TORBAY SAFEGUARDING CHILDREN PARTNERSHIP

CHILD SAFEGUARDING PRACTICE REVIEW (CSPR)

‘C85’

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31.08.21.

1 INTRODUCTION

1.1 TRIGGER FOR CASE REVIEW

1.1.1 In late May 2020, Police were alerted to 'C85', a White British female aged 13, sitting on the 'fall side' of a multi-story car park. It was established that C85 had been experiencing mental health problems for some months. These had initially been described as an eating disorder though later escalated into suicidal thoughts and expressed intent. Attending officers exercised 'Powers of Protection' (s.46 Children Act 1989) and C85 was returned home. In June 2020, as a result of her parents reporting that they were unable to keep her safe and worry about the impact of her behaviours on their younger child, C85 was voluntarily accommodated under s.20 Children Act 1989.

1.1.2 Subsequently, as a result of C85's allegations of abuse by her father, coupled with reported parental opposition to her remaining in voluntary care, Care Proceedings were launched and C85 made subject of an interim Care Order. Since becoming a 'looked after' child, C85 has made further allegations of sexual abuse by several individuals and there have been more self-harm or potentially fatal incidents. To date, joint s.47 Children Act 1989 investigations by Police and Children's Social Care have *not* yielded evidence to progress any prosecutions.

1.1.3 In accordance with national statutory guidance within *Working Together to Safeguard Children* 2018, a 'Rapid Review Meeting' was convened on 22.09.20. Rooted in concerns about how involved agencies had provided and/or co-ordinated services, Torbay's Safeguarding Children Partnership was informed and on 28.09.20 notified the national 'Child Safeguarding Practice Review Panel' that a safeguarding practice review was considered necessary and would be completed.

1.2 SCOPE & PURPOSE OF PRACTICE REVIEW

1.2.1 The review period was determined to be from May 2019 to September 2020 focusing on the following lines of enquiry:

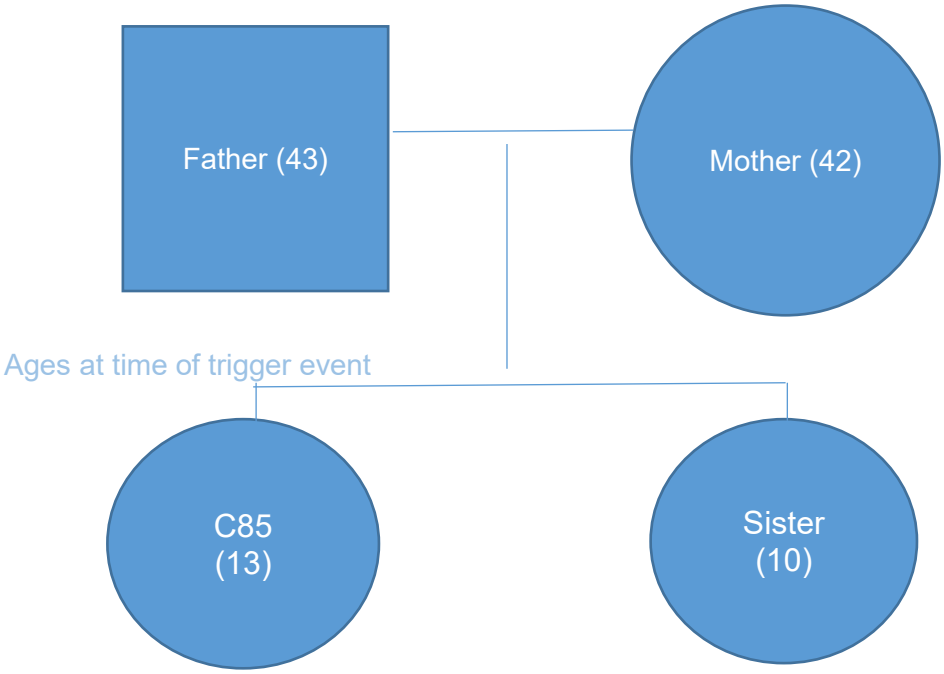
- *C85's Background and Experiences*: reviewing multi-agency case recording to identify pre-existing information and relevant learning, seeking examples of good practice and analysing how escalating risks were understood, responded to and shared across the Partnership
- *Supervision & Oversight*: evaluating nature and quality of supervision and management oversight provided to / by all involved professionals
- *Safeguarding Practice*: establishing how safeguarding concerns were identified, recorded and responded to, how effectively practitioners are supported by their line manager when working with a young person who has made multiple allegations, timeliness and effectiveness of information sharing and review this against local and national guidance regarding self-harm and Adolescent Mental Health

1.2.2 A detailed report was developed from written material supplied by involved agencies, records of a multi-agency practitioners' event and interviews with members of C85's family. The author also was advised and supported at panel meetings with representatives of:

- NHS Devon Clinical Commissioning Group & Primary Care (GP Service, Child & Adolescent Mental Health Service (CAMHS) and local hospital)
- Torbay Children's Social Care (Looked After Children (LAC), Local Authority Designated Officer (LADO) and Independent Reviewing Officer (IRO) Services)
- Devon and Cornwall Police (attending self-harming incidents & investigating alleged sexual offences)

1.2.3 The review was conducted between March and June 2020 and its recommendations accepted by Torbay's Safeguarding Children Partnership in September 2021.

1.3 FAMILY STRUCTURE & INVOLVEMENT



1.3.1 The parents of C85 were informed of this CSPR and, in acknowledgement of their ongoing shared responsibility for C85, invited to contribute. Given C85's reported ongoing mental health difficulties, advice was sought from the currently involved CAMHS / Residential Provider team. C85 was subsequently invited by an advocate with whom she has a positive relationship to respond to a number of agreed subject areas. Regrettably, at the time of writing, the continuing fragility of C85's emotional condition has, after careful consideration, been determined to preclude that planned involvement.

2 SERVICE DELIVERY

2.1 INITIAL DIFFICULTIES NOTED

2.1.1 During her time at Primary School, C85 had shown no indications of vulnerability or additional needs. From late September 2019 onwards, school records refer to concerns that C85 was not eating enough. Following consultation with her mother, the advice of the GP was sought and referrals made to Child and Adolescent Mental Health Services (CAMHS). CAMHS declined the first referral and mother was advised to access an eating disorder charity. Enquiries pursued during this CSPR confirmed that a specialist 'eating disorder function' / team - Torbay & South Managing Eating Pathway Service (TASME) within CAMHS, *did* respond positively to a 2nd referral and remained involved even after it was concluded that C85 did not have an eating disorder**.**

Self-injury episodes 1 & 2

2.1.2 In late October 2019, school pastoral staff were shown the result of C85's superficial cutting of her wrist and her reluctance / refusal to eat at school lunch-time continued. Parents were fully informed and appropriately involved. In mid-November, C85 reported a second example of self-injury. During the remainder of the Autumn term, C85 was incentivised to eat by the promise of being allowed back into school (which she enjoyed) and/or access to her mobile phone. By early December, C85 had returned to school and teaching staff were closely monitoring her consumption of lunch. A subsequent refusal to eat at all resulted in a further withdrawal from school and the possibility of admission to hospital if her weight reached a critical point.

2.2 FIRST HOSPITALISATION / SAFEGUARDING CONCERNS

2.2.1 A week later C85 was admitted to hospital and remained there, subject to tube-feeding, for over 2 weeks. She re-stated her intention to cease eating once she was discharged. C85 was re-admitted at the end of December and on that occasion, for the first time, indicated that she did not feel safe at home. C85 referred in a consultation with a psychiatrist to suicidal thinking. C85 returned home in mid-January 2020. School pastoral records of a conversation with a TASME worker reveal that C85 was no longer regarded as having an eating disorder and that the challenge was more about managing emotions and rigidity of thought i.e. *less* focus by staff or pupils on observing food intake was required.

Self-harm episode 1 – with stated suicidal intent

2.2.2 In mid-January 2020, C85 was presented to the local hospital having overdosed on painkillers and other 'over-the counter' medication. She reported that her intention had been suicide. Self-injury marks over her arms, abdomen and neck were noted. Both parents attended and were distressed. C85 was admitted and remained for 3 days.

2.2.3 Upon discharge, mother took her for a consultation with the CAMHS consultant psychiatrist. C85 returned to school in late January and within days was reporting hearing voices in her head. In mid-February, Police were made aware by the relevant charity that C85 had been

messaging an online support service and expressing suicidal thoughts. Following a home visit, an amber ViST (a vulnerability screening tool graded as red, amber or green) was submitted by officers. It noted that parents were aware of the threat and were supportive. The incident was appropriately relayed to GP and Children's Social Care. A week later, father brought C85 to hospital following a fainting episode and she was admitted for 1 night. A letter from CAMHS reporting an 'undiagnosed restrictive eating disorder, not anorexia', was noted to upset C85, who was at that time refusing to take prescribed anti-depressants ('voices told her not to') and refusing to have her weight recorded.

Loss of schooling associated with pandemic

2.2.4 In the context of Covid 19, the possibility of C85 being allowed to return to school in accordance with a 'vulnerable child' criterion was delayed by an assumption that to satisfy that criterion, s/he must be subject of a 'child protection plan'. In fact 'vulnerability' in Government guidance allowed for professional discretion. The school did anyway maintain contact and encouraged home–schooling. It also helpfully passed on information about an online support source - www.kooth.com.

2nd stated suicidal intent

2.2.5 In late April, C85 called the Samaritans who in turn alerted Police to her report that she was suicidal. Attending officers located her on a footbridge over a railway. She was persuaded to come off, was assessed by attending paramedics and deemed sufficiently fit and healthy to go home to her parents who said that they would call CAMHS for advice. Ambulance records also indicate C85 claimed an intention of jumping out in front of a car to 'kill herself' but had then sat on a footbridge. She was very open about her desire to commit suicide. Her father had attended the scene and was noted to be 'caring'. Having taken advice from the CAMHS Crisis team, and Psychiatric Liaison, hospitalisation was agreed. A safeguarding referral was completed and sent to Children's Social Care, named nurse and her GP.

2.2.6 Hospital records confirm that father attended during his daughter's assessment and seemed very caring, though poor eye contact between them was observed. C85 admitted not taking prescribed medication, though spoke of future plans and becoming a nurse. The CAMHS Crisis Team was consulted and a discharge with an agreed safety plan was agreed. Further exchanges between home and school had clarified that C85 could, in compliance with Covid precautions, be accepted back. During early May, C85 was offered the chance to resume part-time attendance at school and the mentor role transferred from a teacher who was leaving, to an alternative. Based upon inter-agency checks, and discussions with family members, it was determined (justifiably) that there existed no need for Children's Social Care involvement.

2.2.7 Messages sent to Pastoral Care include a cryptic reference by C85 to father 'having done something'. When this was shared with mother, she surmised it might refer to his worried and angry comments when they attended hospital earlier that month.

3rd & 4th stated suicidal intention

2.2.8 On a date in late May 2020, Police were alerted during the late evening by ChildLine, to an online conversation C85 had had with them in which she had stated that she was feeling suicidal. Officers attended at 02.00 and when her mother answered the door, she correctly anticipated it would be due to a message C85 (by then asleep in bed) had sent. Officers were told that C85 was not engaging with CAMHS anymore, possibly linked to what the parents report as an unhelpfully extended period of involvement by the TASME Service, even *after* her difficulties had been concluded to be other than an eating disorder (this has been reported during the CSPR to have been a consequence of repeated self-harming events).

2.2.9 Only 2 days later, C85 was found by a member of public on the 9th floor of a car park reportedly trying to end her life. Police officers used their 'Powers of Protection' to detain her. Whilst at the Police station C85 pleaded to be let her out so she could find somewhere high to jump off. She was taken to hospital and after liaising with the paediatrician and the Crisis Team, transferred under s.136 of the Mental Health Act to Plym Bridge[1] for assessment. She persisted in saying she wished to end her life as soon as possible and alleged her father had hit her when her mother was not present. A strategy meeting was subsequently held and the case immediately allocated to social worker SW1.

2.3 FIRST ALLEGATIONS OF ABUSE BY FATHER

2.3.1 Having been returned home C85 ran away and was subsequently found by Police. Following admission to the Paediatric ward, staff noted scarring from earlier deliberate self-harming as well as a bruise on her right upper arm. C85 threatened to leave and jump from a car park. She began to talk about physical abuse from father and said that there was 'more to tell' but that she 'wasn't ready yet'. The consultant was made aware and messages were left for the social worker. 2 days later, discussions were held with SW1 about discharge planning. C85 was refusing to complete an ABE interview. Hospital and SW1's records note that in the context of agencies formulating their responses to the allegations of physical abuse, father was resisting a move out of the home.

2.3.2 By early June, C85 had changed her mind and a date was agreed for an interview. C85 disclosed (unspecified) sexual abuse which triggered a strategy meeting convened next day. Arrangements were agreed with mother for father to have supervised contact with his younger daughter. Nurses supported C85 in follow -up discussions with Police and she was made aware of an intention to arrest her father. CAMHS continued to provide support and C85 went on to allege to ward staff, what she said that she had 'not' to that point in time, reported to Police i.e. that she had been raped on more than one occasion by her father.

[1] Plym Bridge is 12 bed purpose-built psychiatric unit in Plymouth for teenagers with severe mental health problems or mental illness.

2.3.3 C85 completed an Achieving Best Evidence (ABE) interview and her father was arrested next day. A Sexual Assault Referral Centre (SARC) consultant proposed that a further ABE be completed. In anticipation of C85's discharge from hospital, SW1 began to explore extended family options though could identify none. C85 completed a further ABE, disclosed 3 more rapes and referred to numerous attempts plus daily touching of her breasts and that her father had made repeated threats to stab her.

2.4 ENTRY TO CARE SYSTEM & 1ST FOSTER PLACEMENT

2.4.1 Though not apparent from records submitted, C85 was discharged to a foster carer FC1 in mid-June. Nominally anyway, she remained there for about 2 weeks before being re-hospitalised for a further 3 weeks. In mid-June an initial child protection conference (ICPC) was scheduled but replaced, after C85 entered the Care system, by a plan to convene a s.26 Children Act 1989 review (i.e. a routine case review required by regulation at regular intervals for all children 'looked after' by Children's Social Care).

5th statement of suicidal intent

2.4.2 Within 2 days of her placement with FC1, Police received reports of a female on level 7 of a car park wanting to jump. C85 disclosed to officers attending that her reason for this apparent suicide attempt was because her father sexually abused her. She refused to return to her foster home because of 'the other children' and not liking the carer. *If* returned, she threatened to leave and kill herself. Officers spoke to her CAMHS worker who arranged a mental health assessment at Torbay Hospital. Though not in Police records, Children's Social Care records refer to C85 later describing a scenario *preceding* the above events, when, feeling suicidal, she had gone to pick up some drugs. She reported that having no money, the dealer told her she could pay via sexual intercourse. She sought to reverse her initial agreement but he persisted. C85 (who had no record of substance misuse) declined an ABE interview about her account. Next day, she went missing and was traced to a friend's house. She said she was still having suicidal thoughts and was subsequently taken by SW1 to the local Sexual Abuse Referral Centre (SARC). She co-operated with the planned examination *only* to the extent of providing a urine sample. A strategy meeting next day discussed her reports of sexual assaults in the community, 'missing episodes' and escalating behaviours exposing her to risk of sexual exploitation.

6th reported suicidal intent / detention under Mental Health Act

2.4.3 On a date in late June, C85 again attended a multi-storey carpark threatening to jump. She was reported to have a suicide note (content unknown) and a razor blade. She was detained under s.136 Mental Health Act 1983. The carer described a history of allegations of assault and rape by males e.g. she had been reporting romantic relationships with male police officers. The potential for unfounded allegations was recognised and officers were (sensibly) alerted and advised when possible, to be 'double crewed' and use Body Worn Video (BWV).

Confusion in inter-agency discharge planning

2.4.4 It seems that after her detention at Plym Bridge Psychiatric Unit, C85 was admitted once again to the Paediatric ward at the local hospital. Its records are difficult to follow but appear to indicate:

- A strategy meeting involving paediatrician, CAMHS, Children's Social Care and Police at which the need for a new placement was acknowledged
- A request from C85's parents for further medical opinion and investigations
- A possible overdose whilst on ward, along with a suicide note, leading to removal of medication and sharp implements
- In response to her claim that she had illegal drugs in her possession, an unsuccessful search (this may not have been shared with SW1)
- Scheduling a professionals' meeting
- Further concerns about deliberate self-harm and vomiting

2.4.5 At the professionals' meeting the failure to identify a placement was debated and parental frustration noted. Further medical investigations revealed nothing abnormal. By 17.06.20 a multi-agency meeting was told that no placement had yet been identified and that C85 had made an additional allegation of an incident (no detail provided) 5 years previously. Though the parents were and remain anxious to know if there might be a medical explanation for observed symptoms, correspondence (copied to the parents at the time) of comprehensive medical tests all pointed toward psychological rather than physiological origins. Though not included in the minimal hospital records provided to this case review, the parents remain resentful that a visiting neurologist who examined C85, failed to speak with them.

2.4.6 The ward confirmed C85's readiness for discharge by late June but, Children's Social Care was still unable to find a placement and it was agreed that C85 remain until a suitable one was available. Enquiries have revealed that the acting Head of Service in Children's Social Care submitted an extremely comprehensive and constructive response to the hospital's concerns about the potential impact of an indefinite stay. It noted the need for updated psychiatric input and progression of a plan agreed earlier at a completed DICES[2] assessment. The practical implication of the message was the (wholly justified) need for a multi-agency pre-discharge meeting so that the efforts of all involved agencies could be combined.

2.4.7 On 06.07.20 an independently chaired s.26 Children Act 1989 Review was completed and at a (remote) pre-discharge meeting on 10.07.20 attended by the lead nurse, it was confirmed that C85 *was* medically fit to be discharged. The ward confirmed that C85 was continuing to self-harm and 'becoming attached' to nurses.

[2] DICES = a risk assessment tool developed by the Association of Psychological Therapies

2.5 CARE PROCEEDINGS & 2ND FOSTER PLACEMENT

2.5.1 A week later, the parents are reported to have indicated they no longer supported the use of voluntary accommodation for C85. Apparently in response, an application for an interim Care Order was made at the Family Proceedings Court (and subsequently issued on 28.07.20). C85's younger sister remained at home subject to a child protection plan. The parental account of this period is that they wished that C85 remain on the ward pending a diagnosis.

2.5.2 Torbay's Fostering Service identified a possible replacement carer FC2. It was left for SW2 to liaise with FC2 for a 'Matching Discussion'. In spite of parental opposition, C85 was subsequently placed though went missing the next day. An 'Initial Matching Meeting' convened following placement was *not* attended by the allocated social worker and lacked management input. IRO1 is recorded as supporting the placement and the apparently ambivalent carer left to define for herself what support she might need to sustain the placement which it was hoped would begin again on 18.08.20. Meanwhile C85 (by then subject of an interim Care Order) remained with a friend. Given the intrinsic complexity of C85's needs and significant delay, the placement required a good deal more thought and management support. No record has been supplied of steps taken to authorise or regulate C85's placement in what is presumed to have been a 'connected person' placement. Poor quality of records renders it difficult to be sure of events or their sequence.

Further self-injury

2.5.3 In the first week of August, C85 inflicted superficial cutting of her arm and was taken by a male social worker SW3 (to whom she was subsequently allocated and about whom she would later make allegations) to the hospital to clean and dress her wounds. C85 was later introduced to her proposed new placement. C85 liked FC2 and her home, but insisted on staying with a friend pending a move there. Following transfer, daily CAMHS visits to C85 began. No records of a 'Placement Planning Meeting' or other routine functions have been traced. At a poorly recorded announced visit, FC2 spelled out her support needs and concerns about the risk of further self-harming. She made it clear her that her ability to manage was constrained by other personal priorities. A 'Placement Stability Meeting' was scheduled.

7th stated intent to commit suicide & confusion in responses

2.5.4 Within days of moving to FC2, Police attended C85 on the top floor of a car park and again heard allegations of sexual assaults by her father. C85 also said she was hearing voices and felt worthless. She appeared excited to meet officers not seen before (reinforcing the wisdom of the precautionary arrangements put in place by the Police). She was taken to hospital where SW3 attended and spoke to her. After initial consideration of detention under s.136, CAMHS confirmed she could be taken directly to the Paediatric ward. Whilst awaiting a bed, C85 disclosed that she had been raped by a male (forename given) whom she 'had met on-line' as well as by some of his friends.

2.5.5 Though no formal minutes were kept and uncertainty as to date and attenders remains, a 'Placement Stability Meeting 1' was convened. Its summary reiterated FC2's lack of confidence. Records of internal exchanges between Fostering and Community teams do not provide clarity though the net result is certain i.e. contrary to instruction initially given to SW3 by his head of service and later 'justified' by the support or acquiescence of an alternative manager, SW3 provided direct care ('babysitting') on the evening of C85's return to placement whilst FC2 attended a pre-arranged family event. It remains uncertain whether SW3 was alone with C85 at any time or always accompanied by the carer's elderly mother who was present though might be considered limited in her protective / supervisory value.

8th & 9th stated intent to commit suicide

2.5.6 Within a week of the Stability Meeting, C85 again ran to a car park with the stated intention of ending her life. She did not resist intervention by attending police officers and was willingly returned to placement by SW3. Though not formally minuted, 'Placement Stability Meeting 2' was then convened. It listed outstanding actions including the need to log episodes of running away and self-harm and organise respite for FC2 who was finding the placement very demanding. The consensus was though, (surprisingly) that the placement was a 'good match'.

2.5.7 In late August, a 2nd review chaired by IRO1 was convened involving the Sexual Exploitation Team, SW3, parents and FC2. A 'Safe Care Agreement' was formulated and identified the need for caution amongst males in contact with C85. Given his direct participation in formulation and agreement to the plan, SW3's subsequent conduct was all the more questionable. 3 days following the 2nd review, Police and SW3 attended a train station when C85 had been observed at the edge of the platform. Her response to officers were comparable to earlier episodes. SW3, who eventually took her back to her placement, attributed some of her distress to his imminent departure, reporting that he was something of a 'father figure' to her. C85 was introduced to newly allocated SW4. Having later spoken with her CAMHS worker, C85 ran away again and, evaluated as a high risk missing person, was traced by Police to local woods. C85 was again sectioned under s.136 and, following a mental health assessment, returned to her placement.

2.5.8 In partial response to C85's expressed concerns about his behaviour toward her (which she said she did *not* want followed up because she 'liked' SW3) a 'local authority designated officer' (LADO) meeting was held on 25.08.20 to consider what was a clear blurring of professional lines, in particular the amount of time that SW3 had been spending with C85 which included calling her while he was off duty and late into the evenings. He was also giving her his own personal money. C85 subsequently recognised (in a conversation with ChildLine) the possibility that SW3 had been grooming her. She confirmed receipt of money from him though was equally clear in her refusal to complete a video interview or support any prosecution. An email is reported by Children's Social Care to have been subsequently received from SW3 (by then an ex-employee) admitting to the above behaviours, including giving her money, which he asserted he had been going to reclaim.

2.5.9 The multi-agency chronology provided for this CSPR refers to a 'Risk Management Plan' implemented by SW3 on 26.08.20 and covering self-harm, going missing, social media and school attendance. The plan (not seen) is said to exclude reference to the promised support package, or expectations of allocated support workers. A further record dated 27.08.20 offers an account of the day before, in which SW3 had failed to call to say goodbye to C85 who was reported (having planned to give him a thank you card) to be distressed. It seems likely that any plans SW3 may have had for his final days of employment were not implemented as a result of Management's responses to his suspected professional misconduct.

Strategy meeting & consequent enquiries

2.5.10 By this time, the previous report of sexual offences by her father was due to be filed with 'no further action' but it was noted that C85 had not yet been told, whilst thought was given to informing her without exacerbating her emotional difficulties. A strategy meeting was held on 01.09.20 in response to a new claim made to a community care worker that C85 had been involved in intercourse days earlier with a 'year 11' (estimated 15 year old) male. It was agreed that C85 was at risk of significant harm and the threshold for joint s.47 enquiries was satisfied.

2.5.11 On 02.09.20 a police officer, SW4 and a CAMHS worker visited C85. She agreed to tests for pregnancy and sexually transmitted infection (STI), but declined to offer any further detail or confirm that the event had been non-consensual. She shared with SW4 how close and dependent she had become on her CAMHS worker. In what may be a reference to the same visit, the Children's Social Care chronology also confirms a visit by a social worker and CAMHS worker that day, the aim of which was 'to gain information about her relationship with the social worker SW3'. C85 subsequently called ChildLine stating she had been assaulted sexually by SW3 i.e. he had touched her breasts under her tee-shirt whilst she was in his car. ChildLine informed Police and a visit next morning by a female and male officer to seek evidence may in turn, have triggered the incident described below.

Self-harm incident & 10th suicidal intent statement

2.5.12 In early September 2020 the CAMHS Crisis Team placed a 999 call because C85 was reporting that she had taken an overdose. She told Ambulance control that she was overdosing as they spoke. An ambulance was dispatched and she explained that she had made some superficial cuts to both forearms and made her way to the train station where she took 36 Paracetamol tablets. C85 refused to report any other medication taken and denied any alcohol. A Police Community Support Officer travelled to hospital with C85 and all standard notifications were completed. C85 was discharged to her placement 2 days later and her stated intention, was to resume school the next week. Hospital records capture her account of ingesting 36 Paracetamol and some Sertaline 'obtained from a 21 year old male' with the intention of ending her life. She also referred to 'something happening with a boy' prompting a call to ChildLine.

‘Risk management meeting’

2.5.13 Some days later, a conversation between SSW1 and FC2 was described as a ‘Risk Management Meeting’ (elsewhere a ‘Placement Stability Meeting’). The carer informed SSW1 of the planned strategy meeting and expressed concerns lest allegations be made about her or her son (no age recorded). The need to terminate the placement and the notice period required was discussed. Agreement was reached that the carer would continue until late October. C85 was to be told once a new placement had been identified. The discussion lacked any contributions from the placing social worker SW4 and others and it is unclear why alerting SSW1 to the strategy meeting was left to FC2.

2.5.14 During the second week of September, C85 inflicted further razor cuts on her arm whilst at school. These were managed by the school nurse. She later claimed that CAMHS had agreed with her carrying a blade though CAMHS assured the school that this was not so. This event highlighted that, notwithstanding the enormous care and commitment shown by her school, it remained challenging and potentially risky to reconcile the additional needs of a vulnerable individual against the legitimate needs of the majority of pupils and staff.

11th statement of suicidal intent

2.5.15 On a date in mid-September Police were alerted by a local Charity to a claim C85 made via text messages that she had something around her neck and wanted to kill herself. When Police arrived at the house she said she had done it for attention though *did* want to kill herself. C85 refused to co-operate with a planned ‘Initial Health Assessment’ (a regulatory requirement under Children Act 1989 Regulations). An incident report completed by the foster carer noted daily self-harming and also referred to a new ‘boyfriend’ (a named year 9 pupil).

2.5.16 A partially completed Care Plan dated 22.09.20 was considered at the 3rd LAC review on 24.09.20 chaired by IRO1. Records indicate that the required ‘Permanency Plan’ was either long-term foster care or reconciliation with family.

3 FINDINGS & RECOMMENDATIONS

3.1 CONSTRAINTS

3.1.1 The potential for evaluating professional service delivery in compliance with the terms of reference has been constrained by:

- A dependence upon a merged chronology that was disproportionately dominated by school-based welfare-related records and insufficiently informed by records of the thoughts, assessments and actions of (in particular) CAMHS and hospital practitioners, or (with the exception of the school) agencies' supervision and management of practice
- A probably connected difficulty, of missing or incomplete and inadequate recording of activities across case accountable v family placement provider functions within Children's Social Care

3.1.2 Though additional records supplied in early July have provided some reassurance, the following findings still reflect the uncertainty that follows from the observations in para.3.1.1. Attempts have been made by means of the practitioners' event, meetings with parents and C85's contribution to compensate for these limitations. The recommendations below, if effectively introduced, *should* improve the Partnership's capacity to derive systemic learning from case analyses.

3.2 RESPONSES TO TERMS OF REFERENCE

C85'S BACKGROUND & EXPERIENCES

3.2.1 It seems clear that C85, prior to the concerns about her eating emerging in September 2019 had experienced no known adverse experiences or displayed any needs or difficulties that would have distinguished her from her peers. She appeared to be a bright child from a caring 2 parent family, who was enjoying her attendance at a well-respected and (according to regulator Ofsted) 'outstanding' school.

SUPERVISION & OVERSIGHT

3.2.2 In the material supplied to this CSPR, limited evidence has been supplied of professional supervision or oversight. It remains uncertain on what basis (the first GP-initiated referral to it having been declined) that CAMHS eating disorder team first became involved. It seems probable that involvement was triggered by the aggregated information supplied by a very attentive parent and school and/or the initial thinking and influence of the hospital's consultant paediatrician when presented with a potentially anorexic C85.

3.2.3 Whilst the volume and detail of educational records may have been excessive, they do highlight clearly, a commendable level of compassion, sensitivity and debate between class / subject teachers and those with additional pastoral responsibilities.

3.2.4 An example of positive management practice emerges in June 2020 when Children's Social Care's senior manager submitted a comprehensive response to the hospital which, wholly understandably, was keen to discharge C85.

3.2.5 Supervision and management are not apparent at the time of an immediate need to build-in additional support for FC2 (though this *may* have reflected deceit on the part of SW3). Further comment is provided under the sub-heading of Safeguarding Practice below.

3.2.6 There was a welcome injection of objectivity from IRO1 in late August when she raised concerns about over-involvement of SW3 with C85. The CSPR panel has been reassured to learn that (pending completion of an investigation by regulator Social Work England) SW3 has been suspended and is currently unable to practice as a social worker.

3.2.7 No evidence has been provided to suggest a pre-allocation debate about what gender, experience or skill-set might have been needed to respond to the complex needs of a very vulnerable girl; nor has evidence been seen of the source or frequency of SW3's case supervision.

SAFEGUARDING PRACTICE

Introduction

3.2.8 The following paragraphs offer a brief agency-specific evaluation of the safeguarding practices so far emerging from material made available. It is followed by a more general observation of the net result of those efforts and the untapped potential for a more co-ordinated approach.

School

3.2.9 Whilst school staff clearly made great efforts to sustain their relationship with C85 and through their unwavering efforts, to support her capacity to learn, they were arguably over-involved. It may be that pastoral staff derived more meaning and value from the voluminous records (which included page-shots of numerous communications from C85) than the author has been able to do. Unsurprisingly, some staff did appear at times to feel that they were 'out of their depth'.

CAMHS

3.2.10 Without sight of CAMHS records (community or hospital-based Crisis Team), the rationale for initial rejection of a GP referral, subsequent re-consideration or provisional diagnosis may have been, is uncertain. An absence of formal reports and instead numerous phone calls, added to the volume and some confusion within the school's records shared for this CSPR.

3.2.11 CAMHS' Eating Disorder Team (TASME) introduced a useful distinction in December 2019 when the possibility of a compulsive 'eating disorder' was replaced with the idea of a 'disorder of eating' i.e. C85 deploying eating or non-eating as means of effecting control. Beyond that thought, little progress was made with respect to a diagnosis.

Children's Social Care: Fostering Service

3.2.12 Only after further research by panel members, was it possible to confirm that C85 had been placed with a FC1 prior to her (also disrupted) placement with a FC2. There was insufficient clarity or consensus about processes or widely understood terms and limited evidence of a collaborative approach between case accountable social workers and foster carer providers. Assurances have been provided, though no evidence seen, of supervising social workers for carers, themselves receiving supervision.

Children's Social Care: Case Accountable Service

3.2.13 No written confirmation has been seen to confirm that SW3 received case supervision. Completion of a Social Work England investigation *might* reveal that he elected to circumvent what did not suit him. The CSPR panel is satisfied that the responses to the concerns about SW3's conduct, first identified by IRO1 were prompt and well-informed. It remains unknown whether, during his earlier employment, unprofessional conduct had been identified. Organisational responses in September 2020 were appropriate viz: alerting the director, informing Police and issuing a notification to professional regulator 'Social Work England' so that the latter organisation could take appropriate action.

Children's Social Care: Partnership Working

3.2.14 In addition to the failures to keep C85's school updated about changes of social worker and other events, there was scope for a more collaborative and sensitive approach to her family. In spite of the lack of evidence to support numerous allegations and resulting need for 'respectful uncertainty', there was an insufficiently inclusive approach that accepted that the professional network was (and remains) unable to explain C85's 'inner world' and triggers for her distress. Parental feedback suggested that this remained so and prompted the author to contact the principal social worker / director. The agency's positive response indicates a renewed and welcome attempt to forge an effective partnership with parents.

Police

3.2.15 The responses by officers in attendance at C85's 11+ incidents were (setting aside some minor recording issues) sensitive and professional.

Case Co-ordination

3.2.16 The limited record of CAMHS involvement prior to C85's allegations against her father make it impractical to evaluate what scope may have existed for its efforts and the school being more formally co-ordinated e.g. was the reluctance at the hospital on New Year's Eve 2019 to go home debated between the involved agencies? It was 5 more months before C85 offered (to her school) a more concrete reference to *why* she might be anxious about home.

3.3 RECOMMENDATIONS

Torbay Safeguarding Children Partnership

3.3.1 The Partnership should:

- Clarify its expectations of agency reports and chronologies for a CSPR and take steps to meet any need that emerge from its deliberations, for enhanced briefing or training
- Seek confirmation from local agencies that there exists sufficient clarity, agreement and above all, *confidence* to discern apparent / suspected professional malpractice, distinguishing between the need for internal management action, reporting to relevant Regulatory Bodies and/or reporting of suspected crime

Torbay & South Devon NHS Foundation Trust

3.3.2 The Trust should review expectations and clarify for its staff and colleagues in other agencies, the respective functions within and content and the inter-relationship of all records maintained, by the 'Child & Adolescent Mental Health Service' (CAMHS).

Torbay Children's Social Care

3.3.3 Children's Social Care should:

- Evaluate the extent to which the 'Care Plan' and its implementation (in particular with respect to parental contact and involvement), complied / complies with requirements and expectations of the Children Act 1989 (as amended) and statutory and non-statutory guidance [confirmation in July 2021 from the head of regulated services of a proposed Care Planning Review should serve to meet this need]
- Complete a limited case audit to determine the extent to which the interface apparent in this case between case accountable staff and those responsible for family placements is typical

3.3.4 The agency should also ensure that in what is understood to be a current transition to a new Information Technology / Service User Database, that policies and procedure for 'locking down' material in prescribed circumstances do not have the un-intended consequence (seen to an uncertain degree in this case) of denying access to key information to subsequent operational staff, or those seeking to review service delivery.

3.3.5 Whilst recognising that responses to reports and allegations in August 2020 were prompt and proper, the agency should review the extent to which pre-existing information and/or supervision records offered the possibility of earlier detection of SW3's questionable conduct.

Torbay & South Devon NHS Foundation Trust

3.3.6 The Trust should address and act to ensure that when requested for information to inform a 'Rapid Review' and/or any other form of evaluation of service delivery, that CAMHS and Torbay Hospital have the capacity to do so within agreed time limits.

Torbay Education Safeguarding Service (TESS)

3.3.7 TESS should:

- Seek comments from the very supportive school about its views of un-tapped potential for support by partner agencies and, informed by the results of that exercise
- Develop and introduce guidance with respect to the nature and quantity of pastoral records that are maintained by local schools