OVERVIEW REPORT

Child Safeguarding Practice Review in respect of	Sarah
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1. Executive Summary

The subject of this review is Sarah, at the time her death Sarah was 17 years of age. Since an early age, Sarah had suffered from epilepsy, which had been managed by medication. Sarah suffered her first epileptic seizure at the age of 8 months. Between the age of 4 and 5 the seizures ceased but returned in 2009, with 80% of seizures occurring at night. In July 2017, Sarah underwent a brain procedure to limit the number of seizures she was experiencing.

In June 2017, Sarah became a Looked after Child (LAC) under a voluntary agreement between the Local Authority and her parents. This meant that both Sarah's parents maintained parental responsibility.

Sarah became looked after following her behaviour becoming more challenging and putting other household members at risk. This challenging behaviour meant Sarah became involved with a number of agencies. Sarah was accommodated with foster carers, but when these placements broke down, more latterly she resided in residential accommodation and then semi independent living arrangements.

Over a period of time there were numerous occasions where Sarah was reported as missing from these placements. There were concerns regarding Sarah's vulnerability and in particular the effect of her medical condition. There were concerns regarding Sarah's relationships with men who were older than her and the relationship with one male in particular. Sarah was considered at risk of being criminally and sexually exploited. At the time of her death this male was subject of police bail conditions not to have any contact with Sarah.

In June 2019, emergency services were called to the home address of this male as Sarah had suffered a seizure and was unconscious. Sarah was conveyed to hospital. Sarah's medical support was removed and sadly, she passed away.

The Worcestershire Safeguarding Children Partnership undertook this review in accordance with guidance[1] to identify improvements to be made to safeguard and promote the welfare of children.

All agencies identified were involved in this review and the author has had the opportunity to speak with Sarah's family. The review has identified a number of areas of development to improve how agencies work together to safeguard children and young people.

There were two main areas identified which impacted on Sarah. The first was her medical condition and how this was recognised and managed by professionals, in particular when she became a looked after child. The second was how agencies worked together to identify and manage Sarah's vulnerability to sexual exploitation.

[1] Working Together 2018, HMG

2. Foreword

Worcestershire Safeguarding Children Partnership accepts the findings and recommendations of this report. The Partnership also recognises its responsibility to ensure that the tragic circumstances of Sarah's death, and the challenges she faced during her short life have led to positive change in the safeguarding of children and young people in Worcestershire.

We are grateful to the author of this report that there is clear recognition of the service improvements that have taken place within Worcestershire during the two years since Sarah's death. In acknowledging these improvements, the recommendations do still serve to remind us that we must never accept our position as being 'good enough' and must always strive to improve how we safeguard our children and young people across the county.

In support of this the partnership introduced its Get Safe programme in 2019 so coinciding with the commissioning of this review. The Get Safe programme is an innovative and child-focused approach to tackling the many forms of child criminal exploitation and has brought together child safeguarding agencies from across Worcestershire to design and implement enhanced multi-agency processes for the identification, assessment, planning and response to this problem, based on a contextual safeguarding framework.

As part of the improvement work we have also firmly embedded our joint working arrangements in our care and child protection process for those children and young people. This has included audit, service user feedback and management of performance measures. As a result we have seen a significant and sustained improvement in the contributions of our partner agencies to those child protection processes, for example since 2018 we have seen attendance and contributions of partners to strategy discussions consistently at 98% or above for Police and Health attendance and in a 2020/2021 survey of 107 children and young people 96% told us that they felt listened to and had their views taken into account.

We have strong partnership engagement in our case work and over the past two years 354 partners have undertaken Signs of Safety partnership training so we can talk the same language when we work with families in identifying risk and supporting needs.

This partnership working within the context of exploitation has been further embedded through the development of our Multi-Agency Child Exploitation (MACE) framework, a dedicated Worcestershire Children First Get Safe team which works closely with partner agencies, and weekly reviews of missing episodes. These resources use our multi-agency plan of intervention and support which is based on an approach of prepare, prevent, protect and pursue in order to keep safe those most vulnerable to exploitation. This is all underpinned by a programme of multi-agency training for practitioners across the partnership. In addition, the Climb programme and Community Link Workers have strengthened the support available for young people at risk of, or suffering exploitation. This work has been informed by feedback from local young people who have been helped by these services and has had a positive impact on the timeliness and effectiveness of our collective response to children and young people at risk of exploitation within Worcestershire.

The recommendations within this report have also highlighted the importance of the effectiveness of review meetings for Looked After Children. Again, in the two years since this review was commissioned there has been a clear focus on improvement in this area, leading

to comprehensive change. Quality assurance checks are now undertaken to ensure the review and planning is effective for the child or young person, that the right contributions have been made and that there is no drift and delay in their care planning. This is supported by an audit process which considers partnership attendance, working and communication within the Looked After Child review process.

In 2019 Ofsted reported "*IROs are active in ensuring that plans progress without delay in most cases. IROs use a well-developed escalation process to resolve practice issues*", evidencing independent validation of the role of the IRO and the well-established dispute resolution process.

During the last three years there has also been a significant focus on improving the timeliness and quality of health assessments. A monthly multi-disciplinary meeting is now held that robustly interrogates the completion rates of health assessments whilst looking at solutions for upcoming issues or blocks, to ensure that all children and young people are offered a timely health assessment

The last inspection took place July 2019 under the Inspection of Local Authority Children's Services (ILACS) framework and the report identified the following key findings;

- The Local authority has made considerable progress in improving the quality of services to children and families since 2016.
- Essential steps have been taken to meet the goals in the service improvement plan.
- Senior Leaders and elected members are ambitious for and committed to ensuring the wellbeing, safety and outcomes for children in the county.
- Senior Leaders have successfully created a strengthened workforce of stable and permanent workers who know their children well.
- As a result, outcomes form many children and their families are better, the changes are embedded on core practice and there is evidence of a sustained trajectory of improvement.

The report made eight recommendation for areas of work to focus on. Those recommendations formed part of our business planning 20/21. The WCF business plan can be located at;

Meetings and key documents Information - Worcestershire Children First (worcschildrenfirst.org.uk)

Clearly, the hard work of all involved in this improvement journey over the last two years and the progress made as a result cannot change the outcome for Sarah. We do hope however that the way in which children and young people across Worcestershire are now benefiting from those improved services, and most importantly who are safer as a result, can bring some comfort to all those who knew Sarah.

3. The family view

3.1 Sarah's family would describe there being two Sarah's, one was loving and full of fun and her other side was much more challenging and difficult. This was very much dictated by her condition.

3.2 Sarah would suffer serious epileptic seizures of between 4 and 7 minutes, when they exceeded 5 minutes, rescue medication had to be administered. It was a constant source of family concern that no one would be available to administer this medication when Sarah was moved to more independent living.

3.3 The family had a good understanding of Sarah's condition, having cared for her through some significant epileptic episodes but strongly feel that their voice was not heard when they tried to communicate the level of risk that her condition presented.

3.4 The family feel that Sarah was not capable of caring for herself, if not reminded she would not look after her personal hygiene, she could not manage money, she was easily led and influenced and therefore sometimes, made poor decisions. More concerning for Sarah was that she was not able to adhere to her medicine regime, which presented a real risk.

3.5 The family feel that Sarah functioned emotionally at a level below her years and requested on numerous occasions that this was properly assessed and understood. This was very important for the family as they feel as Sarah moved towards independence her own ability to make good decisions and provide a good level of self-care was not understood and this led to Sarah being placed in accommodation that was not appropriate for her and contributed to her placing herself at risk.

3.6 The family feel that it was clear that Sarah was vulnerable and it was clear that over a period of time, this vulnerability was being exploited by known individuals but this was never effectively addressed and therefore she was not protected.

4. Analysis of involvement

Whilst the analysis will look at areas under the themes identified in the terms of reference, it should be noted that the various aspects are inextricably linked. For instance, medical condition, being linked to cognitive functioning, being linked to behaviour and vulnerability, being linked to exploitation and risk-taking behaviour. The underlying theme is that all of these aspects need to be holistically assessed, understood and addressed in a coordinated child centred manner.

4.1 How effective was the partnership's approach to the recognition recording, information sharing, and management of the risk of Sarah being sexually exploited?

4.1.1 The risk of Sarah being sexually exploited was recognised as early as January 2017, when it was raised by Sarah's foster carer at the time. The early identification and reporting of the concern is noted as good practice on behalf of the foster carer.

4.1.2 Sarah went missing from foster carers and placements with regularity, during the scope of this review which spans 2 ½ years (1st January 2017 to 26th June 2019) Sarah was reported missing on 36 occasions (14 occasions in 2017, 11 in 2018 and 11 in 2019). The Worcestershire Child Sexual Exploitation Strategy 2017-2019 identifies that there is a clear link between children going missing and CSE[2].

4.1.3 The regularity of the missing episodes left agencies struggling to effectively keep up with the most recent incident. Whilst there was discussion about multi agency meetings there seemed to be a confused response and important information that should have been discussed was not. It was not clear at various stages what the planned response was and how risk was to be mitigated. Each of these missing episodes were also accompanied with activity that presented a risk to Sarah and these were not considered holistically. The cumulative and escalating effect of Sarah's behaviour was not effectively assessed.

4.1.4 All of these incidents below warranted consideration of a statutory strategy meeting[3] on the basis that Sarah had suffered or was likely to suffer significant harm. The strategy meeting would have enabled sharing of information and pulling together of recent events as well as behaviours that were also happening during these periods of time, enabling a holistic view of Sarah's lived experience.

- Between 10th and 19th April 2017, Sarah took an overdose, was using cannabis and spoke about heroin.
- Beginning of May 2019, Sarah had assaulted her foster carer, Sarah, 15 years old at the time disclosed she was pregnant by an older male.
- End of May 2017, Sarah had been repeatedly missing, during one episode Sarah was in the company of an older male under investigation for sexual activity with her.
- Mid-June 2017, when accommodated in supported accommodation Sarah made an allegation of indecent assault against another resident.
- February 2018, on a weekend visit to her family it was believed that Sarah was sending sexual images of herself to an 18-year-old male, police were involved and seized the phone.
- December 2018, evidence of concerning contact with Peter which was being denied at this stage by Sarah.
- January 2019, evidence that Sarah was using cannabis, she had been to parties and stated that she had sex with a number of males, this was followed by her seeking medical attention for vaginal bleeding.
- End of May 2019, after the second arrest of Peter, he admitted setting up false social media accounts to contact Sarah and paying her money.

[2] Worcestershire Safeguarding Children Board Child Sexual Exploitation Strategy 2017-2019 (accessed 07/11/20) - Child Sexual Exploitation Strategy 2017-2019

[3] West Midlands Regional Child Protection Procedures (accessed 07/11/20) - West Midland Child Protection Procedures - strategy-meeting-discussion

5.1.5 When a strategy meeting was convened in March 2019, regarding Sarah's contact with Peter, it was acknowledged that Sarah was very vulnerable and being manipulated by Peter. After Sarah failed to engage with discussions with CSC and police the strategy enquiry was closed on the basis that Sarah had not suffered significant harm and the police would continue to seek an interview. This decision did not consider the ongoing likelihood of significant harm. As identified by the CSC IMR author, a legal planning meeting could have been sought at any time. This would have provided the opportunity for senior management oversight as well as legal options to be considered.

5.1.6 Child protection procedures were not followed, and therefore a strategy meeting was not convened with health police and CSC in attendance as a minimum, as well as other agencies who should have been included. The use of Missing Intervention or MACE meeting must not be used in place of child protection procedures.

5.1.7 Where MACE and missing intervention meetings were convened, they did not have appropriate agency attendance and the actions set were not effectively followed up. The meetings did not seek to fully understand what the risk factors were or to investigate and understand what the factors were causing Sarah's missing behaviour and vulnerability. These are often referred to as the push and pull factors. There were numerous opportunities where these factors could have been explored and better understood in Sarah's case, return interviews, missing meetings and MACE meetings to name but a few. Agencies did not routinely receive minutes of the MACE meetings that did take place. This finding would accord with the comments made in response to the Ofsted Monitoring visit of January 2019, which focused on the local authority's arrangements for the protection of children and young people vulnerable to child sexual exploitation and who go missing from home or care.[4]

5.1.8 A more holistic assessment may have understood the contextual safeguarding factors that existed and influenced Sarah's behaviour. The abuse to Sarah was occurring outside of the family and a better understanding of the external influences would have allowed for more detailed assessment and problem solving.

5.1.9 More latterly in the case, the staff at the YMCA feel that they had started to build a relationship with Sarah and she disclosed information to them, which started to indicate a trust. They felt that this was achieved as the staff were present for more extended hours to support her.

5.1.10 The family, on numerous occasions, raised concerns that Sarah was being paid money by Peter on a regular basis. He presented her with gifts in the form of expensive mobile phones and a gift of a sexual nature on her 17th birthday. More latterly it was apparent that Sarah was spending excessive amounts of money on

[4] Monitoring visit of Worcestershire local authority children's services January 2019 - Ofsted monitoring visit 2019

scratch cards and if this had formed into a gambling habit it was an additional factor for Sarah to seek money and therefore the company of Peter.

5.1.11 In June 2019, Worcestershire implemented GET SAFE[5].This agenda coordinates action under the 4 P's of Prevent, Prepare, Protect and Pursue. The initiative includes an risk assessment tool and a GET SAFE pathway. As well as information and support for young people, professionals and parents/carers. This initiative has received national recognition and has received positive evaluation in the year since its launch.

5.1.12 West Mercia Police are enhancing their focus on youth vulnerability by implementing The National Strategy for Policing Children and Young People. They will seek to draw on guidance and continue to develop working relationships with other agencies. This will include each police Problem-Solving Hub having a dedicated Missing Intervention Officer and a Care Home Intervention Officer. Both will focus on young missing persons and facilitating instigation of missing intervention multi agency meetings.

5.2 How effective was the approach to managing the risk the alleged perpetrator presented to both Sarah and others

5.2.1 Apart from the generic risk of Sarah being sexually exploited there were two identified perpetrators. The first was the older (21 year old) male and the second and more enduring was Peter.

5.2.2 In May 2017, Sarah disclosed that she was pregnant by the older male. He had previously been corresponding with Sarah, aged 15 years at the time, claiming to be 14 years when he was in fact 21. He was interviewed by police and released under investigation. Over the next few months, it was apparent that the contact with him continued but the risk was not addressed. At the initiation of the investigation there was no strategy meeting and one did not take place as the risk continued, consequently the known risk was not addressed.

5.2.3 The risk from Peter was first highlighted in records in August 2018, on Sarah's 17th birthday. The family had raised concerns prior to this on a number of occasions. A strategy meeting was convened, and investigation showed that Peter's activity with Sarah and a number of other young people was concerning. Around three weeks later Peter was arrested for sexual grooming offences and his computer was seized. The computer was later found to have extreme pornography on it, for which Peter was later cautioned. Although this arrest was timely it did not provide protection for Sarah.

5.2.4 Peter was released on bail with conditions not to contact Sarah or any young person under 16 years. The issue with police bail is, that if breached there is no power of

[5] GET SAFE (accessed 07/11/20) - WSP - GET SAFE

arrest except of arrest for the original offence under investigation. If the police are not in a position to initiate proceedings, at that stage, by charging the person, the conditions, whilst being deterrent, are in fact 'toothless'. Peter did go on to breach the bail by maintaining contact with Sarah.

5.2.5 The police did seek a legal view on obtaining a civil order to manage Peter's behaviour, this legal advice took some two months to achieve. It advised that a civil order would not be appropriate whilst the criminal proceedings were being progressed.

5.2.6 The time it took the advice to be achieved and the view taken did not assist in managing the risk. The bail conditions offered no enforceable option and without an enforceable order, Peter was at liberty to continue with his harmful behaviour.

5.2.7 Early consideration should have been given to a Sexual Risk Order (SRO) or an Interim Sexual Risk Order[6]. This order does not require an individual to be convicted or cautioned. SROs can be issued when an individual has carried out an act of a sexual nature and there is reasonable cause to believe that such an order is necessary to protect an individual or the wider public from harm.

5.2.8 Another area where there could have been more expediency is Children Social Care seeking legal advice with regard to considering what measures would protect Sarah such as a wardship[7] or court order. Although moving to legal advice was discussed it was not progressed.

5.2.9 Too much emphasis and expectation was put on the criminal proceedings and on any view these were likely to be protracted and in the interim did not afford any protection to Sarah.

5.2.10 Examination of the events indicate that efforts were made to seek to mitigate the risk posed by Peter but there remained a frustration that not much could be done. There was a sense of professional helplessness. The police issued Child Abduction Warning Notices (CAWN) to Peter over his contact with two other young persons under the age of 16. This power, often used as an early intervention and disruption tool, in cases of CSE, whilst open to be used for young people in care of the local authority, it does not cover children or young people looked after under section 20 of the Children Act. This represents a big gap in the use of this valuable tool. This was recognised by the Children Society in 2015, when they lobbied for changes in the Policing Bill to include young people who became looked after under section 20. In 2014 of the 4510 young people aged 16 or 17 years who became looked after, only 190 (5%) were under section 31 and therefore covered by the Abduction Act

[6] Sexual Risk Order, Sexual Offences Act 2013 (accessed 07/11/20) - Legislation Sexual Risk Order

[7] A Wardship is a civil injunction which can be used to prevent an 'undesirable association' between a child and an individual(s). A local authority can make a Wardship application to the High Court to make a named child a ward of court and to seek an injunction against a named individual(s) to prevent that person from making any contact with the child.

(CAWN) leaving the 95% of children looked after under section 20, not covered. This still remains an area of concern and legislatively has not been addressed.

5.2.11 In October 2018, the section 47 was completed on the basis that Sarah was not having contact with Peter. Within weeks there was evidence that this was not the case. Sarah moved to independent living, supported by outreach (fully discussed later) and there was information that Peter was staying at the address and hotels with Sarah. This offered the opportunity for this decision to be reviewed or consideration of another strategy discussion.

5.2.12 There continued to be information and intelligence that Peter was having a sexual relationship with Sarah. By March 2019, this had progressed to Sarah informing agencies that she did feel that she had been groomed by Peter and disclosed sexual activity. In May 2019, Sarah disclosed more sexual activity with Peter and there was continued evidence of their association. Had it been felt that an SRO or other civil remedy was not viable at an earlier stage, by May there was strong evidence to support a civil order, the threshold for proof of which, is lower than that of a criminal prosecution. The police had at an earlier stage sought advice on obtaining an SRO but were informed that a criminal standard of proof was required.

5.2.13 There was a reliance on criminal prosecution, those involved in this were tenacious but the options for this were limited in these circumstances. There was consideration about the level of Sarah's cognitive functioning and whether sexual activity with her as a vulnerable person presented any opportunity. A mental capacity assessment for Sarah was discussed on at least three occasions but this was not progressed. (Discussed in more detail later in the report).

5.2.14 On reflection agencies feel that there could have been a more timely and innovative approach to early intervention and disruption of Peter and his activities. The family strongly feel that when considering the CSE threat their voice was not heard and they felt frustrated that it continued in the area where they lived.

5.2.15 Should the same situation occur today the partnership feels that through 'GET SAFE' professionals will be better equipped to deal with the situation and young people will be better protected. The GET SAFE response pathway identifies what needs to happen next for that child. It uses a Red, Amber, Green traffic light system which determines the right initial response to that child/ young person's GET SAFE risks and vulnerability. Children on the red or amber pathway have the opportunity for direct work from a GET SAFE Link Worker who will work with that child intensively and flexibly in their own environments to understand, educate and support that child with the aim of building safety, being a trusted adult and engaging that child with positive activities or community services with the aim of supporting that child, building safety and disrupting the perpetrators.

5.3 To what extent did agencies working with Sarah consider the level of her cognitive function, and the impact that may have had on her ability to contribute to keeping herself safe and to manage her own epilepsy?

5.3.1 Sarah's family are clear that anyone who had cared for Sarah would agree that emotional function was lower than her age would indicate. *'Left to her own devices' Sarah would struggle with basic tasks such as personal hygiene, managing her money, managing her medication it is very evident that Sarah was not able to do any of these things'.* The family frustration was that despite their requests that Sarah's functioning was assessed, it did not occur. The result of this effected the level of support afforded to Sarah.

5.3.2 Section 3 of the Mental Capacity Act says that any person from the age of 16 is able to make their own decision if they can do all of the following four things:
1. Understand information given to them.
2. Retain that information long enough to be able to make the decision.
3.Weigh up the information available to make the decision; and
4. Communicate their decision.

The Mental Capacity Act starts on the premise that everyone is able to make their own decision, and decisions can only be made on their behalf if it can be proven that they lack capacity to do so.

5.3.3 Sarah's mental capacity was first discussed in a strategy meeting on 30th August 2018, a recommendation for a section 47 enquiry was also recommended. This assessment was delayed and not completed until October 2018. This assessment stated that a capacity assessment was not undertaken but it was the social workers view that Sarah had capacity.

5.3.4 In February 2019, a section 47 enquiry stated that '*Sarah will continue to make choices in relation to her ongoing contact with Peter and has capacity to do so despite there being reason to believe that she is being groomed and manipulated by Peter'* It was recognised that Sarah was not making safe decisions and consideration should be given to her cognitive capacity.

5.3.5 On 17th May 2019, a request was made by the social worker for a formal cognitive assessment, this request was forwarded by the Team Manger to the Group Manager. This request was not put in place before Sarah's death.

5.3.6 The requirement for a capacity assessment was not given the priority that it required. A capacity assessment may have identified the need for a cognitive assessment, which would have assisted professionals understanding of Sarah's ability. The CSC IMR recognises that it is of concern that LAC reviews did not escalate the drift and delay in this assessment taking place.

5.3.7 Training on managing epilepsy was delivered to foster carers and to staff at at the residential placement from the specialist epilepsy nurse. The local authority state that specialist epilepsy equipment was purchased but this is disputed by the family who feel that the right equipment was not offered. In particular when Sarah went into

independent living, where she was most at risk, a mattress alarm was not purchased. The reason given that the flat given to Sarah did not have a phoneline. This calls into question the suitability of this placement. The family felt it was wholly unsuitable and made this known on a number of occasions.

5.3.8 The training on identifying and dealing with epilepsy which was delivered to the staff at the residential placement was not repeated at the YMCA, leaving staff with no knowledge how to deal with Sarah's seizures. In June 2019, Sarah returned to the YMCA late having consumed alcohol, she collapsed and was not responsive. She was conveyed to hospital, where Sarah said that she had suffered two seizures. After observation Sarah was discharged back to the YMCA by taxi, which did not recognise the risk that further seizures or Sarah not going back the YMCA presented.

5.3.9 In October 2018, the specialist epilepsy nurse and doctor raised a concern regarding the risk of SUDEP and a concern regarding Sarah living independently. A month later Sarah was given the placement where she received daily outreach support. Despite tenacious efforts the outreach worker was only able to have limited contact with Sarah.

5.3.10 The family feel that more effective use of their knowledge and experience of caring for Sarah and her epilepsy could have been made. They feel that despite repeated requests their voice was often not heard.

5.3.11 Another factor which influenced Sarah and the way that she managed her epilepsy was Peter. It is recorded by CSC that Sarah had stated that Peter did not believe that she suffered from epilepsy and she had been mis-diagnosed. It is likely that Peter was able to exert considerable influence on the management of her condition. This would have presented another consideration for legal action on the basis that Peter's influence was likely to cause Sarah's significant harm.

5.3.12 Other factors appeared to exacerbate Sarah's condition, one of these was anxiety and the other, the use of controlled drugs. Sarah stated that she was using cannabis and this, when used, appears to have initiated a seizure. The consideration of the use of controlled drugs does not appear to have been properly considered on the risk to her due to her condition.

5.3.13 There needed to be a holistic management plan with regard to Sarah's epilepsy management, which included both the specialists, the family and Sarah. This did not occur.

5.3.14 It was believed at various stages that Sarah was not taking her epilepsy medication. This was confirmed post her death when large quantities of medication were located, and it was established that she had not collected her medication since January 2019. There needs to be a link between the failure of a young person, particularly those who are vulnerable and looked after, not collecting their prescription and CSC, who have the responsibility for their care.

5.3.15 Apart from the specialist epilepsy support that Sarah received there was a lack of recognition of the impact and risks associated with Sarah's epilepsy. Research indicates that Children and young people with epilepsy are more likely to have emotional or behavioural difficulties than children and young people who do not have a chronic illness.[8] There is also evidence that worsening epileptic seizures are a clear risk factor for premature mortality.[9]

5.3.16 When considering the SUDEP risk factors (having poorly controlled seizures, having seizures at night or in bed, having seizures when on your own, frequent and abrupt changes to medication, not taking medication as prescribed, drinking lots of alcohol) many of these applied to Sarah, as identified by the family and specialist epilepsy care. Without careful and constant monitoring and support Sarah was unable to care effectively for herself, particularly when exposed to adverse influence

5.3.17 Support for those involved with Sarah to better understand her condition could have been sought from other specialist organisations such as SUDEP Action[10].Advice if sought may have assisted professionals in understanding the risk and complex nature of Sarah's condition.

5.4 How effectively did agencies balance the competing strands of vulnerability, specifically Sarah's health issues, her risk of being exploited, her missing episodes and the fact that she was a Looked After Child?

5.4.1 The issues of vulnerability, health issues, risk of exploitation, going missing and being a looked after child, and more particularly the root causes, were not viewed holistically and whilst many agencies and individual practitioners worked hard to address the risks and keep Sarah safe, any actions lacked overall coordination.

5.4.2 The family also feel that one area that would have benefitted Sarah was counselling to address any underlying issues. Sarah was receiving CAMHS support in October 2016 but was discharged for what is described as non-compliance and ambivalence to treatment. A number of referrals were made during the course of the case, in May 2017 Sarah was seen in a CAMHS clinic and assessed as having fluctuating mood and emotional dysregulation. In January 2019, the GP recorded that Sarah was seen following an overdose and requested that a referral be made for her.

5.4.3 In August 2018, the consultant wrote a very powerful letter to CSC setting out Sarah's background and the adverse experiences she had endured, linking these to potential attachment issues. The consultant made the case that CAMHS support had been declined and questioned what counselling support was being provided. The

[8] Young Epilepsy, 2019 - Paediatric Epilepsy Research Report (accessed 07/11/20) - Paediatric Epilepsy Research Report

[9] Shankar R, Jalihal V, Walker M et al. (accessed 07/11/20) - Epilepsy mortality and risk factors for death in epilepsy: a population-based study

[10] SUDEP Action - SUDEP Action is dedicated to raising awareness of epilepsy risks and tackling epilepsy deaths including Sudden Unexpected Death in Epilepsy (accessed 07/11/20) - SUDEP.org

epilepsy nurse also gave a view that Sarah was not ready for independent living. These views were not factored in effectively to decision making.

5.4.4 There were opportunities for the various strands to be pulled together and one coherent plan formed. An opportunity for this was the LAC reviews. The LAC reviews tended to focus on Sarah moving towards independence instead of perhaps focusing on whether Sarah was ready to achieve independence and what the risks to her were.

5.4.6 The CSC IMR author makes the point that '*In the LAC review on 21st November 2018, there is no record of the risk Peter posed being discussed within the review meeting. It is also of concern that in the LAC review on the 26th March 2019, the agencies did not discuss in detail the missing and CSE risks and the fact that Sarah had stopped taking her medication and was not collecting prescriptions. The focus of this review was on her placement and independence. The links to actions from the missing intervention meetings and MACE meetings were not pulled together and reviewed in her LAC review and a single child's plan formulated.'*

5.4.7 Whilst it is acknowledged that there was good communication between the social worker and the specialist epilepsy nurse, the health professional did not attend any of the LAC review meetings despite being invited. There was also a delay in the completion of Review Health Assessment by the LAC nurse and part of the rationale given for this is a 30% absence rate in the team at the time.

5.4.8 It would have been the role of the chair of the LAC meeting to pull the concerns together and address the apparent drift in areas such as capacity assessment and legal planning.

5.5 What specifically was Sarah telling professionals, and to what extent was this used to inform the services Sarah received?

5.5.1 Whilst agencies recorded Sarah's views, what is reflected in the agency reports and from the reflective discussion is that Sarah regularly changed her views and wishes for the future and they felt this made it very difficult to make plans. This highlights the real need for a capacity assessment to effectively understand Sarah's ability to make decisions without undue influence from those who had ulterior motives, such as Peter. If it was the case that Sarah regularly altered her views, the reasons why should also have been better explored and this may have revealed a level of coercion from others.

5.5.2 The influence of Peter on Sarah's 'voice' cannot be underestimated, apart from her cognitive ability to make decisions, her ability to make clear decisions must have been inhibited by the coercion being exerted on her by Peter. Professionals stated they never felt that they really knew the real Sarah.

6.5.3 Sarah's family state that too much credence was given to Sarah's desire to move to independent living as they felt strongly she would not be able to take care of her basic needs, this again supports the necessity for effective assessment.

5.5.4 When considering what Sarah was telling professionals it is also important to consider what Sarah was not directly saying but what her actions and behaviour may have indicated. One of the strongest areas voiced by Sarah was her dislike of the independent flat placement in November 2018. From the outset Sarah was not happy in the placement and this was echoed by her family. Sarah did not feel safe and there was no night-time support for her. She regularly absented herself from the flat or had Peter staying there on the basis that she did not feel safe. Sarah remained in this placement until March 2019, when she presented herself as homeless. Sarah's voice at this point could not have been stronger.

5.5.5 During Sarah's time in this accommodation she undertook a number of risky activities aside of the ongoing relationship with Peter. This included drug use and sexual activity which resulted in Peter attending hospital. Sarah went missing and was found at Peter's address, she was conveyed by police back to the placement address, which she had already stated she did not feel safe in.

5.5.6 It is acknowledged that the outreach worker made strident attempts to make contact with Sarah on a daily basis, but this was often futile. It remains that the suitability of this placement and Sarah's ability to live independently were questionable from the outset.

5.5.7 Worcestershire has since this time introduced Supported Board of Lodgings (SBL) which offers care leavers additional residential supported living. Had it been available at the time it is felt that this would have offered Sarah a better alternative.

5.5.8 Although Sarah maintained contact with Peter, through March and May 2019, she did make significant disclosures regarding the influence that he had over her and claimed that she had been blackmailed by him. These disclosures may have been Sarah's cry for help although her actions did not support them, as she continued to reach out to Peter. Sarah stated that Peter was the only one who understood her, and he described her as his fiancée. In January 2019, Peter was informed by police that there would be no further action into the investigation for the grooming offences and this seemed to give Peter an increased confidence, almost a licence to continue his activities. There needed to be a considered assessment of why Sarah was drawn to Peter and what she was possibly trying to convey to agencies.

5. What are the learning points from this case?

5.1 Developmental learning

- **Strategy meetings –** Child protection procedures were not followed, and therefore strategy meetings were not convened with health police and children's social care in attendance as a minimum, as well as other agencies who should have been included. The use of Missing Intervention or MACE meeting must not be used in place of child protection procedures.

- **MACE meetings –** The MACE meetings need to be effective with clear actions, which are recorded and followed through. The meetings need to have appropriate attendance and minutes of the meetings need to be made available to agencies who require the knowledge.

- **Missing meetings –** There needs to be clarity on the process for the convening of these meetings and in particular where there are multiple missing episodes. The specific push/pull factors need to be considered and mitigated appropriately.

- **LAC reviews –** In addition of permanence and independence the current risks, such as CSE, drugs use, and medical risks need to be addressed and form part of the overall plan. Arrangements for LAC reviews need to be communicated to families in a timely fashion to allow their attendance. The chair of the meeting should ensure that there are not areas of drift on actions. All relevant agencies should attend or submit a report in their absence.

It is important there is a clear link and information exchange between these meetings

- **Mental Capacity assessment and cognitive understanding –** Although professionals recorded that Sarah had capacity to make certain decisions a Mental Capacity Assessment would have given clarity and may have led to a cognitive assessment. There were enough professionals concerned that she had an impairment (the impact of her severe epilepsy, serious brain surgery and failure to adhere to her medication regime) that it shouldn't have stopped them undertaking formal assessments under the MCA whilst awaiting a cognitive assessment. This would have assisted in how to best help and support Sarah. There were repeated requests for this assessment, which did not occur. This would have informed some important decisions, such as living independently.

- **Placements and independent living –** There is a view that Sarah was best supported and happiest whilst at the residential placement, she craved more independent living but greater consideration needs to be given to the suitability of any placement. Those who knew Sarah well agree that she needed boundaries and structure and it is difficult to see how this would be achieved in independent accommodation with outreach support. A better understanding of Sarah's capacity would have informed decision making as she became more independent. Where placements are changed it is important that families and other agencies engaged with the young person, particularly those providing specialist care, are notified in a timely way.

- **Understanding Contextual safeguarding –** the risks of abuse faced by Sarah where those outside of her family and home setting. Professionals need to understand the concept of contextual safeguarding. Be able to identify the risks, understand how they may be able to disrupt or change them to make the young person safe.

- **Understanding CSE –** It is important in cases of CSE that there a coordinating keyworker or role, who is able to link important strands of concern and build a relationship with the young person. A better understanding of CSE may be achieved by working with young people who have lived experience.

- **Responding to CSE –** Agencies, including those who advise them on legal matters should be aware of what legal remedies are available to intervene at the earliest opportunity, disrupt activity and protect the vulnerable. Civil orders should not be overlooked on the basis that there is a possible criminal case. Priority should be given to putting protective and enforceable measures in place. There is a substantial gap in the ability to use Child Abduction Warning Notices and this should be highlighted.

- **Mental health support and counselling –** although there were periods where CAMHS were involved with Sarah, this was not consistent either due to her moving areas or not engaging. It remained that Sarah presented emotional dysregulation and mood fluctuations, which were not addressed. Nor, is there any evidence of consideration of how this factored on her risk-taking behaviour and impacted on her medical condition. The family feel that the area of counselling for Sarah was one that was consistently overlooked.

- **Understanding medical conditions –** When professionals are dealing with persons with serious or chronic conditions, they need support to fully understand the implications of it. This support was well provided when requested by the epilepsy nurse and doctor. They briefed the social worker and outreach worker on the need for consistent medication regime and the risks of it not being complied with. What was not clear is who would monitor this on a daily basis. Where there is a looked after child with significant health needs there needs to a consistent health link and this role would most ideally be performed by the LAC nurse, which, at times, was missing in this case. This would have assisted to bridge the gap between pharmacy and GP surgery if, as in this case, the young person is not collecting medication. This specialist support was not available in all situations, such as when Sarah moved to the YMCA.

- **Role of a keyworker –** The reflective discussion event clearly identified a view that in cases such as this there needs to be a keyworker assigned to the young person. To understand CSE a young person needs to trust and build a relationship with a professional. This key worker role would exceed the services provided by a looked after child personal advisor, whose role focuses more on personal development, education and career advice. This is a role which will be available to high and medium risk cases within the GET SAFE initiative.

5.2 Drawing on good practice

- **Specialist Epilepsy support –** There is evidence of good support from the specialist services and that they recognised and highlighted risks of Sarah not complying with her medication regime.

- **Adult support services** – Adult support services which were in place for Peter recognised and reported concerns regarding activity with young people.

- **Role of foster carers –** Very early on in the case foster carers raised the concern of Sarah potentially being sexually exploited and continued to raise these concerns.

- **Social Care support –** Of particular note was supporting Sarah at health appointments. The specialist epilepsy team found it invaluable to have a carer present who knew Sarah and her history.

- **Professional curiosity –** In January 2017, when Sarah was being admitted to hospital for a planned procedure she disclosed, she may be pregnant to a student nurse who displayed good professional curiosity in obtaining more information and appropriately passing the required information on.

6. Recommendations

1. The Worcestershire Safeguarding Children Partnership should seek assurance from all agencies involved in the review that any single agency learning identified in the review has been appropriately implemented within their organisations.

2. The Worcestershire Safeguarding Children Partnership should seek assurance from relevant partners that child protection procedures are followed and strategy meetings are convened appropriately, with health, police and children's social care in attendance as a minimum, as well as other agencies who should be included. The use of Missing Intervention or MACE meeting must not be used in place of child protection procedures.

3. The GET SAFE initiative in Worcester will allow the identification and tackling of Child Sexual Exploitation to be more effective, the learning from this review should be used to enhance the ongoing development of the initiative, with particular focus on: -

    - Ensuring that MACE meetings are convened in a timely fashion, appropriately attended, properly recorded with clear actions that are followed up to ensure outcome.
    - That there is a clear link between the missing meetings and MACE and that the reasons for young people going missing is properly considered.
    - That the ongoing development of GET SAFE considers the views and input from those with lived experience of exploitation.
    - There is a clear link to the police problem solving hubs.
    - Development and use of the role of GET SAFE coordinators to work with and build relationships with young people who have experienced CSE.

4. When dealing with perpetrators of CSE West Mercia Police and Worcestershire Children First should give early consideration to the use of available civil orders

such as Sexual Risk Order or Wardship[11] to provide protection to the young person at the earliest opportunity. Too much reliance should not be placed on criminal proceedings and associated bail conditions, which could be protracted and ineffective to enforce.

5. The Worcestershire Safeguarding Children Partnership should highlight through appropriate channels the restriction in the use of Child Abduction Warning Notices (CAWNS) in cases where young persons are vulnerable, under the age of 18 but looked after under section 20 of the Children Act.

6. The Worcestershire Safeguarding Children Partnership should be assured that LAC review meetings are effective by ensuring that –

    - There are up to date and complete health assessments
    - That the meeting is attended by the relevant professionals or appropriate reports are submitted
    - That the milestones set out in the plan are achieved and not allowed to drift

7. The Worcestershire Safeguarding Children Partnership should be assured that pharmacies and practices will work collaboratively to support Looked After Young People with chronic health conditions to encourage regular collection of prescribed medication required to manage their condition.

8. The Worcestershire Safeguarding Children Partnership should be assured that all agencies working with young people understand the requirements of the Mental Capacity Act when considering the ability of young people to make safe decisions.

9. Worcestershire Children First should ensure that where there is a Looked after Child with a chronic condition or illness that any placement is equipped with the information and knowledge to support and manage the condition and that any placement is appropriate to their needs.

10. Worcestershire Children First should review procedures to ensure that families are appropriately communicated with when a child who is looked after dies and the parents retain parental responsibility.

[11] Department of Education, 2017,Annexes to 'Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation' (accessed 07/11/20) - CSE Guidance annexes - disruption