before, and more clearly following Lena's entry to the Care system, the very significant efforts of the Police Service seem to have been deployed largely in parallel with Luton Social Care rather than in negotiated collaboration with it.

4.22. Records supplied do not include evidence of direct work with either parent. Whilst the use of alternative care was justified and proved helpful in protecting Lena, it was accompanied by an unintended, perhaps inevitable reduction in educational opportunities.

5. CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS

5.1. The paucity of records from Children's Social Care and Education (and more understandably Health sources) means that the narrative in section 2 is incomplete and evaluations of situations and judgments, to a degree, uncertain.

5.2. It is though reasonable to conclude that:

- Early assessments took insufficient account of family history or parental capacity to manage the substantial respective demands of Lena's half- sister (mental health condition) and sister (disability)
- The need for more intense individual support is apparent from the beginning of the review period and could usefully have prompted the earlier involvement of those specialising in CSE support work
- The (insufficiently recorded / traced) strategy discussion / meetings involving only Police and Children's Social Care could usefully have been extended to draw upon Health and Educational expertise
- The need for alternative care (by means of s.20 or s.31 Care Order) should have been acknowledged sooner than it was
- The absence of any reference to case supervision / management within Children's Social Care renders it unclear on what rationale and authority, the case was maintained in the community or subsequent decisions were made
- Records seen offer limited evidence of the planning by Children's Social Care being informed by the views or reports of partner agencies or the well- completed 'return home interviews' though they did reflect Lena's views and the ongoing parental support for formal Care Plans following the use of alternative care.

6. RECOMMENDATIONS

ALL PARTNER AGENCIES

6.1. A multi-agency practitioner event (conducted remotely if Covid restrictions still apply) should re-examine and debate the current potential (strengths and weaknesses) for collective local efforts to protect and support young persons in Lena's situation. Such an event could provide an opportunity to remind participants that maintaining accurate and timely records of contacts / judgements is vital.

LUTON SAFEGUARDING CHILDREN PARTNERSHIP

6.2. The LSCP should debate the extent to which the required balance between medical confidentiality in GP Practice and Sexual Health Clinics and safeguarding of vulnerable individuals by Children's Social Care and Police is being maintained e.g.:

- To what extent are Practices reliably informed in a timely manner of terminations amongst under 16-year-olds?
- How much contextual information typically accompanies any such notification?
- What level of confidence and compliance with current policy / procedural expectations exists within local GP Practices?

6.3. The LSCP should clarify and provide briefings and suitable instrumentation/formats to the local network on what is typically required if an agency is asked to contribute to a Child Safeguarding Practice Review.

CHILDREN'S SOCIAL CARE

6.4. The Head of Services for Looked After Children should check the performance of the IRO Service with respect to:

- Accessibility of the records of completed s.26 Reviews
- Effectiveness of initial and review health assessments including expectations of further responses when faced by reluctance or refusal.

6.5. The relevant Head of Service should take steps to clarify expectations with respect to:

- Professional representation at strategy discussions / meetings (and take all reasonable steps to enhance Health and Education contributions)
- Agree output records of such discussions and meetings and audit compliance
- Records of completed 'return home interviews' and how the learning about individual young people may most effectively link to and inform, ongoing care planning for individuals.

LUTON & DUNSTABLE HOSPITAL

6.6. All opportunities generated by scheduled briefings, training events and procedural updates should be taken to remind staff in the Emergency Department and on the wards, of the criteria for alerting the hospital's 'Safeguarding Children & Young Persons' Service'.