Bristol Safeguarding Children Board

Serious Case Review

'Becky'

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The Reviewers would like to extend their condolences to Becky's family and all who knew her.

Contents

1. Introduction 3
Why This Case Is Being Reviewed 3
The Lead Reviewers 3
The Review Team 4
The Case Group 4
Structure of the Review Process 4
Methodological Learning 4
Terms of Reference for the Review 5
The Family 6
Family Involvement 6
2 The Findings of the Serious Case Review 8
Introduction 8
Appraisal of Professional Practice in This Case 8
Becky's Step-mother Seeks Support 8
Initial Assessment 8
Services Provided by FISS 10
Referral to CAMHS 11
Referral to Hospital Education Service 12
Referral to Family Therapy 13
Referral to Eating Disorder Clinic 15
CAMHS work finishes 15
HES Referral to First Response 16
Early Help Response to Referral 17
Visit by Action for Children 18
Involvement of Youth Services 19
3. The Findings 20
Finding 1 20
Finding 2 24
Finding 3 27
Finding 4 28
Finding 5. 30
References 32

1. Introduction

Why This Case Is Being Reviewed

1.1 This serious case review (SCR) was commissioned by Bristol Safeguarding Children Board (BSCB) as a result of the murder of Becky. The criteria contained within Working Together 2015[i] makes it clear that it is mandatory to carry out an SCR where a child dies, and abuse is known or suspected. The evidence of abuse in this case is the murder itself. Becky was reported as missing on the 19th February 2015 and her body was found on the 3rd March 2015. Becky's Step-Brother stood trial for her murder, and in November 2015 was convicted and received a custodial sentence of life imprisonment with a minimum term of 33 years. His partner was convicted of manslaughter and received a custodial sentence of 17 years.

1.2 This review looks at the three and half year period before Becky died where professionals were involved in providing services to her and her family. The review does not consider the circumstances in which Becky died or the contributory factors related to her Step-Brother and his partner, as this is being addressed by a Domestic Homicide Review (DHR) as would be expected in line with current guidance[ii].

Methodology

1.3 This Serious Case Review has been undertaken using systems methodology, based on the Learning Together approach developed by SCIE[iii]. The focus of a case review using a systems approach is on multiagency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper, underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them should contribute to improving practice more widely. Data came from semi-structured conversations with the involved professionals (the case group), documents, contextual documentation from organisations and the family. A fundamental part of the review was talking to professionals to try and understand what they thought and felt at the time they were involved in the case, avoiding hindsight as much as possible. The review has sought to try and make sense of what factors contributed to their actions at the time and to the decisions they made.

The Lead Reviewers

1.4 This review was undertaken by Jane Wiffin and Bridget Griffin who are both SCIE accredited Reviewers. Jane and Bridget are qualified Social Workers who have extensive experience of working in safeguarding. Both are experienced Serious Case Review Authors and Chairs, and are independent from all the agencies.

The Review Team

1.5 The Review Team consisted of a team of senior representatives from local agencies who had no direct dealings with the case. They analysed the conversations and documents, identified key practice episodes and contributory factors and helped to make sense of the key Findings. This report is the shared responsibility of the Review Team in terms of analysis and conclusions, but was written by the Lead Reviewers.

Review Team Members

Service Manager, Additional Learning Needs (Education)
Safeguarding in Education Team Manager
Service Manager (South), Child and Family Support (Social Care and Early Help)
Deputy Designated Nurse Safeguarding Children (Bristol CCG)
Named GP Safeguarding Children (Bristol CCG)
Child and adolescent mental health services (CAMHS)
Safeguarding Board Manager
Avon and Somerset Constabulary (Police)

The Case Group

1.6 The members of the Case Group are the professionals who worked with or made decisions about the family, and who had individual conversations with the Lead Reviewers. The Case Group comprised of 22 people (although not all these people were able to attend the case group meetings). They met with the Review Team on three occasions to share in the analysis, identification of contributory factors, and to comment and contribute to the final report.

Structure of the Review Process

1.7 The Review Team met on five occasions, and three times with the Case Group. They worked on the data, analysis of practice and the identification of the Findings and issues for Bristol Safeguarding Children Board consideration.

Methodological Learning

1.8 Throughout the review period it was often difficult get hold of agency records and to make sense of them; some of these difficulties were caused by the way case recordings were made in agency records, some were hand written and were difficult to read, some took a very long time to access, and some were so poorly written that it was never possible to make sense of them. Ultimately all records were accessed and so the only

impact was that it caused some delay. The concerns regarding poor recording practices can be found in **Finding 2**.

1.9 This SCR was one of a number of reviews into Becky's death. The Child Death Overview process, a Domestic Homicide Review and one agency's own internal review of practice have also been conducted. The decision to undertake a Domestic Homicide Review was made by the Bristol Community Safety Partnership 'Safer Bristol' two years after Becky's death and when the SCR process was significantly advanced. This decision was helpful as it provides analysis of professional involvement with Becky's Step-Brother and his partner, however the completion of the SCR has been delayed as the SCR reviewers have triangulated the information provided to the DHR by agencies to ensure that there is consistency across the two processes.

1.10 It is very important that there are clear linkages between different review processes, to ensure that all learning and knowledge is shared. An agreed process to do this was not in place at the start of the SCR. This was subsequently addressed, and all information shared. Going forward it is essential that the BSCB SCR process makes clear the need for, and facilitates, formal links where different types of reviewing mechanisms coexist.

Terms of Reference for the Review

1.11 The SCR was commissioned to consider the following two research questions:

- How is the psychosocial history of family members (with particular reference to early trauma) held in mind in multi-agency assessments and service provision?

- How do agencies and services work together to understand the day to day life of a young person with complex needs and how are services co-ordinated when there is limited multi-agency involvement?

1.12 The review was commissioned to consider the involvement of professionals in Becky's life in the three and a half years before her death. It is not the remit of this Serious Case Review to review the involvement of organisations in Becky's early years, but the review did seek to understand how professionals considered and assessed the impact of Becky's early life on her needs and difficulties in the period under consideration.

1.13 This Serious Case Review report will refer to Becky's early experiences of trauma and abuse. Becky's parents were separated when Becky was born, and Becky spent her early life living with her mother. When Becky was a young child her Mother struggled to meet Becky and her Older Brother's needs on her own. Mother told the review she requested a two week respite placement from Children's Services when Becky was 3

years old. This led to a period when Becky was on the Child Protection Register[1] and following respite Becky was taken into the care of the local authority at age three due to concerns about neglect. She was placed in foster care whilst her Father's parenting was assessed. Her Father was granted a Residence Order and she lived with him until her death. Further details related to this period are not relevant to the content of this report.

The Family

Becky – 13 at the start of the review period	Maternal Grandmother - with whom Becky stayed at weekends
Father - with whom Becky lived	Brother – lived with Mother
Becky's Step-mother - with whom Becky lived	Step-brother – lived independently
Mother - with whom Becky stayed	Step-brother's partner – lived independently
The Family are White/British	

Family Involvement

1.14 The Lead Reviewers met with Maternal Grandmother, and spoke to Mother, Father and Becky's Step-mother on the telephone. This was difficult for all of them and we are grateful for their time. All were positive of the services they and Becky had received. There remained many questions for Maternal Grandmother and Mother and the reviewers have attempted to clarify several uncertainties for them. The views of all have been integrated into the appraisal of practice and the Findings that follow.

1.15 Having read the report family members were given the opportunity to comment on its findings. Mother and Maternal Grandmother said that it was important for the public and professionals to hear how important it was for children and young people to be believed when they talk about their worries and that they were not blamed for their behaviour. They said that the review had shown that Becky was expected to engage and meet with too many different professionals and so could not build the trust she needed to speak out and they hoped that systems would be changed as a result of this. They said they did not know about many of the worries and concerns Becky had and so could not support her as well as they would have wanted to. They asked that professionals consider all family members, including those who do not live with the child full time, when providing services to children and young people.

[1] This is now known as a child subject to a plan
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

1.16 Becky's Father and Step-mother said that in hindsight they could see that the behaviour from Becky which they found challenging to manage was worse at times when her Step-brother was around. They said they wished they had realised the bullying she was experiencing from him at the time so they could have intervened to keep her safe. Father said he was not included by professionals and was not given the parenting support he needed so relied on strategies such as telling Becky she would have to move out of the home if she did not behave to manage her behaviour. He said he now understood that this behaviour was partly as a result of what Becky was experiencing from her Step-brother. He asked that professionals offer services at times working parents can attend so they can be more involved.

2 The Findings of the Serious Case Review

Introduction

2.1 This section begins with a summary and appraisal of the professional response to the needs of Becky and her family over a three-and-a-half-year period. This sets out the view of the Review Team about the quality of the professional response provided. Care has been taken to avoid hindsight bias and to focus on what was known and knowable at the time. The report then discusses in detail priority findings that have emerged from the SCR.

Appraisal of Professional Practice in This Case

2.2 All those professionals who knew Becky were shocked and saddened to hear of her murder; the subsequent criminal trial and SCR have been difficult for all those involved particularly because these processes required people to think back to time they had spent with Becky. All the professionals involved in this review have contributed fully and been open and reflective about the professional response to Becky and family. This SCR has found no evidence that the murder of Becky could have been predicted or prevented by any professional working with her. However, inevitably, in any review of the professional response to a young person there will be lessons to be learnt and so it is here; these are outlined below and in the Findings section.

Becky's Step-mother Seeks Support

2.3 The review period starts when Becky was just turning 13. Records show that Becky's Step-mother visited the local Children and Young People Services (CYPS[2]) office to ask for help. She reported that Becky was finding it difficult to go to school, that she had anxieties about being outside of the family home as well as there being conflict between Becky and Father. The records say that Father had "*not smacked her*" but described him as being at "*breaking point*". Appropriately this self-referral was accepted, a social worker allocated and an Initial Assessment (IA)[3] commenced in a timely manner.

Initial Assessment

2.4 The quality of any assessment at this stage is important, and although the completed Initial Assessment contained a reasonable amount of information, it was more descriptive than analytical and drew almost exclusively on the one perspective provided by Becky's Step-mother who was the only person seen. Becky's Step-mother provided information about family history, the circumstances in which Becky came to live with

[2] The CYPS has now been subject to notable change – see https://www.bristol.gov.uk/documents/20182/239407/CYPS+is+changing+2013_06_25.pdf/818c0733-0bd4-44eb-8adf-c912fbe61976

[3] The *initial assessment* is a short *assessment* of each child referred to Children's *Services* focusing on establishing whether the child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm.

her Father and concerns about Father and Becky's poor relationship. There was a lack of recognition or reflection that as a "blended" family with a complex past there might be differing family perspectives. Little information was sought regarding the current role played by Mother and Maternal Grandmother or the relationships between siblings.

2.5 Overall, this meant that there was neither an accurate nor objective picture of the complex family dynamics. Becky's Step-mother's engagement with professionals was caring and often very thoughtful, but unintentionally her perspective dominated, and an objective or holistic view was not formed. This over reliance on what adults said about the past and present (adult self report) emerges as a theme across the review period and is discussed in **Finding 4**.

2.6 The initial assessment was also negative in the language used about Becky who was described as "*controlling*", "*lacking aspirations*" and "*not engaged in the assessment*" without an analysis of what this meant regarding Becky's current circumstances. She was not seen alone and there was no sense that the assessment considered circumstances from Becky's perspective. This suggests a lack of understanding regarding the needs of a 13-year-old adolescent - who reported feeling isolated with significant fears about the outside world - for whom the process of meeting new people might be difficult precisely because it focused on Becky as the problem. This issue of the difficulties in professionals recognising the needs and circumstances of adolescents is discussed in **Finding 1**.

2.7 There was clearly a need for an in depth (core) assessment, indicated by the number of concerns which remained unexplored, such as the reported risk of physical altercations and the impact of Becky's past trauma and neglect on present attachment relationships. The absence of this meant that there was no clear analysis or formulation[4] and no understanding of the nature of the overall family difficulties or bringing together of all the available information to make sense of what were the underlying issues and develop a holistic plan for addressing them. From this point on the focus was on Becky being problematic and having problems, without a consideration of what was the cause and what, therefore, might be the solution. This was a theme across the review and the importance of a holistic formulation or analysis which does not just focus on young people as the problem is discussed further in **Finding 1**.

2.8 The conclusion of the assessment was that Becky was considered to be a Child in Need (CIN). This should have meant that a CIN plan was formulated in partnership with the multi-agency network, and there should have been CIN meetings and regular reviews of the plan[5]. This did not happen, and this meant that there was no lead professional or

[4] Formulation is the process of making sense of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them.

[5] A child is in need if s/he is under 18 and either s/he needs extra help from Children's Services to be safe and healthy or to develop properly; or s/he is disabled. Children's Services decide if a child is *in need* by assessing their needs. If they decide the child is *in need* they will normally draw up a plan setting out what extra help they will provide to the child and their family. This is called a child in need plan. The plan should also say when and how the plan will be reviewed.

process for overseeing the multiagency work and coordinating the different services offered. This inconsistency in the approach to planning, setting of goals, sharing thinking across the multi-agency group and a lack of a clear review process across agencies is echoed across this review and is discussed in **Finding 2**.

Services Provided by the Family Intervention Support Services (FISS[6])

2.9 A month after the initial assessment was completed the family were offered services by FISS and this support would continue for the next 6 months. It was helpful that there was a focus on the whole family as a starting point, but in reality, as the plan continued, there was an over emphasis on Becky's needs and on what was described as her problematic behaviour. A family support worker was to offer parenting support and explore the reported conflict between Becky and her Father and there was an individual support worker for Becky who was to focus on supporting her return to school and increasing her confidence. A social worker was tasked with overseeing the work and also engaging with Becky about her anxieties. The confusion about the need for a CIN plan appears to have been caused by the involvement of FISS who generated their own plan of action. This was important, but it was not multi-agency in nature and so served only as a single agency plan. This team does not exist anymore, and significant action has been taken since the time under review to strengthen CIN arrangements.

2.10 This plan of work was agreed during a home visit, but the expected outcomes of the interventions offered were not articulated making it unclear what was hoped to be achieved and therefore hard to monitor or evaluate progress. The records of the planning session describe Becky negatively, but the family support worker was proactive in finding a way of speaking to Becky alone. Becky reported feeling scared about a lot of things, including going back to school and being out alone, caused, she said, by reading about abduction cases and watching horror movies. The social worker was charged with addressing these concerns, but Becky did not attend any of the planned sessions. These anxieties were addressed in part through the work with the individual support worker, but the issue of what action Father and Becky's Step-mother could and should have taken to limit the watching of these programmes was not addressed because the parenting sessions did not happen. This meant the meaning of these films for Becky and why she watched them was never established. The lack of an initial analysis/formulation or subsequent reviewing mechanism meant that this gap was never addressed.

2.11 Becky's Step-mother reported that there were continued concerns about Becky's relationship with her Father, and although this was discussed with Becky's Step-mother and Becky, Father did not engage with any of the sessions with the family support worker (and never really engaged with any other services). There was no analysis or comment regarding this at this time which meant that there was no focus on the role

[6] FISS is a specialist service within Children's Services with the overall aim of preventing family breakdown through the provision of intensive support services. This team no longer exists.

that Father played in his relationship with his daughter or an outline of what he could and should do to help change the situation. This is discussed in **Finding 5**.

2.12 The individual work with Becky focussed on getting Becky back into mainstream school; although there was a clear plan of action put in place this was not achieved. The individual support worker was successful in engaging Becky in weekly activities and enabled her to feel more confident in going out.

Referral to CAMHS

2.13 The FISS team made a referral to Child and Adolescent Mental Health Services (CAMHS)[7] at the start of their involvement because of concerns around Becky's social anxiety. Four weeks later CAMHS organised a meeting[8] which was attended by the family support worker, the individual worker for Becky, Becky's Step-mother and CAMHS professionals. Most of the information was provided by Becky's Step-mother and there was no exploration of the wider family's view or any reflection on the circumstances from Becky's perspective given that she was not present. CAMHS agreed they would make a referral to Hospital Education Service (HES) and the clinical psychologist would meet with Becky to undertake an assessment of mental health needs and plan future work.

2.14 There were no formal minutes produced, but professionals were copied into a letter from CAMHS to Becky's Step-mother summarising what had been covered at the meeting, what actions would happen next and handwritten notes were kept in the CAMHS files. There were several problems with this approach to record keeping and updating the referring agency (Children's Social Care) of future plans. The handwritten notes[9] are hard to read, and the content of the letter was focussed on Becky's Step-mother's views/description of Becky's circumstances, as opposed to a more robust professional analysis. This inadvertently added to the professional overreliance on Becky's Step-mother's view of the family circumstances which is discussed in **Finding 4**. The issue of different styles and approaches to report writing and record keeping and its impact on multi-disciplinary work is discussed in **Finding 2**.

2.15 The lack of a child in need meeting/process meant that there was no overall coordination of the services provided by CAMHS with the existing package of support being provided by FISS. Consequently, there was overlap in the support offered, and Becky was required to engage with a number of different professionals. Some discussion was needed about how these different services would dovetail together and how Becky's acknowledged uncertainty about engaging with a number of new adults would be overcome. This is discussed in **Finding 2**.

[7] CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.
[8] CAMHS call this *a complex case meeting*
[9] This approach to recording was part of established custom and practice internally at CAMHS at this time because of capacity and resource issues. This is currently in the process of change.

2.16 The first meeting with the clinical psychologist at CAMHS took place a month later and was attended by Becky and Becky's Step-mother. There were seven further meetings over a 14-week period, attended by Becky and Becky's Step-mother or Becky's Step-mother alone and a number of telephone calls prompted largely by non-attendance at a number of appointments. Becky's Step-mother tried to support Becky to attend these meetings. Becky's Step-mother provided information about her knowledge and perspective of the family history, but this was not checked with Mother who had a different view of the past family history. The information shared by Becky's Step-mother was that Becky was neglected when young, she was fearful of the outside world and had concerns about being abducted and had problems with eating. There was no formulation developed as would be expected at this point and the subsequent sessions were designed to focus on Becky's anxieties and she continued to be highlighted by the family as the person with problems and no wider formulation was developed.

2.17 Goals were not set and there was a lack of clarity of what was to be achieved. The cause for this lack of a clear focus appears to be Becky's lack of engagement in the sessions and refusal to be seen alone. Given that the social worker also expressed concerns about not being able to engage Becky there should have been a review of focus and progress, and the meaning and expectations explored. The meaning of this lack of engagement and participation needed further analysis and exploration. This is discussed in **Finding 1**.

Referral to Hospital Education Service

2.18 At the same time as the CAMHS work started a referral was made appropriately to the Hospital Education Service (HES[10]) because Becky was out of education at this time. HES met with Becky and Becky's Step-mother at home, and a clear personalised education plan was agreed with a gradual and staged approach to attendance. This plan was effective and with the support of the FISS individual worker, HES staff, and Becky's Step-mother, Becky started attending HES lessons three months later.

2.19 Six months into the work with the FISS team they evaluated that their intervention had been successful; Becky was settled in HES school provision and reported feeling more confident to go out. FISS worked much longer with Becky than they would normally do so, but the conclusion focussed exclusively on Becky and although the closing summary acknowledged that conflict between Father and Becky had been an issue it did not acknowledge that work regarding this had not been undertaken and parenting support had not been engaged with. FISS informed all agencies of the closure, but did not provide a copy of the brief closing summary and therefore those agencies did not know what progress had been made, what issues remained unresolved or what needed to be addressed in the future and by whom. This lack of a clear handover process is addressed in **Finding 2**.

[10] Hospital education services is specialist educational provision designed to support young people who are unable to access mainstream education because of medical needs.

2.20 On case closure FISS asked HES to undertake a CAF[11], and a member of HES staff was designated as the lead professional. It is not clear what the purpose of this was or what was hoped to be achieved. CAMHS were still working with Becky and her family and there was a lack of coordination with those services. It would have been expected that given that the FISS services were being provided under the auspices of a CIN process that there would have been a CIN meeting to coordinate the transition to what was supposed to be a new organising framework.

2.21 At this time, the CAF work was overseen by a panel and the CAF process took place separately from the other services. There were three meetings of the CAF panel. Another agency, Action for Children[12] were asked to provide services and support as part of the CAF over a six-month period, but it is not clear exactly what these services were because there are no written records (this issue of very poor recording practices is being addressed by Action for Children as outlined in their internal review), but they included some home visiting and some attempts to work individually with Becky. What is clear is that once again there was some overlap with other services being provided and a lack of coordination. There were no multi-agency meetings of everyone involved.

2.22 This lack of coordination between the CAF panel, services delivered by Action for Children and other services such as CAMHS meant that at the same time as Becky, her Father and to some extent Becky's Step-mother were not fully using existing services and support, new services were being offered. This highlights some confusion about how services should be coordinated in the context of the CAF and when there is no obvious framework such as a child in need plan/involvement of CYPS. This is discussed in **Finding 2**.

2.23 HES also reviewed progress, something they did regularly over the next 18 months. This review was attended by HES and CAMHS staff which enabled there to be a discussion about both educational and psychosocial issues; something that was lost when agencies were no longer involved and HES were working with Becky alone some months later. The importance of full support to HES and the complexity of their work is discussed in **Finding 3**.

Referral to Family Therapy

2.24 CAMHS also held a case discussion, four months after the work with the clinical psychologist had started. This included a full summary of the family history and current concerns were said to be related to Becky's social anxiety, eating problems, possible depression, insecure attachment and her difficult relationship with her Father. The

[11] The Common Assessment Framework (CAF) is a process for gathering and recording information about a child for whom a practitioner has concerns, identifying the needs of the child and how the needs can be met. It is intended to help to identify in the early stages the child's additional needs and promote coordinated service provision to meet them.

[12] Action for Children is national charity who are commissioned within Bristol to provide support services to children, young people and their families.

outcome of this discussion was a referral to the Family Therapy service[13] within CAMHS.

2.25 This was an appropriate referral and represented a further opportunity to encourage all those adults responsible for Becky's care to consider the impact of the past and the present on her. In part this was achieved in the five sessions attended (Becky and Becky's Step-mother attended all the sessions, and Father came to one and Mother to another). A lot of family information emerged; this included Becky talking about significant conflict with Father and early worries for Becky that Father did not want her at home. Becky also talked about significant conflict with her older Brother and being unkindly teased about her weight by her Step-brother. Becky discussed the impact of the past on her, the complex family relationships and her worries about Becky's Step-mother and Father who were both unwell and undergoing tests. The conclusion of the Family Therapists was that all the adults in Becky's life faced challenges which meant they could not fully focus on Becky's needs, an important conclusion that moved the focus from Becky having problems, to a more holistic and family focused view.

2.26 The family therapy sessions took place over a five-month period and in the final session Becky talked about still feeling afraid of people and places and the conclusion was that this was likely to be connected to her traumatic past and current complex family circumstances. This was an important point, as up until this moment Father, Becky's Step-mother and Mother had not acknowledged that the complex family circumstances and relationships could be having a negative impact on Becky's emotional wellbeing. Unfortunately, at this time there were significant concerns about Becky having an eating disorder, Becky's Step-mother was becoming very unwell, Father was also physically unwell and these pressures meant the family felt unable to continue to attend family therapy.

2.27 This important family focussed formulation and analysis was not discussed with any of the other agencies or with the other professionals within CAMHS who were working with Becky and her family. This meant that the progress made in moving fixed family and professional thinking from Becky having problems to there being complex family relationships which were impacting on her was lost and this is discussed in **Finding 1**.

2.28 The effectiveness of this work was also not supported by appropriate recording (notes of all the sessions being handwritten and difficult to read), there was limited evidence of reflection or analysis, and there was no closing summary or final analysis of the work undertaken and this is discussed in **Finding 2**.

[13] Family Therapy enables family members, couples and others to express and explore difficult thoughts and emotions safely, to understand each other's experiences and views, appreciate each other's needs, build on strengths and make useful changes in their relationships and their lives. Individuals can find Family Therapy helpful, as an opportunity to reflect on important relationships and find ways forward. http://www.aft.org.uk/consider/view/family-therapy.html

Referral to Eating Disorder Clinic

2.29 At the same time the Family Therapy sessions were started, the Clinical Psychologist met with Becky and Becky's Step-mother after a gap of 7 weeks. Becky was noted to have lost a significant amount of weight and was complaining of physical symptoms such as fainting. The Clinical Psychologist organised an immediate psychiatric and medical assessment. Becky was assessed as having anorexia nervosa[14] and initially inpatient treatment was considered, but Becky made progress and she was referred to the Eating Disorder clinic within CAMHS. The Clinical Psychologist provided a full summary of the family history (as provided by Becky's Step-mother and to some extent Becky) and support provided by CAMHS thus far to ensure consistency of approach.

2.30 Becky was provided with an appropriate treatment programme for anorexia, including meeting with the specialist eating disorder nurse, medical support from the GP, and psychiatric support. Becky and Becky's Step-mother attended 13 sessions over a 13-month period. Father attended one and Mother four. These sessions focussed on getting the family to work together to support Becky and this was successful with a reported improvement in family relationships. The family were encouraged to continue to attend the family therapy sessions as an important part of the treatment approach[15] for the anorexia nervosa and they did so for a further two sessions. CAMHS worked hard to engage the whole family and Becky's health and wellbeing improved. She reported coping better at HES, developing friendships, attending sleepovers and engaging in group activities. This was considerable progress and at the end of the 13-month period Becky was assessed as having recovered from her anorexia nervosa, and her social anxiety was assessed as being much improved.

2.31 The GP who was part of the team offering medical support around the anorexia nervosa was kept updated about progress and the wider CAMHS team were copied into these letters. This was usual practice for the work of CAMHS, but again raises important questions about the impact of different approaches to record keeping and information sharing across the multi-agency group which is discussed in **Finding 2**.

CAMHS work finishes

2.32 HES were informed of the planned case closure because the work of CAMHS had been successful, and it was made clear that HES could make contact with CAMHS in the future if they had any concerns about Becky in recognition that they would need to support the continued complex needs of this family. This was helpful, but the process for doing this was not clear; HES believed that they would need to make a completely new referral through the GP, whereas CAMHS thought they were offering direct advice. It is important that the complexity of the needs of the children being supported by HES is recognised and that the process by which they can access advice and support

[14] Anorexia nervosa is a serious mental health condition. It's an eating disorder where a person keeps their body weight as low as possible.
[15] http://www.nhs.uk/Conditions/Anorexia-nervosa/Pages/Introduction.aspx

from CAMHS or other specialist services is made clear and this is discussed in **Finding 3.**

2.33 HES had concerns almost immediately about Becky's low mood, poor behaviour and concentration. These issues were discussed in the regular progress reviews, which were now only attended by HES staff. The conclusion was that the probable cause of these difficulties was Becky's worries about Becky's Step-mother being very unwell. Before HES could take any action to address these issues Becky returned to mainstream schooling at the end of term, and this was appropriately facilitated.

2.34 After eight weeks at the new school Becky returned to HES because she had not felt able to cope. There were initial issues regarding Becky being bullied which were successfully addressed. The previous concerns about poor concentration (an educational assessment was completed and proved inconclusive), low mood, conflict at home and poor behaviour were immediately evident, and these were viewed again in the context of Becky's Step-mother's continued poor health. These concerns were regularly discussed at the student review meetings, but no overall plan of action was formulated to address them or keep track of progress – were things getting better or worse, and what was an appropriate response. A referral was made to the Young Carers[16] project, but despite being followed up no progress was made and there was no further formal discussion regarding what might be causing Becky's difficulties.

2.35 Over the next 10 weeks HES concerns about Becky continued to deepen. She reported that Father had thrown her out of the house over Christmas (she went to stay with friends) and from this point Becky exhibited serious anxiety about being asked to leave home permanently; something she reported that Father threatened her about. This was a serious issue given that she continued to have fears about the outside world and her safety. Becky appeared distracted, was observed to be low in mood, behaving inappropriately and she complained that she was hungry. She was provided with individual support at this time and a referral to Brook Advisory Service was suggested which she declined. She also started attending a group off-site to look at her post 16 options. HES considered Becky's behaviour was likely to be caused by Step-mother's illness and the impact on the whole family.

HES Referral to First Response

2.36 The staff at HES were increasingly worried about Becky's low mood, her sense of hopelessness and fears about being "made" to leave home by Father. They understood how serious this was for her because home and Becky's Step-mother were very important to Becky. In May 2014 HES made a verbal referral to CYPS First Response[17] Team. The referral was comprehensive; it included full information about what was known about Becky's complex past family history, and present concerns were said to be evidence of possible adolescent neglect, Becky being a young carer, a risk of sexual

[16] A service offering support to Children and Young People who hold caring responsibilities
[17] First Response is the Bristol front door service for referring concerns about children

exploitation and homelessness. At the conclusion of the referral conversation, it is recorded that HES thought there was a need for youth services support and some family support. This did not represent the level of concern HES felt for Becky, and it is unclear why this mismatch occurred. Current policy is for referrals to be provided in a written format so that these misunderstandings about a child's needs are avoided.

2.37 First Response accepted the conclusion of HES, despite its mismatch with the information shared. It is the view of the Review Team that given the long history of concerns and the current level of risk, this verbal referral should have been accepted for assessment, but instead the case was quickly passed to the Early Help Services. At this time the First Response Team were newly established, and the existing arrangements did not routinely involve a qualified social work manager in decision making. Since then, changes to the First Response Team have been made including the routine involvement of qualified senior social workers/ managers who are responsible for reviewing referrals, summarizing concerns and clarifying the risks before referring to other services. This would have made a difference to the progress of this referral. This also highlights the critical importance of providing written referral information. This is now an expectation of all agencies.

2.38 HES were informed of the decision of First Response to pass the referral to Early Help, and although they were disappointed with this response, they believed that First Response were the experts and did not think it was appropriate to question or clarify the decision.

Early Help Response to Referral

2.39 The subsequent response from the Early Help team was muddled. They made an onward referral to the youth service as had been agreed with HES; they also asked a commissioned voluntary family support service (Action for Children) to undertake "*a safeguarding home visit*". It is unclear exactly what this meant; this type of visit is not part of existing policy and procedures[18]. This visit was agreed because Early Help had no social worker available and the Action for Children Manager was a qualified social worker and there was recognition at this point of the seriousness of the concerns. There was also discussion about Action for Children providing services to the family. Action for Children were commissioned by Bristol City Council to work with children aged 0-19, with a particular focus on children aged 5-13. Following the visit to Becky and her Father, Action for Children determined that Becky's needs were not such that a service from them was required.

2.40 The manager from Action for Children made one attempt to contact HES but they did not speak to anyone and did not leave a message, so no contact was made with the referrer and the professionals who knew Becky best. Contact was made with the family who said they were going on holiday and it was agreed that contact would be made on

[18] http://www.proceduresonline.com/swcpp/bristol

their return. It is not clear why responsibility for the home visit was not passed back to the Early Help Team, given that the urgency of the situation had dissipated. It appears Action for Children wanted to ensure continuity as they had already contacted the family.

2.41 At this time the Early Help Teams were at the very early stage of development, there was limited capacity and decision making did not routinely involve qualified social work practitioners. Significant changes in capacity have since been made, and decsion making is now overseen by suitably qualified practitioners.

2.42 A week after the referral had been made, Becky shared concerns with staff at HES about a young male peer threatening to publish explicit photographs on the internet and worries about 'sexting'. HES made verbal contact with Early Help with the intention of linking this information with the recent referral, but this did not happen and this request for help and advice was treated in isolation. HES made it clear that Becky was scared to discuss this issue at home because she was worried about her Father's reaction and that he might "*throw her out*". Advice given was for HES to support Becky to make a complaint directly to the police and for HES to consider a referral to Brook Advisory service and/or Barnardo's. This was incorrect advice, and the additional information should have been seen as strengthening the previous concerns raised about possible sexual exploitation. The information about sexual exploitation concerns was shared with Action for Children.

2.43 HES talked to Becky who did not want to contact the police because she said she was frightened of repercussions.

2.44 HES were not happy with the advice they had been given but felt that this issue would be addressed through the Early Help response. HES did not seek clarification of next steps, and they were not informed that a home visit had been organised. Again, HES did not feel that they could do anything about the decision made. They also felt uncertain about how much further they could explore the concerns with Becky. They felt constrained by the advice in the child protection procedures which say that when dealing with disclosures "*the child must not be pressed for information, led or cross-examined*" and did not know how far to explore the concerns. This is discussed in **Finding 1**.

Visit by Action for Children

2.45 Father was telephoned by Action for Children three weeks later and agreed to a home visit. During this visit, Father denied that he had threatened to ask Becky to leave, but said he expected her to attend college or find a job. Becky refused to be seen alone, but the Action for Children Manager spoke to Becky briefly alone outside the house and provided her with leaflets about a local specialist Barnardo's Child Sexual Exploitation project. They did not have a proper conversation about the concerns regarding the explicit photographs and the attendant professionals' worries about the risk of sexual exploitation. These should have been regarded as unaddressed and requiring further action. Although the decision taken by Action for Children to undertake the home visit

was because they recognised that Becky and her family needed to be seen, and they wanted to support their overstretched colleagues in Early Help, this stepping outside of role and task added further confusion to an already muddled response (this has been addressed by Action for Children through actions within their own internal review). The issues raised within the referral were never properly assessed and the issue of family relationships, and particularly the concerns about the relationship between Father and Becky remained unaddressed.

2.46 A referral to Barnardo's child sexual exploitation project was discussed, but did not happen due to confusion about whose responsibility it was. It appears each of the three agencies involved, HES, Action for Children and the Early Help Team believed the other was going to make the referral, and the continued lack of any coordination of services meant that no one realised it had not been done. This issue is addressed in **Finding 2**. HES were not made aware of the outcome of their referral, so also did not know that this issue had not been addressed, and at this point school ended and Becky left HES and moved to post 16 education provision.

Involvement of Youth Services

2.47 A referral had been made to the youth services by Early Help and an experienced youth worker visited the family home at this time. Becky was reluctant to engage, but the youth worker persevered and a period of individual work started. The focus was on building Becky's confidence, supporting her to attend post 16 education and to work on her relationship with her Father. The youth worker sensitively discussed the concerns about sexually inappropriate behaviour and Becky dismissed these and reported no concerns. The youth worker was not aware of the issue of explicit photographs and so was not able to explore this. Becky engaged well with the youth worker and used the time to continue to explore her worries about her poor relationship with her Father and her continued worry that he would ask her to leave. After 12 weeks in September 2014 Becky decided she did not want further involvement with the youth service; at this point Becky was attending post 16 education and she reported feeling much happier about home. The case closed, but the youth worker made it clear she could re-engage in the future if she needed to. Becky made contact a month later for some brief support but did not attend a subsequent appointment. Becky continued to attend post 16 education provision but did so erratically until the time when she was murdered.

3. The Findings

3.1 The central purpose of a Serious Case Review is to learn lessons about how to improve the safeguarding system for the future. In essence, the review looks back at one case in order to look forward to what would improve the practice in the wider safeguarding system. Although this case was unique to those involved, there are aspects that are familiar to all professionals who work with vulnerable children and their families, and therefore this one case can provide useful organisational learning to underpin improvement more widely.

3.2 The evidence for the findings comes from the case itself, the knowledge and experience of the Review Team and the Case Group, from the records relating to this case and other documentation from agencies, and from relevant research evidence.

	Findings
1.	**Services need to be focussed on an evidence based understanding of the needs and circumstance of adolescents; the absence of this can lead to adolescents inappropriately becoming the focus of concern, and being seen as "troublesome" rather than troubled because of their circumstances.**
2.	**The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.**
3.	**Children in receipt of specialist services from Hospital education services (HES) have complex needs, and some require a multi-agency response to meet these needs. Despite this, HES are often working alone in providing services to children; such lone working does not meet the needs of all children.**
4.	**The propensity for professionals to take parent/carer perspectives at face value without triangulating information from other sources, including observations of how a child or young person appears, can lead to a limited understanding of a child or young person's needs.**
5.	**Professionals are less challenging of the lack of engagement of Fathers in child welfare practice leaving the risks they may pose unassessed and the contribution they could make to children's lives unknown.**

Finding 1: Services need to be focussed on an evidence based understanding of the needs and circumstance of adolescents; the absence of this can lead to adolescents inappropriately becoming the focus of concern, and being seen as "troublesome" rather than troubled because of their circumstances.

3.3 This review builds on the Findings of the recently published Operation Brooke Serious Case Review[iv] that raised important questions about the service response to vulnerable adolescents locally and nationally. There has been concern over the past few years from

professionals, policy makers and researchers that services across the safeguarding continuum do not recognise the risks that adolescents face and do not adequately meet their needs. This is despite the evidence that many adolescents experience significant abuse and neglect and this abuse and harm has a more global negative impact into adulthood than childhood-limited maltreatment (Radford et al. 2011[v]). It is, therefore, essential that adolescents are provided with services that they are able to access to meet their needs.

3.4 This review has found that there were three key areas where more understanding of Becky as an adolescent who had a traumatic past and complex family relationships was required. These are:

- Ensuring that professionals do not focus entirely on adolescents as the problem and develop a clear formulation or analysis which is family focussed;
- Engagement of adolescents;
- Enabling adolescents to talk about concerns and worries.

Ensuring that professionals do not focus entirely on adolescents as the problem

3.5 Adolescence is a time of considerable biological, psychological and social change and consequently the transition from childhood to adolescence can be difficult [vi]. Adolescents who have experienced early trauma and abuse and whose family and social circumstances are complex have not always been equipped with the skills and emotional repertoire to manage this transition and can thus find it more difficult[vii]. These difficulties are not always then perceived as a result of those early experiences or current family difficulties, but as a problem with, and of, the adolescent. Research[viii] and SCR's[ix] have highlighted that because adolescence is a time of independence, when adolescents become known to services there is a tendency for professionals to evaluate their difficulties in isolation and they can become seen as "troublesome" rather than "troubled by their circumstances"; their behaviours and responses should be understood as a manifestation of trauma, not a manifestation of adolescence.

3.6 Unpicking these issues requires careful assessment and the development of a clear formulation or analysis; in essence in order not to compound an adolescents' feelings of low self-worth and self-esteem professionals need to understand the causes of adolescent difficulties and carefully locate them in the context of their past trauma, current family relationships, social circumstances and individual needs. This requires professionals to ensure that parents/family members understand this holistic approach and resist attempts to blame the adolescent for their problems.

3.7 Becky came to the attention of service when she was 13. It was known that she had a traumatic past and complex family and social circumstances. The first assessment was an important opportunity to bring all this information together and build a formulation or analysis of her and her family's needs which should have provided the foundation for appropriate interventions. The assessment offered was an initial assessment and this did not provide the framework for an in-depth assessment. Services were offered and

located as a response to the potential for family breakdown. However, the work became focussed on Becky and her problems. This was compounded by the referral to CAMHS and HES; both were appropriate to Becky's individual needs, but because none of the services were joined up this reinforced the view that the focus of attention was on Becky.

3.8 The organising framework should have been the CIN plan, but this was not formulated, and no multiagency meetings were planned. FISS worked with Becky for six months, and although her mood improved, the family problems that caused the initial contact remained, and services offered to address these issues were not engaged with. The lack of a transition arrangement meant that this information was not shared with any other agency and was not really acknowledged by FISS.

3.9 A CAF was initiated, and this was a further opportunity to establish a formulation and analysis of what the issues were that needed addressing and how they were to be addressed. Again, this did not happen, and the focus was on Becky and what was seen at this time as her problematic behaviour.

3.10 The provision of Family Therapy meant that there was some discussion regarding the role of the past and current complex family relationships, but this was disengaged from. The absence of an overarching plan, based on a formulation or analysis, with goals and objectives which were holistic meant that the move back to providing services to Becky as an individual with the problems was not acknowledged or addressed.

3.11 The referral to First Response by HES was a further opportunity to understand Becky's circumstances in the context of her family. This was addressed in a muddled way, and instead of an assessment one home visit was completed, where Father did not acknowledge any of the concerns and the focus became again on Becky and the provision of support services to her alone. This individual support was appropriate, but it needed to be located in the context of a holistic formulation bringing together the past and present and helping Becky understand her difficulties as not her own, but as a result of the context she lived in.

Engagement of adolescents

3.12 The recent evidence scope; *That Difficult Age,*[x] has highlighted the importance of working positively with what is known about adolescent development and thinking carefully about the implications for services. This is particularly necessary in considering engagement with services where adolescents can be perceived as difficult to engage, per se. The responsibility is often placed with them, and there can be a perception that they are making a free and informed choice. However, research makes it clear that adolescents' struggles with services are often connected with their past experiences and they may be cautious about services which they perceive will destabilise their established strategies for coping with their problems. Services which are focussed on problematic behaviour can reinforce feelings of low self-esteem and depression; many vulnerable adolescents will also have had to engage with large numbers of professionals, and there are often issues regarding trust and perceived

reliability. All of this requires professionals to think carefully about how to enable vulnerable adolescents to engage with services.

3.13 Becky was often described by professionals as not engaging with services and not being motivated to change. This was not sufficiently reflected on. During the time under review she was asked to engage with 17 different professionals and there was often overlap with a number of professionals trying to engage Becky in individual work without there being any discussion of whether this would be too many new people and too much to engage with.

3.14 **Finding 5** focuses on services' failure to engage fathers, yet the contradiction that this was not subject of comment or criticism was not acknowledged. It is not clear the extent to which Becky was aware that professionals considered that she was difficult to engage, or that she was somehow making a free and informed choice not to access services, but this perception is likely to have a negative impact on an adolescent's sense of self-worth.

3.15 For Becky, it would have been more accurate to say that she was engaging in some services, she formed good relationships with some professionals and there was evidence that she was able to make good use of these services. What was missing was a broader reflection of the meaning of what was termed her non-engagement in the context of wider case coordination and planning. This reflection should have focussed on what services and professionals could do differently to enable her to engage.

Enabling adolescents to talk about concerns and worries.

3.16 It is critical that adolescents are enabled to talk to professionals about their concerns and worries, particularly about their safety and potential experiences of abuse. Although there is no evidence that Becky was abused during the time under review she did share worries that lead to concerns regarding possible sexual exploitation, which she found difficult to discuss. This led to a referral to First Response, passed to Early Help and then Action for Children. She was not seen for three weeks, due to a family holiday, and refused to be seen alone. Given that she had not met either of the workers from Action for Children, this is not entirely surprising. This Finding focusses more generally on professionals enabling children and adolescents to be able to talk about any abuse they may have experienced. Local and national guidance makes it clear that children and adolescents must be offered an opportunity to be sensitively enabled to "tell their story" as well as disclose concerns and harm.

3.17 Research by the Office of the Children's Commissioner[xi] found that as few as one in eight victims of abuse come to the attention of professionals and many victims wait until adulthood before being able to tell someone about their experiences. Research by the NSPCC[xii] highlights that this is not because the children do not seek help, but because they are often not heard, not believed, or adults do not notice the behavioural signs that indicate something is going on for them.

3.18 There are significant issues regarding enhancing the skills of all professionals to work in this area and enabling children and young people to seek help safely. Research

demonstrates[xiii] that there are significant barriers to children feeling able to talk about abuse and worries for their safety and for professionals to notice that this might be an issue for the children they are working with and asking them about it.

3.19 Children and adolescents say[xiv] they need professionals to be able to discuss concerns about abuse openly and without embarrassment and be prepared to ask questions and explore what children's/adolescents' concerns are. The current policy and guidance framework, developed because of concerns raised by the Cleveland Inquiry[xv], suggests to professionals that they need to exercise great caution when talking to children about sexual abuse. The mismatch between what children say they need and what policy prescribes needs urgent attention locally and nationally.

3.20 Becky talked about her worries about someone she described as a boyfriend having explicit photographs of her and threatening to publish them. The staff at HES were worried about her and gave her time to talk about these concerns, but they felt constrained by guidance which suggests that they could not ask leading questions. They were uncertain about how to enable Becky to talk about what she was worried about. They are not alone in this concern. Recent research from the NSPCC [xvi] and as highlighted in the Brooke SCR [xvii], professionals generally, and social workers specifically, lack confidence in this area.

Questions for the Board

- Are services appropriately structured in order that evidence-based approaches can be provided for adolescents that agencies find hard to engage?

- How can BSCB support professionals to feel equipped and confident to carry out this complex work?

- What can BSCB learn from the work of voluntary sector agencies about dealing effectively with disclosures?

- How will BSCB be informed of changes achieved through the learning and development in this area?

Finding 2: The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.

3.21 Critical to interagency work is a joint understanding and ownership of assessments and plans, and a shared vision of what constitutes good outcomes for a child. The need for information sharing is well-rehearsed in statutory guidance, and concerns about the nature of this information sharing is the subject of numerous Serious Case Reviews.

There is less notice given to the disparity of multi-agency information sharing in relation to case recording, planning, and review.

3.22 During this review, the Review Team were struck by the differences in how agencies recorded information about a child and family and how difficult it was to bring this information together to make sense of shared outcomes, assessments and plans.

3.23 There were significantly different approaches (within and across agencies) to case recording and it was clear that different custom and practice had developed across agencies, making multi-agency work more complex. For example, CAMHS approach to sharing information is through the issue of letters. The information contained in these letters is comprehensive, but is addressed to one agency, in this case the GP, and other involved professionals within CAMHS and outside are copied in. This is a very different approach to, for example, Children's Social Care. Although each agency has its own rationale for recording approaches, there is a danger that these differences can confuse practitioners and undermine multi-agency practice, and leave children without a joined-up approach. There was evidence of this here.

3.24 Each agency undertook its own assessment process, and drew up a plan of action which was single agency in approach. This was exacerbated by the lack of child in need processes, and confused by the CAF arrangements that happened separately from other service provision. There was little connection between what support had been provided, what the implications were of any unfinished work, what that meant for future work and for Becky feeling listened to. Overall, Becky's needs were split between different services and as a result the provision was fragmented. There was little transfer of care or information between services, and little meaningful dialogue or connections between services leading to duplication and confusion. Multi-agency involvement was marked by a lack of coming together to think about Becky and consider what response she needed, by whom, in what timescale, and for what purpose. Who was best to do the job in the interests of Becky and her family, how could they be supported to do this, and how could agencies and services work together to understand Becky and meet her needs?

3.25 This confusion was particularly highlighted in relation to the role of the Lead Professional. When there was a CAF in place for Becky, the Lead Professional chaired the CAF meetings but took no active role in the coordination of services.

3.26 Since the time under review the arrangements for the delivery of CAF's has changed and there is now greater clarity about the role of the Lead Professional. The delivery of services to Becky, however, raises questions about the coordination of services when there is no involvement of Children's Social Care and no CAF. The multiagency network looks to Children's Social Care to provide a coordinating function, even when it has no role to play in service provision (because the needs of children and young people are being met by other services). However, it is important that the other agencies in this situation are prepared to take a coordinating role to avoid the duplication and fragmentation seen in this case.

3.27 The approach to reviewing mechanisms in this case was almost entirely single agency. Although single agency reviews did take place, the quality was variable and it was noticeable that agencies seemed to be focussed on different outcomes. There were few opportunities where agencies got together to review collectively. In the early days of service provision this was because of there were no child in need meetings. This was outside expected practice, and is an issue which is currently being addressed by Children's Services as part of its transformation programme. When the child in need process was finished there was a CAF in place; this should have been an opportunity to coordinate all services and review progress. This was not achieved, and this appears to have been caused by the arrangements in place at the time for the provision of CAF's.

3.28 This review found that the points where planning and review were least effective were at points of transition from one period of service provision to another. When the FISS work finished, the closing summary of their work was not shared with those agencies who remained providing a service to Becky, and therefore they did not know what had been effective and what remained outstanding. In fact, the CAF put in place almost identical services. These were not connected to the work of CAMHS, and so when one plan to offer individual support was being very successful, but time limited, another offer of individual work with a different focus was unsuccessful, and Becky was described as 'unwilling to engage'. Exactly the same issue occurred when the FISS team were involved. The lack of any sort of multi-agency reviewing mechanism meant this duplication of effort and pressure on Becky to engage with several different professionals was not understood. This same dynamic was played out in the support to Becky's Step-mother and family support more generally.

3.29 In this case, the different systems and structures that are in place and the pressures on agencies to fulfil their own responsibilities appears to have impacted on their ability to work in a multi-agency way. This, paradoxically, caused more work, rather than less by leading to duplication, and a lack of analysis of what needed to happen at points of transition. It became clear through the work of the review team with the case group that locally there is a tendency for all agencies to look to Children's Social Care to facilitate the multi-agency approach.

Questions for the Board

- Is the Board confident that record keeping is suitably robust in each agency and the function of record keeping is clearly understood by across all agencies?

- What current mechanisms are in place to ensure that complex, multi-factorial risks and needs are effectively assessed and reviewed within non-statutory multi-agency interventions?

- How will the Board ensure that new multi-agency and multi-disciplinary developments are informed by this finding?

Finding 3: Children in receipt of specialist services from Hospital education services (HES) have complex needs, and some require a multi-agency response to meet these needs. Despite this, HES are often working alone in providing services to children; such lone working does not meet the needs of all children.

3.30 Children with complex health, mental and social care needs who are unable to access mainstream education provision are provided with education through a variety of specialist placements, including hospital-based education services. In these circumstances, children are either educated within a hospital or attend specially adapted sites where dedicated teachers provide education. For children to receive this service, a referral must be made by a health consultant. The staff team considers the referral, and a decision is taken about whether the resource can meet the child's needs. Despite providing highly specialist services to children at what could be considered a Tier 4 level of intervention, and therefore requiring a multi-agency approach, when a child receives hospital education the experience of HES is that other services such as CAMHS or Children's Social Care often cease their involvement with a child and family.

3.31 Becky was referred to HES by the CAMHS consultant. Becky had a history of significant mental health difficulties, and whilst the extensive services provided by CAMHS had led to some clear improvements in Becky's mental health, she remained a child with complex needs and so met the criteria for this specialist service and was offered a place at the school. At this point, the FISS Team closed Becky's case, and some 13 months later, CAMHS also closed their involvement.

3.32 During the following 13 months, Becky continued to have multiple health and social care needs and it was evident that stresses at home were mounting, responding to her needs was a complex multi-layered task. HES took their support of Becky seriously, with many members of the team involved; although they reviewed their work regularly, no member of the team was provided with reflective supervision because this is currently not provided. This meant they had no opportunity to reflect on this complex work. No support was provided by other agencies.

3.33 HES were aware that CAMHS had offered to be available for advice but knew that obtaining such advice would entail a complicated route involving re-referral of Becky to the service and this could not be done by them. They made a formal referral to First Response; this was passed to Early Help and then a commissioned service. As such HES were outside this professional network, with no sense of how their concerns were being understood or what action was being taken. It is clear that the passing on of verbal information, with no written account from the referrer, led to a dissipation of concerns, and the lack of a feedback loop to HES meant that this was not known. What was needed was a multi-agency dialogue between these safeguarding partners to agree on what should happen next to best respond to Becky.

3.34 The Review Team learnt from HES that despite working with children and families who are coping with significant complex needs, they are often the only service who are

providing support to the child and family. This single agency approach often leaves HES working alone and in isolation, reducing the possibility that the holistic needs of a child will be met. The reason for this is not entirely clear; it was suggested that differences in agency focus, thresholds, the volume of work, historical practice and the internal organisational pressures to confine agency involvement to a limited duration, all impact on this issue.

3.35 Much policy and guidance assumes that children's needs for health, social or educational services can be separated out and provided by different agencies. However, research[xviii] shows that this assumption does not tally with the experiences of children with complex health and social care needs and their families, whose needs are inextricably linked and form part of their everyday lives. Therefore, dividing a child's needs into separate categories and responding to these needs in isolation is untenable. Children with complex needs require a multi-faceted, integrated, multi-agency response.

Questions for the Board

- How can the Board facilitate the development of a partnership and accessible pathway between specialist services and other services that improves the coordinated multi-agency, multi-disciplinary response to a specifically vulnerable group of children?

- How can the Board support specialist services such as HES in undertaking the role of Lead Professional in cases at this threshold?

- How can the Board support the implementation of supervision arrangements for these specialist services?

Finding 4: **The propensity for professionals to take parent/carer perspectives at face value without triangulating information from other sources, including observations of how a child or young person appears, can lead to a limited understanding of a child or young person's needs.**

3.14 It is essential that all professionals working with children and their families do so in a respectful and open way. This is the cornerstone of partnership practice as embedded in the Children Act 1989 and subsequent guidance and legislation. However, research[xix] and Serious Case Reviews emphasise the importance of not taking at face value what parents or carers say when asked about the wellbeing of children. The Munro review commented that adults in this situation have a number of motives for not always providing a full picture of their or their children's circumstances. The task of professionals is to remain in a position of "*respectful uncertainty*" and display "*healthy scepticism*" which in practice means:

- checking the validity of information provided by parents/adults by cross referencing/triangulating with other sources

- testing out the level of parental care and concern for children and the extent to which parents feel a sense of responsibility for their children and their well-being.

3.36 There were a number of examples in the work of involved agencies illustrating this finding. A great deal of information was provided by Becky's Step-mother, and this self-report often formed the basis on which Becky's needs were understood. The reliance on self-report and the absence of respectful uncertainty about the information provided led to an assessment of Becky and family life unintentionally dominated by the perspective of one family member.

3.37 Becky's Step-mother provided information about family history from her perspective, but this information was taken by professionals as a factual account without other perspectives being sought or considered. Little account was taken of the complexities of blended families, where there can be conflict, and different family members will have their own understanding of what happened in the past or what is happening in the present. This meant that the progress made by Becky's Mother in her personal difficulties was not reflected upon, nor the fact that Maternal Grandmother became abstinent during this whole period and played an emotionally and financially supportive role in Becky's life.

3.38 There was little reflection on Becky's perspective and concerns from Becky's Step-mother about her early adolescent behaviour meant that assessments and reports were often negative about Becky.

3.39 It was the view of case group and review team members that this pattern can be seen in a range of the work across the multi-agency spectrum. Case members commented on their experiences of reading assessments where the perspective of the child or young person was missing. They emphasised the importance of professionals being clear about the source of the information and of attempting to make sense of the information gathered in terms of what it meant for the child or young person; they felt this to be particularly important in circumstances where it has not been possible to speak to the child or young person alone, where there are speech and language difficulties, lack of engagement by young people, where young people have mental health difficuties or in non-verbal or pre-verbal children.

3.40 Evidence for professionals accepting what adults say at face value also comes from several National Serious Case Reviews and the most recent Government initiated Triennial Review of Serious Case Reviews[xx].

Questions for the Board

- How will the Board ensure that partner agencies provide the tools, reflective supervision and culture which help professionals to remain in a position of "respectful uncertainty" and display "healthy scepticism"?

- Is the Board assured that multiple hypotheses are used to explore and better understand complex family dynamics and is evidenced in recordings?

- Do Board partners have information systems and information sharing arrangements in place which adequately facilitate accurate triangulation of information?

- Are professionals encouraged to pose and consider reflective questioning within multi-agency discussion in order to improve assessments and understanding of family functioning over a period of intervention?

Finding 5: Professionals are less challenging of the lack of engagement of Fathers in child welfare practice leaving the risks they may pose unassessed and the contribution they could make to children's lives unknown.

3.41 There is considerable research and public policy evidence that child welfare services have often focused their attentions on working with mothers, and that fathers or father figures are often absent from the work and from the thinking of professionals[xxi]. The reasons for men to be less engaged than women are complex, and include men's own reluctance to be involved, mothers acting as gatekeepers and a professional culture whereby gendered ways of understanding problems in families and responding to them become taken for granted within organisations[xxii]. The marginalisation of fathers or father figures is a significant issue because research shows that they are very important for children's wellbeing and safety and can also pose significant risks which need to be evaluated .

3.42 When Becky came to the attention of professionals in 2011 one of the key issues was the relationship between Becky and her Father. However, he was not involved in the subsequent assessment and there was no reflection on his absence or what responsibility he needed to take to improve family relationships. The FISS team offered parenting support to improve family relationships. Father was not part of this, and based on the records seen as part of this review it remains unclear why, because it is not commented on in the record of parenting sessions or analysed in the closing summary. Father engaged briefly in the family therapy sessions and the support for Becky's eating disorder, but was not part of the review process with HES despite there being growing concerns about Becky, including reporting that he was threatening her to leave home.

3.43 He was seen as part of the CAF and when the voluntary organisation visited he was asked directly about the threats to make Becky homeless, which he denied. What is striking throughout the period of review is that Becky highlighted that the poor relationship she had with her Father was an important issue to her, yet there is more analysis of her relationship with Becky's Step-mother. There was also much professional discussion about Becky's non–engagement with services (see **Finding 1**) but Becky's Father's non-engagement was not acknowledged or understood.

3.44 During this SCR Becky's Father's perspective was sought, it was clear that he was not aware of the range of services involved with his daughter. When he was asked about his

views regarding what was helpful (and what was not so helpful) about the services that were provided, it was evident that he had little knowledge of the services provided by FISS, CYPS or Action for Children. Becky's Father acknowledged that he largely left this part of family life to Becky's Step-mother and that he did not actively pursue involvement. However, he felt that little was done to include him in the work. When he was asked about whether he would like to say anything to the services involved he asked for services to better understand the constraints faced by parents who work full time and asked that a more flexible approach is taken when meetings are arranged/visits are made *"so that they do not only happen 9-5"*.

3.45 Services need to consider not only how to enable fathers to engage with services, but also how to factor in a professional understanding of their role in causing difficulties that bring children into contact with services or the contribution that they can make to solutions to ensure children's well-being, even when they are absent.

Questions for the Board

- Can the Board be assured that the Think Family approach to considering all family members has been fully embedded within frontline practice?

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