HARROW AREA CHILD PROTECTION COMMITTEE

Part 8 Review Summary Report

October 1999

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OUTLINE OF THE CASE OF CHILD I

This case review considered the life of a girl of Jordanian/Muslim and Irish/Christian parentage who was born in London in November 1984. She died in North West London on 18th October 1998. She was 13 years 11 months of age. A Coroner's Inquest, held in February 1999, found she had died of self-induced methadone poisoning.

For the purposes of this report the girl will be referred to as 'CHILD I' as the Harrow ACPC consider it important that they maintain the confidentiality and respect that a case of this nature warrants. Any reference to family members has also been similarly respected.

During her life, CHILD I and her immediate family received services from each of the agencies who took part in this Review to meet a wide range of health, educational, social care, child care and other needs. CHILD I and her family had contact with over 230 staff from these agencies. CHILD I was the subject of a number of child protection concerns from 1989 onwards.

CHILD I lived in a number of different settings, but for the majority of her life stayed either with her Mother or her Father, and other relatives and friends. Some of these matters were subject of proceedings under s.8 of Children Act 1989. Her parents separated shortly after her birth. She had a total of 68 moves between carers in her life.

CHILD I lived abroad with her Father on several occasions, the most recent being two periods in 1997. This meant that her school attendance in the UK was not continuous, and there was discontinuity in a range of other services that were being provided to her. During her earlier years, she spent some short periods in foster care, which was arranged at the request of one or both of her parents.

As a result of the changing circumstances, CHILD I was known by three different surnames which made it more difficult for agencies, working with CHILD I and her family to always co-ordinate information.

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In the last year of her life CHILD I lived variously with her mother, father, friends and relatives. From March 1998 Father no longer had a residence order (s.8 Children Act 1989) in respect of CHILD I.

In 1998 CHILD I was 'accommodated' (provided with a care placement at the request of parents: s.20 Children Act 1989) by Harrow Council on five occasions. It was not considered necessary, at that time, to take Care Proceedings (s.31 Children Act 1989). This restricted the powers available to the Local Authority to plan for CHILD I. Accommodation was provided by two foster care placements and by three residential units.

At the time of her death CHILD I had been 'accommodated' by Harrow Council for a period of five weeks and had been living in a specialist residential unit for girls for the past three weeks. For the previous two weeks, she was placed with foster carers. For the eight weeks prior to this she had lived at her mother's address.

In her final year CHILD I went missing on numerous occasions from her parents' homes and from the residential establishments and foster homes where she was placed. It was usual for her to return of her own accord, but whilst she was accommodated by the Local Authority, in accordance with procedures, the Police would be informed and they found her in a variety of locations, mostly in London. For the most part CHILD I was evasive about where she had been and why she had run away.

From March 1998 onwards CHILD I spoke to a range of professionals alleging she had been abused by family members and other people known to her. She later retracted a number of these allegations, but some were subject to investigation by the Police.

Agencies subsequently became increasingly concerned that CHILD I was becoming beyond the control of her parents and the professionals working with them. There was growing evidence that she was being abused and exploited through prostitution and was coming under the influence of drugs and alcohol. During this time CHILD I was receiving services from the majority of agencies party to this review.

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In September 1998, it was decided to apply for a Secure Accommodation Order (Children Act S.25 & Secure Accommodation Regulations, 1991). This would enable the containment of CHILD I in an enclosed residential unit for an agreed period of time. Under the terms of the Children Act, the Local Authority has the power to agree an initial temporary period in Secure Accommodation for a maximum of 72 hours for children over 13 years. In the meantime, the case must go before the Court and a judgement made about whether the criteria are met to contain a child or young person for a further period, the duration of which will be decided by the Court.

The Local Authority agreed to seek a Secure Accommodation Order on 16th October 1998. At the time CHILD I was missing. Therefore the 72 hour provision was never activated and subsequent application for the Secure Accommodation Order was not made, as CHILD I died before this could happen.

This case raises a number of fundamental questions, not least about the appropriateness of depriving a young person of their liberty when, in fact, they are the victim of crime and abuse through childhood prostitution. There are no easy answers to such dilemmas, particularly as secure accommodation can never be a long term solution. However, in this case it is acknowledged that the local authority's response was not sufficiently robust or timely, and that there are lessons to be learnt.

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CONCLUSION AND KEY MESSAGES

The Harrow ACPC acknowledge that this case has raised a number of issues about how agencies work together with parents and family members to safeguard and protect children. This is probably all the more difficult to do effectively in the case of an older child who is fast approaching adolescence and having to cope with the additional pressures that this period of life can bring for some young people and their families. However there were, undoubtedly, in this case some significant shortcomings in inter-agency working and communication which have to be recognised and addressed.

Harrow ACPC also recognises that it is important for all professionals working with children to be tenacious in hearing, listening to, and acting on, any concerns that they may have about a child who they feel may be at some kind of risk. The need to achieve this is particularly critical in cases where there is a slowly emerging pattern of ongoing emotional damage that may be attributable to the less obvious forms of neglect, abuse, and to the possible exploitation of children through prostitution. It is essential that there are robust methods in place to try to identify and protect children who are facing such risks, and to deal with those who perpetrate this particular form of insidious abuse. It is acknowledged that there was not a sufficiently effective response on the part of all agencies who worked with CHILD I in the last year of her life.

The External Reviewer and Part 8 Case Review Group have therefore identified four key messages that emerge from this Review:

1. Child care agencies must actively '*listen*' when children tell us that they are being abused. Although some agencies tried to listen to CHILD I, child abuse concerns were inadequately interpreted and communicated between the agencies. Staff need to develop better *hearing and listening* skills. More attention appeared to be given to the needs of adult family members than to CHILD I.

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2. This complex case, which covered nearly 14 years of CHILD I's life, has demonstrated, like many previous inquiries, the need for closer and more proactive inter-agency working. Many agencies acknowledged the concerns raised about CHILD I. Few agencies had the tenacity to follow up these concerns to ensure that CHILD I was always protected from abusive situations and to work closely with other agencies.

3. The creation, availability and accessibility of suitable strategies for managing older children whose parents are unable to look after them and whose own actions may place them at risk must be urgently reviewed. In particular, the use and availability of specialised contained placements, particularly for young girls over 12 years must be carefully examined.

4. There is an urgent need to facilitate a way of analysing all the information available in order to complete a clear strategy for children who are '*looked after*' by the local authority and to be able to complete robust risk assessments. There was no such comprehensive analysis of information or risk assessment in order to determine clear planning for CHILD I. This omission was particularly apparent in the last year of CHILD I's life.

These key messages have been endorsed by Harrow ACPC.

Harrow ACPC considers it is also appropriate to repeat a message that has emerged from previous Part 8 enquiries, and which has central significance for this case and all who work with children to try to safeguard them from harm:

> "Child protection is not solely the responsibility of any one individual, discipline, statutory or voluntary agency. Child Protection is a shared responsibility and is everybody's business; both child care agencies and the local community".
>
> *'A Child in Trust', The Beckford Inquiry 1985.*

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KEY RECOMMENDATIONS

Although recommendations for individual agencies are listed in the full confidential report, there are 18 Key Recommendations which the reviewers believe to be of national as well as of local significance. They have implications for training, supervision, updating of child protection procedures and resources.

1. LISTENING TO AND ACTING TO PROTECT CHILDREN

Message

Professionals in all agencies should actively listen to and hear the child's views, concerns and worries. The child must at all times be heard when offering their own perceptions about abuse.

Recommendations

This case seriously demonstrates the need for further development in *hearing and listening* skills for all staff. Staff must act swiftly and appropriately in response to what the child has said in order to safeguard the child. Independent sources for children to be heard should also be made available.

Responsibility

Area Child Protection Committees (ACPCs).

2. PLANNING FOR CHILDREN

Message

This case seriously demonstrates a lack of child care and child protection planning, poor inter-agency communication and a failure to implement multi-agency procedures, particularly in the last year of CHILD I's life. It also highlights the urgent need for agencies appropriately to share information in the required forums about children of concern who are thought to be suffering significant harm, who run away, who misuse drugs and who are victims of prostitution.

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Recommendation

All agencies must ensure that they have all necessary information available in order to determine clear and effective child care plans. This has been prioritised in the London Borough of Harrow's 'Quality Protects' agenda. An initial assessment of 'looked after' cases has recently been undertaken by the London Borough of Harrow.

Responsibility

The Local Authority has the main responsibility within a multi-agency context.

3. THE LOOKED AFTER CHILD

Message

Although there are a number of policies and procedures used by the Local Authority to monitor the care of the 'looked after' child, in line with local and national guidance, there was a gap in achieving the same continuity and consistency of service for this child who was intermittently 'looked after', compared with children who are continuously 'looked after' by the local authority.

Recommendation

The ACPC must improve inter-agency awareness, communication, intervention and sharing of information about 'looked after' children particularly when children are either formally or informally 'looked after' by the Local Authority

Responsibility

The Local Authority has the main responsibility for this within a multi-agency context.

4. RESPONDING TO THE NEEDS OF CHILDREN WHO ARE BEYOND CONTROL

Message

In 1998, CHILD I went missing on many occasions. The Police Child Protection Team was usually notified. Both CHILD I's parents asked Social Services to look after her as they felt unable to do so.

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Recommendation

The creation, availability and accessibility of suitable strategies for managing children whose parents are unable to look after them and whose own actions may place them at risk must be urgently reviewed by the Department of Health. In particular, consideration must be given to the use and availability of specialised contained placements for young girls who are over 13 years of age. There is a need for continued specialist support once the child leaves secure accommodation which is a short-term option. In circumstances when a child is missing for over 48 hours and there are concerns about the child suffering significant harm, this should be dealt in accordance with child protection procedures.

Responsibility

Home Office, Secretary of State, Department of Health, ACPC, Local Authority.

5. CHILD VICTIMS OF PROSTITUTION

Message

During the last year of her life, CHILD I became a victim of child prostitution and drug use which may have led to her premature and unfortunate death. She was a victim of coercion and not a criminal. Yet little was done to identify the adult abusers and take action to pursue prosecution. Multi-agency organised abuse procedures were not actioned.

Recommendations

- The Home Office Consultation document on Childhood Prostitution should be urgently activated to minimise the risk to other children who may be victims of childhood prostitution.
- All ACPCs should continue to acknowledge that the child who is abused through prostitution is a victim of coercion.
- ACPCs must continue to provide appropriate training and develop further procedural guidance on this subject.

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- In Harrow existing multi-agency organised abuse and child protection procedures must be implemented when there is a suspicion or evidence of a child or children involved in prostitution.
- There must be cross-borough collation of intelligence to identify adult perpetrators and bring them to justice.

Responsibility

Government Bodies.

ACPCs.

6. CULTURE AND RELIGION

Message

Assumptions were made about CHILD I's culture which led to inappropriate decision-making.

Recommendations

- The child's own perception of their cultural and religious identity must be taken into account in childcare planning and decisions about choices of placements, within age-appropriate boundaries.
- When a child is of mixed parentage and the parents are in conflict, access to culturally sensitive, specialist trained counsellors should be considered. This recommendation is of national as well as of local significance.

Responsibility

ACPC.

7. EMOTIONAL ABUSE AND IDENTIFICATION OF SIGNIFICANT HARM

Message

Throughout her life, CHILD I was at high risk of emotional harm. From her birth until her death, child protection issues were regularly identified. Despite involvement from

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many agencies, CHILD I suffered abuse and neglect by more than one perpetrator. All forms of abuse include a component of emotional abuse. Research suggests that children who are abused by more than one perpetrator are at great risk of significant harm. The agencies failed to recognise this feature in CHILD I's case.

Recommendation

All agencies must continue to be alerted, updated and reminded of the devastating consequences of emotional abuse. There must be earlier recognition of the indicators of abuse, in order to prevent a downward spiral into further and more serious forms of abuse.

Responsibility

ACPC.

8. FAMILY MENTAL HEALTH AND DOMESTIC VIOLENCE

Message

CHILD I grew up in an environment where she regularly witnessed domestic violence and lived with family members, some of whom had mental illnesses.

Recommendation

The ACPC must continue to raise awareness of the issues of Domestic Violence and Family Mental Health and their impact on children.

Responsibility.

ACPC.

9. RECORDS AND DOCUMENTATION

Message

The recording of child protection concerns in some agencies' files was inconsistent.

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Recommendation

A Multidisciplinary Records Working Party should be convened to provide systematic guidance and reinforcement of individual, regulatory and national guidance on records and documentation.

Responsibility

ACPC and individual agencies

10. CHILD PROTECTION TRAINING

Message

Harrow ACPC provide comprehensive and regular child protection training. Yet attendance at Child Protection Training was inconsistent.

Recommendations

Agencies must encourage all staff who have contact with children to attend child protection training programmes. A Child Protection Training Needs Analysis should be carried out throughout all agencies. This should be prioritised as a future initiative of Harrow's ACPC Training Sub-Committee.

Responsibility

ACPC and individual agencies.

11. SUPERVISION AND SUPPORT

Message

The availability of staff supervision appeared inconsistent within the agencies.

Recommendations

- Professional supervision and peer support should be strengthened for staff in all agencies, in order to discuss and review serious child protection cases and to acknowledge the stress that long term exposure to Child Protection work causes.

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- Methods of supervision and support should be agreed within the agencies and should adhere to standards recommended by individual regulatory bodies.
- Each agency should identify appropriate resources and finances for supervision.

Responsibility

All agencies.

12. CONFIDENTIALITY

Message

Staff did not always appreciate that they may not be able to guarantee confidentiality, if they believe that a child may risk abuse. At the same time, staff must encourage children and young people under 16 years to continue using services and reassure young people that confidentiality will be respected, wherever possible.

Recommendations

All staff who work with children must ensure that they fully comprehend their duties owed to children under the Children Act 1989 and the 'Working Together' guidance, and also be made aware of the responsibilities and respect for confidentiality under other legislation, such as the Venereal Disease Act 1974.

Responsibility

All Genito-Urinary Medicine and Sexual Health Clinics.

13. TRACKING CHILDREN OF CONCERN WHO LEAVE THE JURISDICTION

Message

Child I spent regular periods abroad. She rarely attended school during the last year of her life. Her whereabouts was often unknown to many of the agencies

Recommendation

There must be more robust methods of monitoring children in need of protection who

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attend school irregularly and/or who often go abroad.

Responsibility

All agencies and the Department of Health.

14. LEGAL INTERVENTION TO SAFEGUARD CHILDREN

Message

The risks in relation to CHILD I were assessed as very serious but were inadequately analysed. The legal options were not explored on a multi-agency basis. This includes the use of Court Ordered Investigations, Care Proceedings and Secure Accommodation Orders.

Recommendation

The Local Authority must ensure that staff can make appropriate use of legal procedures to protect children suffering significant harm.

Responsibility

Local Authority Legal and Social Services Departments and the ACPC.

15. INTER-AGENCY WORKING

Message

There is a statutory responsibility by professionals to safeguard children from significant harm. In this case multi-agency guidelines were not sufficiently adhered to.

Recommendation

While all agencies need to keep innovative and creative practice on individual agencies' agendas, there must be re-emphasis on the importance of inter-agency working, audit and compliance with inter-agency procedures.

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Responsibility

ACPC and all agencies.

16. CHILD PROTECTION PROCEDURES

Message

Harrow ACPC have comprehensive child protection procedures. Some ACPC procedures may require amendment and updating. The issue in this case was not the lack of procedures but the failure of agencies to comply with them at all times. Staff must have the tenacity to follow procedures and to seek advice if they believe that procedures are not adhered to.

Recommendation

All staff must be given the time and opportunity to familiarise themselves with, as well as to carry out, procedures. Staff must also be given appropriate support and advice in order to carry out procedures.

Responsibility

ACPC.

17. FINANCE AND RESOURCES

Message

Some agencies have experienced significant budget cuts over the last few years which inevitably impacts on service provision.

Recommendations

There must be available resources and finance to implement the above recommendations within a realistic time scale. Staff who work with Children and Families must be able to access the required services that are identified as necessary, in order to safeguard the child and meet their needs.

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Responsibility

All agencies.

18 . RECORD SYSTEMS

Message

CHILD I used different surnames during her life. Furthermore her name was spelt in various ways. This resulted in some agencies and institutions creating more than one file for the same child. Information was, therefore, not always consistent and cross-referenced

Recommendation

All agencies and institutions must ensure that if children are known by more than one name, all names and correct spellings are recorded on the files and computer systems and are cross-referenced.

Responsibility

All agencies and institutions.

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