



# **SERIOUS CASE REVIEW**

**“Olivia”**

**Jane Wiffin**

**March 2017**

Publication Date: 13 June 2017

The independent lead reviewer and all those who have been involved in the Serious Case Review extend their deepest condolences to Carol's family for their loss. The extreme nature of Carol's murder had a significant impact upon those professionals who worked closely with her over many years and knew her well.

While this review seeks to capture as much learning as possible it should be acknowledged at the outset that no professional or agency could have foreseen that Carol would be murdered in the manner that she was or predicted the actions of the young people.

The murder of Carol was shocking to all in the professional community. The SCR's have been an opportunity to explore the role of professionals in both girls' lives and to consider whether this incident could have been foreseen and therefore prevented. We have found that neither girl had any history of violent offences; they were angry, abusive and hostile to those around them and there is considerable evidence that they experienced abuse and neglect which had an impact on their well being and behaviour. We have tried to understand the detail of the professional response to that abuse and neglect, and how trauma manifests itself in young people's lives. We have emphasised the non linear nature of this story, because although we have learnt lessons about how we understand adolescent neglect more broadly, and the likely trauma it creates, we cannot predict how this will manifest itself on a daily basis or how it might interact negatively with other factors. These issues are beyond professional control.

It is important to highlight that those involved with both girls took their circumstances and obvious distress and hostility seriously, and sadly there were plans in place to address these issues at the same time as the murder took place. In talking about these factors in the girls lives, we do not intended to take away from the fact that both girls have been found guilty of Carol's murder and are serving custodial sentences as a result. This is why we have concluded that this serious incident was not predictable and therefore not preventable, but we can focus positively on all ways that trauma manifests in young people's lives and address these effectively.

<b>1. INTRODUCTION</b>	<b>Page</b>
Why this case is being reviewed?	4
Summary of the Case	4
Summary of the Review Methodology	5
The Review Team	6
Family Involvement	7
Independence and Expertise	7
<b>1. APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE</b>	
Appraisal of professional practice in this case: a synopsis	8 - 20
<b>2. THE FINDINGS IN DETAIL</b>	
Findings in Detail	21 - 39
<b>3. APPENDICES</b>	
Appendix 1 -Methodology and process of the review	40 - 41
Appendix 2 –Bibliography	42 - 44

# 1. INTRODUCTION

## Why this case is being reviewed?

- 1.1 This Serious Case Review (SCR) was commissioned by Hartlepool Safeguarding Children's Board (HSCB) because Olivia (aged 14 at the time) and another child, Yasmine (who is subject to a separate review) were arrested, and subsequently found guilty of the murder of a vulnerable adult (who is subject of a concurrent Safeguarding Adults Review). Olivia is now subject to a significant custodial sentence. Although these circumstances do not fit the existing regulations<sup>1</sup> for undertaking a Serious Case Review the HSCB took the decision that because of the serious nature of the incident a Serious Case Review should be undertaken to provide the best framework to capture professional learning, improve systems and professional practice for the future.
- 1.2 Serious Case Reviews play an important part in the broader efforts of the LSCB to achieve a safer Child Protection system and ensure all children and young people are effectively safeguarded. Consequently, it is important to consider what happened and try and discover why in a particular case, but then to go further and reflect on what this might reveal about underlying gaps and strengths in the child welfare system that may reappear in other cases.
- 1.3 There was some delay in the review proceedings because of criminal processes which took 16 months to complete. This did not prevent early data collection, or key agencies reviewing their existing services to see what immediate action might need to be taken. Each agency involved with Olivia has produced an action plan from this early analysis and these plans have been regularly reviewed.

## Summary of the case

- 1.4 This review is about Olivia<sup>2</sup>. She is one of six siblings and all have the same mother. Two of her siblings (Sibling 1 and 2) are older than her and they have a different father. Olivia has a sibling (Sibling 3) who is 18 months younger and they have the same father. There are two younger siblings and they have different fathers<sup>3</sup>. The family's ethnicity is White/British.

---

<sup>1</sup> Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely: 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. (2) For the purposes of paragraph (1) (e) a serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

<sup>2</sup> All names are anonymised within the report

<sup>3</sup> Exact ages are not given to ensure anonymity

- 1.5 Olivia lived with her mother and older siblings until she was five years old. At this time all the siblings came into foster care because of concerns regarding mother's poor mental health, drug and alcohol use and Olivia made unsubstantiated allegations of sexual abuse by a family member. When Olivia was aged nearly 7 she and sibling 3 moved to live with their father under a Residence Order<sup>4</sup> with support for one year under a supervision order<sup>5</sup>. When this order expired there was no further contact with specialist services until the start of the review period at the beginning of 2012 when Olivia was just 12. During the time living with father, Olivia had no contact with her mother; the reasons for this are unclear, but Olivia told professionals that her father had said that her mother was dead.
- 1.6 In late 2012 Olivia moved to foster care for a three-month period. She returned home to her father's care, but over time there was chaos and confusion about which parent she was living with. There were concerns about her care and in late 2013 legal orders were sought and she was permanently removed from the care of her parents. At this time, she was placed with a foster family and she remained there for 9 months.
- 1.7 There followed a brief third foster placement, before she moved to the specialist children home in the summer of 2014 where she stayed until the murder.

### Summary of the Review Methodology

- 1.8 The expectations of a Serious Case Review as contained in Working Together 2013<sup>i</sup> is that they are conducted using a systems approach, but no specific methodology is prescribed. This review has been undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence and more details about this can be found at <http://www.scie.org.uk/publications/guides/guide24/index.asp> SCIE provided quality assurance supervision at key points in the data analysis process and at the end when the final report was in draft form.
- 1.9 Information is provided in Appendix 4.1 about the methodology and process of this review.
- 1.10 The review was also assisted by a case group of frontline professionals across all the relevant agencies who mainly had direct involvement with Olivia. This also extended to professionals who were managing or supervising those professionals involved and the foster carers. They provided data and sensitive critical reflections to the review to best understand the professional response to Olivia at the time but also the current systems of work. This has not been an easy thing to do given the

---

<sup>4</sup> A **residence order** is an Order settling the arrangements to be made as to the person with whom the child is to live. - The Children Act 1989, s 8

<sup>5</sup> A **supervision order** is a court order placing a child or young person under the supervision of a local authority or a probation officer where care proceedings are appropriate - The Children Act 1989, s 31

circumstances and the independent reviewers are genuinely grateful to them for their honesty and openness.

- 1.11 Interviews were held with all professionals who had contact with Olivia and her family. From this early data gathering all reports and a substantial quantity of case records from across the agencies was accessed and reviewed. This data was analysed by the Review Team and formed the basis of this report. The Case group were involved in subsequent discussions about emerging findings and agreed with the subsequent analysis.

### The Review Team

Title	Agency
Named GP for Safeguarding Children	Hartlepool and Stockton-on-Tees (HAST) Clinical Commissioning Group (CCG)
LSCB Business Manager	Hartlepool LSCB
Detective Chief Inspector	Cleveland Police
Service Manager CAMHS	Tees Esk & Wear Valleys NHS Foundation Trust
Assistant Director Children's Services	Hartlepool Borough Council
Designated Nurse Safeguarding Children and LAC	Hartlepool and Stockton-on-Tees (HAST) Clinical Commissioning Group (CCG)
Named Nurse - Out of Hospital Care	North Tees and Hartlepool NHS Foundation Trust
Head of Commissioning and Clinical Quality	Commissioning and Clinical Quality Section Hartlepool Borough Council Public Health
Named Nurse	Safeguarding Children Team Tees Esk & Wear Valleys NHS Foundation Trust
Community Safety & Engagement Manager	Hartlepool Borough Council
Head of Safeguarding and Review, Children's Services	Hartlepool Borough Council
Principal Educational Psychologist	Hartlepool Borough Council
Senior Service Manager	The Children and Family Court Advisory and Support Service (CAFCASS)

## **Family Involvement**

- 1.12 Olivia was asked if she wanted to contribute knowledge to the review process and she agreed to do so. She was visited by the reviewer where she is held in custody. Olivia provided many key insights to her view of services she received and these are woven into the fabric of the report.
- 1.13 Olivia's mother and father were also asked to contribute to the review but despite considerable efforts to make contact with them, they have not felt able to take part.

## **Independence and expertise**

- 1.14 The lead reviewer, Jane Wiffin, is accredited in systems learning and the SCIE "Learning Together" model and is an experienced independent investigator and safeguarding lead who has undertaken many serious Case Reviews nationally over the last 15 years. Jane has a professional background in social work, training and policy development. She has never worked for any agency in Hartlepool and is completely independent.
- 1.14 Medical expertise was facilitated by NHS England (NHSE) under Appendices 1 and 3 of the NHS Serious Incident Framework 2015. Under this Framework the North NHSE region had begun collaboratively to commission single investigations in joint cases which meet all of the statutory requirements of Mental Health Homicide investigations, Domestic Homicide Reviews, SCRs and SARs.

## **2. APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE**

- 2.1 This section provides an appraisal of the multi-agency professional response and provision of services to Olivia and her family. This sets out the view of the review team about how effective the professional response to Olivia and her family was during the time under review. Where possible, it provides explanations for this practice, or indicates where it will be discussed more fully in the detailed findings. This is followed by the priority findings that have emerged from this Serious Case Review.
- 2.2 This review covers just under a three-year period from when Olivia was just 12 to when she was nearly 15. During this time, Olivia, her siblings and family received a great deal of support from a consistent, caring and hard working group of professionals. These professionals met regularly, provided reports to the many multi-agency meetings that were held to consider the growing concerns about Olivia and communicated often and in a detailed way. Professionals also escalated their concerns over time to the appropriate senior managers. There is considerable evidence that they acted in a professional manner throughout and the appraisal and findings that follow are not meant to be seen as a linear story linking the unfolding events with the end outcome which triggered this review, but a reflection of the professional response up until this unforeseeable and completely unexpected event.
- 2.3 Work with vulnerable adolescents who are victims of abuse and neglect, and engaged in anti-social behaviour, bullying and other harmful behaviours for themselves and others, requires professionals to balance the need to ensure that parents/carers provide children/young people with appropriate, safe and authoritative care alongside those professionals holding young people responsible for their own behaviour in the context of harmful care. Over time, this balance was not always maintained for Olivia and this is a theme that permeates the review and is addressed through the findings that follow. This review is clear that hostility, abusive behaviour and aggression to others is unacceptable and must always be addressed in an empathetic but authoritative way.
- 2.4 There was no indication to professionals during most of the time under review that Olivia would be involved in a serious violent crime. There were consistent concerns about her poor behaviour, bullying others, anger and verbal aggression, which was usually directed at those close to her but the first indication that she could be physically aggressive to others was when she assaulted three members of staff at the children's home four weeks before the murder. The children's home appropriately sought advice from CAMHS<sup>6</sup> regarding this, and their concerns about an escalation in her abusive behaviour to others. A forensic assessment was organised.

---

<sup>6</sup> CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

At this time there was recognition across the multi-agency network that a decision needed to be made regarding where Olivia should live which would address her needs. A complex case meeting chaired by a senior manager from the local authority was held. Further planning was awaiting the outcome of the forensic assessment in order to make informed decisions which did not take place because Olivia was arrested on the day it was due to take place.

### **Request for help and assessments: February 2012**

- 2.5 This review begins in February 2012 when Olivia was 12 years old. She was living with her father and sibling 3. Father made contact with the duty social worker team and reported that he was struggling to cope with Olivia's hostile, aggressive and destructive behaviour at home and that she behaved in a similar way at school. It was agreed that an initial assessment<sup>7</sup> would be undertaken. Father told the allocated social worker that he believed that Olivia's difficulties had started six months earlier when she discovered that her mother, with whom she had had no recent contact, had two young children. The subsequent assessment concluded that Olivia was experiencing adolescent transition difficulties, that father was struggling to manage behaviour and that support would be provided by the early help team, and a Family Support Worker (FSW) was allocated.
- 2.6 This worker met with the family and started the process of completing a common assessment<sup>8</sup>. This noted that Olivia had some health problems, difficulties with anger and aggression and some anxieties which caused problems in social situations. A referral to CAMHS was agreed. The FSW began supporting the family and although there were team around the child meetings, there was no early help plan developed and there were no aims or objectives formulated. This meant the lack of progress or change was not recognised. These were early days for the early help offer in Hartlepool, and it is now expected practice that the Lead Professional always formulates an early help plan, with aims, objectives and outcomes which are reviewed.

### **Olivia (aged 12) moves to live with mother: March 2012**

- 2.7 At the beginning of March, the FSW agreed to organise for Olivia to meet mother and to start the process of resuming contact. Olivia became very angry when the FSW could not organise this meeting for that same day and was hostile, rude and verbally abusive. The FSW managed to calm Olivia down after several hours. The FSW was concerned about the level of anger and hostility that Olivia exhibited, and thought that parenting support for father would help to improve boundaries and address the concerns.

---

<sup>7</sup> The **initial assessment** was a short **assessment** of a child referred to Children's **Services** focusing on establishing whether the child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm and further, more comprehensive (a Core Assessment) is needed. Practice has now changed and there is now a single assessment in place nationally.

<sup>8</sup> The **Common Assessment Framework (CAF)** is a process for gathering and recording information about a child for whom a practitioner has concerns in a standard format, identifying the needs of the child and how the needs can be met.

- 2.8 It was agreed that the contact meeting with mother would take place the next day. It was reported by Olivia that the first contact went well, and Olivia and sibling 3 arranged to meet mother again over the weekend.
- 2.9 From this point they both moved in to live with mother. The FSW was not aware of the need to make a referral to Child and Adult Services regarding the need for an assessment and a rehabilitation home plan. These were unusual circumstances; they did not meet the criteria for a reunification plan as outlined in the Hartlepool Child Protection Procedures, but given mother's previous neglect of all the siblings, as well as the need to explore the impact of this move on the two young children (aged 7 months and 3 years old at this time), and concerns regarding Olivia's behaviour, a referral would have been expected. Within Hartlepool there is a framework for the reunification of children home from care<sup>9</sup> which highlights that there should be a clear plan made, based on a current assessment. In discussion with the Review Team it became clear that this guidance would be enhanced by the use of a structured framework. This is action that Children's Services will take forward.

### **Allegation of physical abuse: March 2012**

- 2.10 A week after Olivia moved to live with her mother she made an allegation of historic physical abuse against father and it was agreed that a second initial assessment would be completed. Father agreed that he had used physical chastisement in the recent past because Olivia and sibling 3's behaviour was so difficult. This blaming of Olivia and her sibling for his abusive behaviour was not recognised or challenged and this issue of parents blaming children is discussed further in Finding 3. Mother was also seen and her views of the positive changes in her circumstances are reported almost verbatim without sufficient analysis. This issue of the uncritical acceptance of parents'/carers' own views of their family's difficulties and the impact on the likelihood of child-centred assessments is also discussed in Finding 3. Olivia's anger, hostility and aggression were described, and the proposal of a referral to CAMHS noted, but there was no holistic analysis of the likely cause of these serious difficulties and no specific plan to address them. This is discussed in Finding 2 - a recurring theme across the period under review.

### **Early help support: March 2012 – September 2012**

- 2.11 The FSW continued to provide support to Olivia and sibling 3 and they lived with their mother during the week and with father at the weekends. This period of time was characterised by mother's complete lack of engagement with any services, and Olivia's intermittent attendance at school. When she was there she was aggressive, hostile, and anxious and there was evidence of her bullying other pupils. This was responded to through routine behavioural management approaches, but was not part of a holistic plan. The FSW discussed all these concerns with her manager, and it was agreed

---

<sup>9</sup> <http://www.teescpp.org.uk/guidance>

that a support worker was to be allocated for Olivia, but she struggled to make contact with mother or Olivia and they met on only a few occasions.

- 2.12 In June 2012, a professionals' meeting was held at CAMHS to discuss the referral made by the FSW in March (a previous meeting had had to be cancelled). The FSW and school representatives attended. Concerns about Olivia's behaviour at school and the quality of care she was receiving from her mother were discussed. It was agreed that the FSW would produce a chronology of events for the next meeting and next steps would be agreed. This meeting took place in July 2012 and it was agreed that an assessment of Olivia's mental health was needed, but this was further delayed by mother's non-attendance at a subsequent meeting aimed at gaining consent. The assessment took place in September 2012 and some sessions were offered to Olivia and her father (see 2.21).
- 2.13 In June Olivia went to see her GP on her own and asked to be admitted to hospital because she was feeling unwell. The Practice nurse contacted the FSW to say that they were worried about Olivia and that the GP noted that concerns about the low iron levels and associated ill health had been raised with father in February and no action had been taken. This was discussed with the FSW and father was tasked with addressing these issues. This did not happen and the issue of Olivia's poor health, which remained an unaddressed concern until she came into foster care, was not sufficiently recognised as a significant indicator of adolescent neglect, which should have been connected to Olivia's non-school attendance whilst in her mother's care, and mother's non-attendance at appointments such as CAMHS which were designed to improve Olivia's circumstances. This issue of the recognition, assessment and actions to address the serious issue of adolescent neglect is discussed in Finding 1.
- 2.14 At the beginning of August 2012, the FSW visited the family home, and was told by Olivia that her mother's partner (father of sibling 5) was in the house and he was a drug user. Appropriately the FSW contacted the duty social work team and a further initial assessment was undertaken. Olivia and sibling 3 were seen; they confirmed mother's partner's drug use, but said that although they had seen him under the influence of drugs on the street he had never used drugs at their home and they had no concerns about his presence. A discussion took place with mother about the risks that her partner's drug use could pose to the children. The conclusion was that mother recognised the concerns and would continue to work with the FSW. Despite this reassurance, mother failed to be available for any appointments over August 2012. When the FSW did manage to see her at home she found mother in a distressed state; mother reported not being able to cope with the behaviour of Olivia and sibling 3 and mother reported that that Olivia was drinking, going to parties, possibly having sexual intercourse and hitting the younger siblings. Although the FSW was challenging of mother's lack of engagement, she did not specifically address the contradiction between mother not using services which had been designed to address the very problems she was now holding Olivia entirely responsible for. This issue of parental non-attendance at services designed to improve the outcomes and

circumstances of their children and young people is addressed in Finding 2, and the blaming of children and young people for family/parental difficulties (despite not having used available support) is discussed in Finding 3.

- 2.15 The FSW sought advice from her manager and a programme of focused parenting support was planned. The FSW took the parenting worker to meet mother two days later and found mother in a further distressed state. She reported concerns about her partner stealing from her and worries about his verbal abuse. Mother's partner denied these concerns, but when asked by mother to empty his pockets, a packet of drugs fell out. The FSW asked mother's partner to leave, and a referral was made to the duty social work team. Appropriately a strategy meeting<sup>10</sup> was held. Olivia reported at interview during this review that although she was aware that some action was being taken "out there" she did not know what, and she felt that she was held responsible by her mother and partner for increased professional involvement because of her behaviour, rather than concerns about drug use. The importance of challenging parental blame of young people for the professional involvement in the context of real concern about parental care is discussed further in Finding 3.

### **Strategy meeting held September 2012**

- 2.16 The police were invited to the strategy meeting but they decided as there were no current concerns that a crime had been committed they would not need to attend, but would provide full information about the backgrounds of mother, her current and former partners. The nature of strategy meetings are that they are intended to explore whether there is a risk of significant harm to a child or young person and what action is need to address it. This will mean that the need for police attendance may only become apparent during the meeting itself. This was evident here as some additional concerns emerged before the meeting that Olivia, who was aged 12, reported having sexual intercourse with a boy aged 14; there were no specific details about who this was and Olivia suggested he was a stranger. This subsequent information was not shared with the police. Current practice locally is that the police will attend all strategy meetings.
- 2.17 Comprehensive historic police information was provided to the strategy meeting regarding mother as the victim of historic domestic abuse by her ex-partner (father of sibling 4) and past abuse by her current partner (father of sibling 5). Information was shared about the history of drug use and related criminal activity of mother's current partner (father of sibling 5). It was appropriately agreed that child protection enquiries would be undertaken, and an Initial Child Protection Conference<sup>11</sup> (ICPC) would be convened.

---

<sup>10</sup> A **Strategy Meeting** (sometimes referred to as a **Strategy Discussion**) is normally held when there is an indication that a child has suffered or is likely to suffer Significant Harm. The purpose of a **Strategy Meeting** is to determine whether there are grounds for a Section 47 Child Protection Enquiry.

<sup>11</sup> An Initial Child Protection Case Conference is a multi-agency meeting often attended by family members which takes place within 15 days of the [strategy discussion](#)/meeting if as a result of the child protection enquiries a child or young person is considered to be at risk of significant harm. Those at the meeting (conference) discuss the risk to the child and decide what needs to happen to make sure they are kept safe.

- 2.18 Olivia would provide no details regarding early sexual activity, and so no legal action was possible. The notes of the strategy meeting record the view that Olivia herself was not taking the concerns seriously, was finding them “funny” and the language used about her is negative in tone. The issue of taking a holistic approach to addressing potential harm to adolescents is addressed in Finding 2.

### **Initial Child Protection Conference: September 2012**

- 2.19 The Initial Child Protection Conference (ICPC) was held in a timely way. Comprehensive reports were provided, and all relevant professionals were present with the exception of the police who provided a great deal of historic information. This was a complex meeting which had to discuss four children aged 12,10,4 and 18 months, three different fathers and the adult siblings. The responsibility of mother to ensure the safety of the children was emphasised and the significant concerns regarding mothers partner shared. Appropriately all the children were made subject to child protection plans for neglect and it was agreed that parenting support would continue, that there would be a full assessment completed and the Public Law outline<sup>12</sup> initiated. These were all appropriate actions.
- 2.20 The conference discussions regarding Olivia’s behaviour reflected the negative approach from the strategy meeting, and the concerns about early sexual activity were acknowledged. The issue of Olivia’s anger and hostility was noted, and the plan was a referral to CAMHS (although in fact there was an outstanding referral which had been delayed by mother’s non engagement). Overall, the concerns and vulnerabilities were not contextualised alongside the extensive family history of domestic abuse or the allegations of physical abuse to Olivia from father, and the importance of making connections between young people’s aggressive and hostile behaviour, childhood physical abuse and witnessing domestic abuse, and this lack of a holistic approach is discussed in Finding 2.

### **Olivia moved to Foster Care November 2012 – February 2013**

- 2.21 In the period after the ICPC there was significant conflict reported between mother and Olivia and the police were called regarding Olivia’s aggression and disruption at home and her going missing. Olivia moved to live with her father, but over the next four weeks she spent time between her father, mother and aunt and in November 2012 father said he could not cope and asked that she be placed in foster care for a period of time. This was agreed. Olivia was unhappy about being placed with a foster family and although this action was taken to support the whole family, it served to reinforce that the focus was on Olivia and her behaviour, rather than balancing this with challenge about the neglect and poor quality care she

---

<sup>12</sup> PLO or pre-proceedings meetings. When social workers are concerned about the welfare of a child, they may be thinking about taking the case to court so that they can ask the court to make orders to protect the child. In most cases the Public Law Outline requires the social services department to arrange a meeting with the parent(s) to see if it is possible to reach agreement about what needs to happen to protect the child from , so that court proceedings can be avoided.

was experiencing. The issue of how agencies deal with demands by parents that their children come into foster care, placing blame and responsibility on the children and young people, rather than accepting responsibility for neglectful parenting, is discussed further in Finding 4.

- 2.22 There remained significant concerns regarding Olivia's attendance and behaviour at school and sanctions and supports were put in place. Olivia was seen by CAMHS with her father. She was assessed as having no mental health disorder but was diagnosed with oppositional behaviour, an emotional response to inconsistencies in the parental home and placing herself at risk. Olivia and her father agreed to attend sessions to assess Olivia's anger and to be provided with advice about the management of this.
- 2.23 There was a Review Child Protection Case Conference in December 2012. This was well attended and comprehensive reports provided. The full Core Assessment<sup>13</sup> had been completed and overall provided a good outline of the current concerns regarding all the children, mother's inconsistent care and poor engagement with services. The Public Law outline had not been initiated and this remained an action to be completed for the next conference. A full child protection plan was developed and covered many areas of neglect. For Olivia, this focused on support regarding sexual behaviours and emotional support, a referral to a drug and alcohol agency and work with CAMHS to address anger and hostility. The analysis from the conference was that father was struggling to manage Olivia's difficult and unreasonable behaviour, rather than that his inconsistent parenting was likely to be contributing to those difficulties, and although Olivia was made subject to a child protection plan for neglect, the responsibilities of the parents were not spelled out and this is discussed in Finding 3 regarding adolescent neglect.
- 2.24 Olivia remained in foster care until February 2013 and during this time she had regular overnight contact with her mother and father. She started preventative work with the sexual exploitation and drug and alcohol workers. There were two sessions with CAMHS where both Olivia and father reported an improvement in relationships and Olivia being calmer. They said they no longer needed support, and CAMHS agreed to cease contact. This decision appears to have been made in isolation from the other plans and was not contextualised alongside a period of relative stability whilst Olivia was in foster care. The sessions stopped as she returned home to further instability.

---

<sup>13</sup> A **core assessment** is a structured, in-depth **assessment** of a child or young person's needs where their circumstances are complex. Practice has now changed and there is now a single assessment in place nationally

- 2.25 The Public Law Outline meeting was organised and the parents were made aware of the concerns held by professionals and the actions required of them to address those concerns; this was comprehensive, addressed issues regarding neglect broadly, but the information would have been enhanced by a clearer outline of the timescales and specific actions required of each parent.

### **February 2013: Olivia returned to her father's care**

- 2.26 In February 2013 Olivia returned to the care of her father. Over the next six months the arrangements for where Olivia and sibling 3 would live and with whom were extremely chaotic. Mother and father continually argued over the arrangements and there were times when both girls would be sent in a taxi late at night from one parent's house to another, and there would be no one at home. Father and mother engaged inconsistently with the support provided and there were concerns regarding mother being domestically abused by her partner.
- 2.27 Olivia continued to struggle at school, was aggressive and disruptive and sanctions and support continued to be provided without any recognisable change. There was continued conflict and aggression at home and Olivia was reported missing to the police on a number of occasions, although she always returned home and was seen for an interview in line with current procedures regarding young people running away from home. Although she attended services to address sexual exploitation, and drug and alcohol use, both workers felt that she did not fully engage and the sexual exploitation worker became very worried about Olivia, and appropriately considered whether she had been sexually abused and needed specialist services. This was the first time that Olivia's early sexual activity had been linked to possible sexual abuse, but it was felt that without a disclosure no work could be undertaken.
- 2.28 The Review Child Protection Conference took place as planned in June 2013 and the following month a legal planning meeting was held where it was agreed that care proceedings would be sought regarding the younger siblings, and that Olivia and sibling 3 would remain in the full time care of their father with increased support. This was an overly optimistic plan given recent evidence of poor and inconsistent care. This decision was influenced both by Olivia's strong desire not to come into care, and the analysis that although father struggled, he could provide appropriate care with support.
- 2.29 In July 2013, Olivia was involved in a road traffic accident and spent two weeks in hospital. She had few visitors and it became clear that she was actually quite isolated from her family. It is the view of the review team that the evidence at this point was that neither parent could provide safe and appropriate care which should have led to a prompter decision regarding legal action but a few weeks later in early September 2013 the decision was made to seek care proceedings for all the children.

- 2.30 The social worker produced clear reports regarding the circumstances of all four children and Interim Care Orders<sup>14</sup> were immediately granted and the children were removed from their mother's care. Mother asked her solicitor to appeal the temporary removal of all four children and the presiding Judge agreed that the younger siblings would be temporarily returned to mothers care before the final court hearing. This was despite the concerns raised by the social worker and her manager that this was not a safe or appropriate thing to do; the younger siblings remained at home until they were permanently removed 10 weeks later in December 2013. During this time, they were provided with daily support. This decision upset and confused Olivia who could not understand why her younger siblings had been sent home and the evidence suggests that this had an impact on sense of stability in the early days of her placement with foster carers. This issue highlights the importance of courts and the Judiciary engaging with Local Safeguarding Boards and SCRs to explore learning and best practice.

### **Placement with foster carer in September 2013 to July 2014**

- 2.31 Olivia was placed with a foster carer with the intention that this would be a long term permanent placement. Olivia was initially angry at being in care, and confused about why her siblings were at home, but gradually settled, and there was a period of 6 months where overall her circumstances were slightly more settled than they had been for some years.
- 2.32 In October a referral was made to CAMHS and an assessment completed in November 2013. Olivia was reassured that she did not have an underlying mental health condition but individual support was offered and subsequently support was also provided to the foster carer. Olivia engaged well with the assistant psychologist and began to open up about her worries and anxieties. The foster carer was also provided with advice and guidance from CAMHS.
- 2.33 There remained concerns at school, where Olivia exhibited aggressive and hostile behaviour and she was excluded on a number of occasions. The issue of her education was discussed at the regular Looked After Reviews (LAR<sup>15</sup>) held, but no different plan was formulated. At the beginning of February 2014 school staff discussed Olivia with the educational psychologist and concerns about possible Attention Deficit Hyperactivity

---

<sup>14</sup> An interim care order (ICO) is a temporary order made by the court which says that the child should be looked after in the care system for a temporary period. It means that the court has good reasons to believe a child has been seriously harmed or is likely to be seriously harmed, and that an Interim Care Order is the best thing for the child until there is a final hearing.

Under this order, Children's Services share parental responsibility for the child with the parents. This means that they must find out parents' wishes about any decision concerning their child, but Children's Services always have the final say and can make plans for the child even if the parents don't agree with them.

<sup>15</sup> Looked After Reviews (also called a Statutory Reviews) are held at specified intervals in relation to all **Looked After** Children. Looked After Reviews are normally chaired by an Independent Reviewing Officer and are designed to ensure that adequate plans are in place to safeguard and promote the overall welfare of children; and to make recommendations, as necessary, for changes to those plans.

Disorder (ADHD)<sup>16</sup>, anxiety disorder<sup>17</sup> and attachment disorder<sup>18</sup> were discussed. It was appropriately agreed that the Educational Psychologist would offer Olivia some individual sessions. These planned sessions did not go ahead due to exclusions from school, changes in educational placements and numerous crises which impacted on practical arrangements. Olivia also refused to engage with CAMHS services at this time.

- 2.34 In March 2014 Olivia told the sexual exploitation worker that she had engaged in under age sexual activity, but when interviewed by the police denied the incident had happened and they had no further intelligence which would enable them to take action. Olivia also refused to talk with any other professional about what happened.
- 2.35 There were concerns from the Police Community Support Officers (PCSO<sup>19</sup>) regarding a group of young people including Olivia causing a nuisance at a convenience store. This was the first direct concern that Olivia might be engaged in anti-social behaviour in the community when she went missing. This was at a low level at this time, but this highlights the importance of clear links between Community Safety and child safeguarding processes which is discussed in Finding 5.
- 2.36 In March 2014 mother was taken to hospital as a result of being stabbed by her partner. Mother subsequently discussed other incidents of abuse and her partner's current threats to her and her children who were now no longer living with her.
- 2.37 Later that month Olivia became unsettled in the foster placement, and then made a disclosure that she and sibling 3 had been sexually abused by father when they had lived with him. Olivia was interviewed by the police and said that although the allegations were true, she did not wish to make any charge. Father was interviewed and denied the allegations. The older siblings and Sibling 3 were interviewed and they made no disclosure of abuse. This meant that no further criminal proceedings could be sought, but contact with father was stopped at this time. Olivia received support from the social worker with the aim of encouraging her to talk about her feelings about what had happened, but Olivia struggled to engage with this support and became increasingly angry with all professionals at this time. Olivia also disengaged from CAMHS support despite the tenacity of the assistant psychologist.

---

<sup>16</sup> **Attention deficit hyperactivity disorder (ADHD)** affects children and adolescents and can continue into adulthood. **ADHD** is the most commonly diagnosed mental disorder of children. Children with **ADHD** may be hyperactive and unable control their impulses. Or they may have trouble paying attention.

<sup>17</sup> Anxiety Disorder can be defined as a disorder in which the sufferer feels in a constant state of high anxiety and is often known as 'chronic worrying' or a 'free floating' anxiety condition.

<sup>18</sup> The term attachment disorder can relate to specific disorders of mood or behaviour, and the inability to form social relationships due to a failure to form attachments at a young age. Typically, attachment disorder affects young children, but if left untreated it can apply to school-age children and even adults.

<sup>19</sup> Police Community Support Officers (PCSO) are members of support staff employed, directed and managed by their Police Force. They will work to complement and support regular police officers, providing a visible and accessible uniformed presence to improve the quality of life in the community and offer greater public reassurance.

2.38 From this point onwards Olivia continued to be unsettled. She was reported missing by the foster carer to the police on a number of occasions, and was found and brought home. There were arguments with the foster carer and Olivia was verbally aggressive to the foster carers' older daughter, on one occasion pushing her out of the way. Olivia continued to be aggressive during contact with sibling 3 and on one occasion she came home from contact with a black eye, caused by her mother during a fight. The social worker addressed this directly with mother; Olivia wished to take no action regarding this incident. The foster carer discussed her concerns with CAMHS and the social worker. Eventually in June the foster carer decided to end the placement and Olivia moved to her third foster carer. The day after she left the foster carer discussed worries with CAMHS that Olivia lacked care and empathy. This was not discussed with the social worker and did not influence the next foster placement.

#### **New Foster Placement: July – August 2014**

- 2.39 Olivia stayed with her third foster carer for around five weeks. This was seen as a temporary placement whilst plans were made to move Olivia to the local specialist small children's home. There was no complex case meeting as would be expected, and the placement agreement did not cover clearly enough the concerns which had led to the previous placement breaking down or Olivia's growing anger and hostility.
- 2.40 There was a planning meeting regarding all the children at this time, and the need for Olivia to engage in therapeutic work was acknowledged but she was still refusing to attend CAMHS or any other support. This was a very difficult time for Olivia and the foster carer. Olivia went missing on a regular basis and was often brought back by the police.

#### **Move to Children's Home – September 2014**

- 2.41 In August 2014 plans were made for Olivia to move to a small specialist children's home. The aim was to provide her with a safe and supportive environment, where she would have individual support from staff, remain in contact with her family and begin to build confidence and independence skills. There was a clear plan put in place and a risk assessment undertaken. However, the lack of available specific information about the neglect Olivia had experienced over time, and some analysis about how these long term traumas might manifest in her behaviours in the home meant that there was no specific plan to address these issues. The importance of specific discussions about the likely traumatic impact of adolescent neglect and emotional abuse on young people when they are placed with alternative caregivers has been recognised by the children's home as part of the learning from this review and they have added a question about how early trauma is manifest in children's behaviour to their referral form.

- 2.42 Olivia moved to the children's home at the beginning of September 2014. Olivia challenged the boundaries from the beginning, but for the children's home this was expected, given her background and recent moves and they put support in place. She was angry and aggressive, there were concerns about her bullying other children, she was using drugs and alcohol and was reported missing on a gradually increasing number of occasions. The children's home put in place sanctions, and engaged her in individual support sessions in which she seemed to be making some progress. Olivia continued to have contact with her mother and older sisters, and although the children's home tried to regulate this, it was often chaotic and unplanned. The children's home staff sought advice regarding Olivia's behaviour from CAMHS and Olivia agreed to engage in some individual sessions which was progress; CAMHS started to provide advice to staff regarding behaviour management. Olivia was attending offsite school provision at this time, but there continued to be discussions about suitable educational provision for her and an acknowledgement that finding the right place was complex.
- 2.43 In October 2014 there were a number of worrying incidents. Olivia caused destruction to the children's home, which was addressed and sanctions put in place. Olivia assaulted three members of staff, and was arrested by the police. The children's home staff did not want any criminal action to be taken and Olivia was sent home with a police warning. Olivia was reported missing to the police on a number of occasions, and she was brought home. The police were frustrated that she would often just leave the home again immediately. The children's home had no powers to stop her but made sure they met with her after each incident to explore how the running away could be addressed in line with current policies and procedures.
- 2.44 At this time Olivia also took another young person from the home out with her for the evening. This led to this young person being injured by one of the boys they were with. Olivia asked her to lie about the details of this. When the incident was reported to the police, Olivia threatened the young person. Action was taken regarding the boy and he was arrested and charged. Olivia's part in this was discussed at a number of complex case meetings and it was agreed CAMHS would complete a comprehensive chronology regarding Olivia and make a referral for a specialist forensic mental health assessment. This was done and an appointment offered in early December.
- 2.45 In November 2014 there were a number of incidents where Olivia was rude, aggressive and hostile to adults and Olivia and Yasmine were allegedly involved in the theft of a mobile phone from a young person who refused to press charges to the police. This was the first occasion on which Yasmine and Olivia were known to have been together. This was discussed at further complex case meetings, and although no direct action was taken to address this with Olivia, it was perceived to be part of the information for the forensic assessment.

- 2.46 At the beginning of December there was a senior managers' meeting regarding Olivia and acknowledgement of the need to consider placement and education options. Olivia was also discussed at the VEMT (Vulnerable, Exploited, Missing and Trafficked) Group<sup>20</sup> and the link between Olivia, Yasmine and other young people was noted. These were the early days of these meetings, and it is now routine practice that the connections between young people are explored. In addition, these meetings need to address more clearly the likely risks that these connections might pose in the community and this is discussed further in Finding 5.
- 2.47 Olivia did not attend the forensic assessment as on the same day that this was scheduled she was arrested on suspicion of the murder of Carol. A trial ensued and she was found guilty and is now serving a custodial sentence.

---

<sup>20</sup> VEMT stands for Vulnerable, Exploited, Missing, Trafficked and is a multi-agency meeting convened to understand and address the issues relating to children who are at risk due to going missing from home and care and / or are at risk of sexual exploitation and trafficking.

### **3. THE FINDINGS**

- 3.1 The aim of a Learning Together case review is to use a single case as a 'window on the system', to uncover more general strengths and weaknesses in the safeguarding system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case specifics, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the reconstruction of the unfolding case, documentation and an examination of the key practice episodes.
- 3.2 The second step is to consider whether the issue observed in this case is 'underlying and that it is not simply a 'quirk' of the case. The third step is to consider how geographically widespread and prevalent the issue is within the national system. Sometimes it is not possible within the scope of a review to collect this data. The sources for these steps will be information from the review team and case group; any performance data; national research and other reviews in a variety of combinations.
- 3.3 The last step is to articulate why this issue matters and what are the risks to the safeguarding system. The findings reflect the wider national context and challenges for safeguarding children and questions are formulated for the SAB.
- 3.4 This review has prioritised five findings. They are related to the needs and circumstances of young people who have experienced harm in their formative years and who present a range of complex behaviours, which often exacerbate already pre-existing harm. They are all interlinked, and point to the national challenge of providing an effective service and response to this critical group of young people – who will be the adults of the future. The findings are the same for both girls (with the exception of one additional one for Yasmine). This is not because they knew each other well over the time under review. Their connection only became apparent to professionals in the last four weeks. They are the same because they are focused on the lives of abused and vulnerable teenagers who lacked appropriate parental care and support to manage the transition from adolescence to adulthood.

Findings	Typology
<p><b>Finding 1: There is insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm.</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 2: Professionals working in the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 3: Parents blaming young people is not sufficiently recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.</b></p>	<p><b>Family – Professional interaction</b></p>
<p><b>Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.</b></p>	<p><b>Multi-agency working in longer term work</b></p>
<p><b>Finding 5: There is a disjoint between both children’s and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.</b></p>	<p><b>Management system issue</b></p>

**3.5 Finding 1: There is insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm adolescent behaviour, leaving young people at risk of harm.**

**What is the issue?**

- 3.5.1 At a national level there is significant recognition across practice, policy and research networks<sup>ii</sup> of the serious negative impact of long term neglect on children’s wellbeing and outcomes across the developmental lifespan into their future as adults. This has led to an increased practice focus on the development of effective identification processes, assessment frameworks and tools and interventions that will address neglect and break the long cycle that is often seen from generation to generation. Much of this work has focused on young children because of their vulnerability and the need for sensitive and attuned parenting in the early years.
- 3.5.2 In comparison there has been limited research and policy development in the field of adolescent neglect (see Stein et al<sup>iii</sup> and the Children Society<sup>iv</sup> or exceptions to this). This lack of attention may be due to the perception that adolescents are less vulnerable and less reliant on good quality parental care. As has been argued in Finding 1, this is clearly not the case.
- 3.5.3 Adolescence is a time of rapid development, including brain and cognitive development, physical growth and sexual maturity as well as the development of moral reasoning, pro-social behaviour and empathy for others. Adolescents need effective, warm and authoritative parenting to successfully complete these developmental milestones, and the ramifications of not receiving good quality parenting is deficits in some or all of these areas. The consequences and outcomes for adolescents who have been being neglected over the longer term are far reaching and have consequences for the successful transition into adulthood. This group is over represented in adult mental health services prisons, unemployment and homelessness<sup>v</sup>.
- 3.5.4 It is essential that professionals are equipped to recognise, assess and intervene effectively. This requires a focus on the quality of care provided across the developmental domains of physical care, health education, supervision and safety as well as emotional care, including the development of a moral compass and pro-social behaviour.
- 3.5.5 Gaps in the care provided in all these areas should be considered as “global” neglect and requiring serious attention. Understanding which areas of a young person’s life are most affected provides both a pathway to appropriate interventions and protective activities, but may also help to understand current complex and difficult behaviour. For example, if a young person is experiencing poor emotional care, they are unlikely to have well developed empathy skills or know how to engage in services. Young people whose needs for safety and supervision are not met are likely to be those who run away, or engage in anti-social behaviour. Continued neglect will mean that

they are not given the internal structures to enable them to address these behaviours.

- 3.5.6 Alongside a detailed understanding of the quality of care across the developmental domains, it is also essential that professionals assess parental attitude. Neglect is often assumed to be an act of omission with parents /caregivers struggling to provide effective care because of their own impoverished and deprived circumstances. This is very often the case and this knowledge provides a pathway to appropriate support and intervention. However, for some parents or caregivers neglect is an act of commission; they take no responsibility for the quality of care they provide and are often hostile or dismissive to advice or interventions. These parents do not agree with professionals' concerns and do not engage in services designed to improve their children's circumstances. These render those services ineffective and require robust challenge.
- 3.5.7 The lack of responsibility on the part of parents often tips into blame. Children and young people are held responsible for the poor quality care they receive, with parents citing their young people as too difficult or too damaged to care for and this attitude has a powerful impact on young people's lives – something touched upon in Findings 3. This issue of the connectedness between what care is provided and the parental attitude towards it receives insufficient attention in current practice.
- 3.5.8 Underlying all of this is the importance of trying to establish why parents and caregivers neglect their young people and, having established this, attention needs to focus on addressing those primal issues, rather than only dealing with the consequences such as addressing poor physical living standards. If the primary cause is not assessed and addressed, the pattern will continue.
- 3.5.9 Adolescent neglect is a complex area of practice which requires the workforce to be equipped to identify it, seek out the causes and address the quality of care and parental attitude towards the provision of that care – alongside linking that care to the presenting problems of young people in order to provide a holistic approach.

#### **How did it manifest in this case?**

- 3.5.10 There was significant evidence that Olivia had been neglected in her early childhood and this was responded to through specialist support from CAMHS. She then had no contact with specialist services until she was 12 years old. She very quickly moved to live with her mother and there were early signs of neglect. Support was again provided, but crucially neither parent fully engaged. There were concerns regarding the shared care arrangement, where Olivia and sibling 3 moved constantly from mother to father's house, because of their adult arguments. This was then blamed on the difficult behaviour of Olivia, but was not addressed as neglectful care.

3.5.11 The most powerful example of the neglect she experienced at this time was when she went into hospital after a very serious road traffic accident. She had few visitors, and when father did come he was observed to be unsupportive and complaining of the trouble she had caused him. Mother never visited, yet neither parent was held responsible for this neglectful care.

3.5.12 Olivia was then made subject to a Child Protection Plan for neglect, but the focus was on providing services to address Olivia's behaviour, rather than a detailed look at what impact the neglect she was experiencing was having on all aspects of her current development (her health needs would have stood out – alongside education), what her parents needed to do to address poor and inconsistent parenting and their emotional response to her, what was causing the neglect in detail or how their attitude, which was one of blame, was likely to impact on the efficacy of any support offered.

### **How do you know it is underlying?**

3.5.13 The Review Team recognised that adolescent neglect was a significant issue in their work. Research<sup>vi</sup> and the Ofsted<sup>vii</sup> analysis of Serious Case Reviews also suggest that adolescent neglect is a significant national issue.

### **How prevalent is the issue?**

3.5.14 Overall the national evidence suggests that neglect is a significant category of maltreatment both during childhood and adolescence.

### **Why does it matter?**

3.5.15 If we are to address the needs of vulnerable adolescents who present professionals with a range of complex behaviour we must address the adolescent neglect as a significant issue which has a profound effect on young people's lives. Recognising and responding to adolescent neglect is a critical part of addressing significant harm.

## **Finding 1**

### **Questions for the Board to consider**

- How will the Board seek assurance that adolescent neglect is recognised and addressed effectively by agencies?

- 3.6 Finding 2: Professionals working in the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.**
- 3.6.1 This finding concerns the extent to which current systems are sufficiently sensitive to the needs of vulnerable adolescents, able to recognise the impact of long term harm, abuse and neglect and able to recognise that this abuse is likely to cause a range of behaviours, often described as problematic, but which are in fact the manifestation of trauma and need treating in a holistic or trauma focused way. The focus on the manifestation of the early experiences, can lead to problem focused work, and unwittingly be self-reinforcing of the poor self-esteem of vulnerable and complex adolescents. Services need to be provided in ways that foster resilience, promote self-esteem, self-efficacy and which rest on the importance of addressing the quality of the adolescents' relationships with their family and others.
- 3.6.2 There is considerable national evidence from research, inspections and serious case reviews that the multi-agency safeguarding system and the professionals that work within it struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs<sup>viii ix x xi</sup>.
- 3.6.3 Adolescence is a time of considerable biological, psychological and social change which makes young people more likely to engage in experimentation, risk taking and impulsive behaviour. Recent neurological research suggests that this is a normal and important stage of development in preparation for adulthood<sup>xii</sup>. These behaviours can cause tensions and difficulties with parents, family, school and the community, but are usually successfully negotiated through support from friends, family, services and the community.
- 3.6.4 Adolescents who have been exposed to a range of risk factors in the long term, such as neglect and abuse, parental substance misuse, domestic abuse and poor parental mental health are likely to struggle to manage this transition<sup>xiii</sup>. There is considerable evidence of the long term negative impact on outcomes and wellbeing of this harm in all areas of a young person's life. The impact of the abuse and adversity means that the personal tools required to cope with these changes, such as self-efficacy, good self-esteem, effective problems solving skills - in essence, resilience - are eroded in the context of poor, critical and harmful care.
- 3.6.5 Despite this evidence, adolescents have been seen as more robust and resilient than younger children<sup>xiv</sup> and less dependent on parents and family and therefore are less likely to be subject to formal safeguarding processes, though this is changing. They are also often viewed as independent from their caring relationships, parents and family and seen to be making their own choices, willfully engaging in risky behaviours. This belief in self-

determinism can lead to professionals being overly judgmental or condemnatory of behaviour which adolescents often feel that they have no control over and for which they lack processes to help them develop control or an accurate moral compass because of harsh, critical and neglectful care.

- 3.6.6 There is a paradox here, covered in Finding 3, that young people can end up feeling to blame for the lack of care provided to them, and this can be unintentionally reinforced by professionals who may feel sympathy for their parents or caregivers in the complex task of parenting adolescents.
- 3.6.7 It is important for these vulnerable adolescents that their complex behaviours are understood as a consequence of harm, a manifestation of trauma, and the primary goal is to understand the root cause, to address it and rebuild the context of warm caring relationships and personal skills required to foster resilience. This is complex for professionals who are often presented with a series of crises, and adolescents who are reluctant to engage, and who are on the face of it, dismissive of concerns. It is unsurprising that a fragmented response emerges, as professionals have to deal with the outcome of the abuse, and deal with the crisis.
- 3.6.8 This requires professionals who work with vulnerable and complex adolescents to be provided with effective reflective supervision to maintain a more objective and child focused stance.
- 3.6.9 Adolescents who have been harmed and abused unsurprisingly find it difficult to trust adults and need opportunities to build good quality relationships with a small group of professionals. They also need services which take a sophisticated approach to issues of engagement, recognising that providing a whole host of services at the same time is not helpful. In this context adolescents are often described as “not engaging” or “cannot engage” when what is required is an approach that asks, “What have we (the professionals) done to enable them to engage and what could we do differently?”.

#### **How did this manifest in this case?**

- 3.6.10 There was significant evidence that Olivia had experienced early abuse and neglect, and had lived in circumstances of domestic violence, parental substance misuse, and parental poor mental health. The impact of these at the time was addressed through support from CAMHS when she was aged six; just before she moved to live permanently with her Father and there was then a period where she had no contact with specialist services. During the period of this review there were concerns around Olivia’s hostility and aggression, substance abuse, peer sexual exploitation as well as school problems, and running away. These were often described in professionals’ meetings and records as “engaging in risky behaviour” as opposed to being vulnerable because of her experience of abuse and her current lack of appropriate care which caused her to be more vulnerable whilst taking risks.

- 3.6.11 It was when Olivia was aged of 12 that her father sought support to help her behaviour. Support was provided to father to manage this behaviour, rather than asking him to reflect on her early neglect and her lack of contact with her mother. Over time there a lack of a holistic approach, which connected the past with the present more clearly. Although many professionals worked hard to establish boundaries and improve parenting, the root cause was not sufficiently discussed until much later; strategies were not put in place to help her contain those feelings, or to encourage either parent to support her in doing this. Research regarding early aggression and hostility is clear that underlying factors are very often early abuse, domestic violence and conflict in the home environment. The underlying causes and influences were not made clear, and a pattern of self-reinforcement emerged; Olivia was seen as essentially aggressive and hostile, services were put in to address this, and she began to believe that this was who she was, reinforced by the parental view.
- 3.6.12 Olivia continued to display a range of complex behaviours. She misused substances, she ran away from home, sometimes overnight and she was engaged in early sexual activity about which she would provide no information. Although different services were provided, they attempted to address each vulnerability as it arose, without the root cause being understood. Individual services were supportive and caring, but as part of the overall child protection plan they were problem focused and lacked an emphasis on poor parenting and poor family relationships, which were likely to have impacted on her coping and control skills. This compartmentalising of problems led to her needing to engage with a number of different professionals without there being discussion about whether this was possible or helpful. At one time there were plans for her to see at least five different professionals regarding sexual exploitation, drug and alcohol abuse, CAMHS support, the social worker and Learning Mentor.

### **How do we know it is an underlying issue?**

- 3.6.13 Nationally<sup>xv</sup>, it is reported that resources have been redirected and youth work services have been cut. This, alongside an assumption that adolescents have a greater resilience to the impact of abuse, leaves adolescents with a system that struggles to respond to their complex and differing needs.
- 3.6.14 The case group of professionals who provided services to Olivia spoke of feeling like their work was crisis driven. They considered that in the pressure of dealing with crises such as running away, they had little time to step back and consider the bigger picture. Although the review found that most professionals received supervision, this did not overall serve to challenge the notion of “difficult adolescents” and there was also an acknowledgment that professionals needed more knowledge regarding trauma related care.

### **How prevalent and widespread is the issue?**

3.6.15 This is not just problematic locally. The recent report by NSPCC and the Children Society highlights that child protection processes and procedures tend to be designed for work with young children in the family context.

### **What are the implications for the reliability of the safeguarding system?**

3.6.16 Whilst services continue to be fragmented responses to particular needs of the adolescent, as opposed to a service designed around their circumstances and emotional developments, it is likely that professionals will continue to experience difficulty in reaching out to adolescents at risk of significant harm. The consequence of this is that there will continue to be about their wellbeing and their ability to build internal mechanism to cope with this period of development.

#### **Finding 2**

##### **Questions for the Board to consider**

- How will the Board support its partner agencies to develop the multi agency workforce to be able to respond to the holistic needs of adolescents rather than relying on presenting problems in decision making forums?

- 3.7 Finding 3: Parents blaming young people is not sufficiently recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.**
- 3.7.1 Parental attitudes to young people which are about blame, harsh and critical care and scapegoating are recognised as a key indicator of emotional abuse and neglect<sup>xvi</sup>. Emotional abuse has the capacity to impact negatively on children’s development in the short and long term<sup>xvii</sup>.
- 3.7.2 Parental blame, in the context of adolescent neglect, has the potential to undermine helpful interventions, because of parental denial of their own responsibility for change. It is a self-reinforcing process whereby young people, who have already experienced harm and abuse which has undermined their self-esteem and resilience, are now held responsible for that poor quality care. This is something like a cognitive “catch 22” or a “no win” situation which has the capacity to cause great emotional damage and impact on moral development. Ultimately the message from parents to children is often that they do not warrant or deserve appropriate and loving care.
- 3.7.4 The challenges of addressing the needs of adolescents who present difficulties as a manifestation of their hurt and pain/trauma is that they are not easy to work with or form relationships with. This can lead professionals to empathise with parents, unintentionally colluding with parental blame and reinforcing the young person’s sense of poor self-worth and self-esteem.
- 3.7.5 It is particularly striking that parental blame of children and young people means that the routine repair that goes on in family life when parents get things wrong does not happen. This is critical in the context of abuse, where it is necessary for children and young people to know that what happened to them was wrong (this shapes moral development), that there are consequences when someone harms you or anyone else (this shapes an understanding of right and wrong) and that there is some form of repair, which might be sorry or regret (this shapes attachment relationships); and the absence of incremental reparation will mean that the damage is cumulative over time.
- 3.7.6 It is essential that professionals are equipped to recognise and address the blaming of young people by parents as emotionally neglectful and abusive, and to recognise when blame of young people for the “risky” or “willful” behaviours becomes part of the professionals’ response. It is also important that professionals notice when young people are harmed where there is no acknowledgment that this is wrong, there are no consequences for those who harmed and no repair of the immediate harm.

### **How did it manifest in this case?**

- 3.7.7 Olivia experienced a difficult childhood, and moved home a number of times. She did not see her mother and did not know that she had younger siblings. There is some evidence that she had been told her mother was dead. Given these circumstances it is unsurprising that she experienced transition difficulties coming into adolescence. These manifested early on through problems at school, bullying others and conflict and aggression at home. Father consistently blamed Olivia for these difficulties; he did not acknowledge that her poor early start might be influential or that his parenting style might play a part.
- 3.7.8 When Olivia and sibling 3 moved to live with their mother they were in a chaotic household, where there had been domestic violence and where there was the presence of a chronic drug user. The physical circumstances in which they lived were poor and overcrowded. At this time Olivia was being abused sexually by peers, and mother saw this as her choice and part of being “promiscuous” rather than recognising her vulnerability and need for protection. During this time mother consistently complained about Olivia, holding her responsible for the problems of the younger children. The FSW was challenging of this, but gradually over time as Olivia’s behaviour became more difficult and complex, the professionals’ network began to focus disproportionately on her; the Initial Child Protection Case Conference was said to have been convened because of her “risky behaviour”, not because of the poor quality care and supervision she had received.
- 3.7.9 When the reviewer visited Olivia in prison, she expressed her feelings that she had always been held responsible for the family problems, both by her parents and, she felt, by professionals. She was concerned that professionals often took her mother’s word over hers, and quoted the time when the FSW and a social worker had been present in the home to discuss mother’s partner’s drug use and its impact on the household. During this meeting mother denied that her partner lived in the home, and the partner denied using drugs. At this point a packet of drugs fell out of his pocket and he was challenged. Olivia’s understanding was that mother and her partner were believed, and that attention moved quickly to her and her behaviour. In fact, significant action had been taken to address these concerns, and they led to the Initial Child Protection Case Conference, but Olivia had not understood this, and the power of parental blame meant that she felt responsible – rather than the adults.

### **How do we know it is an underlying issue and not something unique to this case?**

- 3.7.10 The review team recognised in their work the pattern of professionals not consistently noticing when parents deflect responsibility for their actions, by holding young people responsible for what has happened to them. Professionals reflected that there was also a tendency to more readily accept what they are told by parents even when it contradicts what they are told by young people.

### **How prevalent and widespread is this issue?**

3.7.11 There is little available evidence regarding how widespread and prevalent an issue this is. It is not part of the processes of auditing cases and the Review Team and Case Group considered that parents blaming children has been underestimated as a significant factor in assessing parental capacity, adolescent neglect and the extent of significant harm. It has also not been connected to adolescent complex behaviours or recognised as one part of a root cause.

### **Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.7.12 Children and young people who grow up in homes where they are constantly baled, berated and belittled may experience self-confidence and anger problems and they will struggle to develop the internal skills required to manage the transition through adolescence. Adolescents who do not get the love and they need from their parents or primary caregivers may find it difficult to develop and maintain healthy relationships with other people later in life. Adults who have been emotionally abused as children have higher levels of depression and health problems compared to those who have experienced a different form of child abuse<sup>xviii</sup>. There are significant consequences for young people if this issue is not addressed

#### **Finding 3**

##### **Questions for the Board to consider**

- How will the Board assure itself that member agencies have processes in place to support staff to recognise and challenge inappropriate parental blaming of children and the subsequent emotional impact of this behaviour?

- 3.8 Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.**
- 3.8.1 This finding looks at the way in which parental non-engagement can undermine attempts to ensure that vulnerable young people with complex emotional needs are supported to remain living in their families and communities of origin can lead to rejection and abandonment for those young people, with the consequent negative impact on self-esteem and resilience.
- 3.8.2 One of the key principles highlighted by the Munro review of safeguarding<sup>xix</sup> is that a child and young person's family is usually the best place to be brought up where it is safe and appropriate to do so. This is endorsed by research<sup>xx</sup>, and underpinned by the UN Convention on the Rights of the Child 1989 (UNCRC)<sup>xxi</sup>, the Human Rights Act 2000<sup>xxii</sup> and the Children Act 1989<sup>xxiii</sup>. This emphasis has led to a policy focus on services to support families and prevent family breakdown. This is particularly important for young people who are the largest group in care; in 2015 almost half (45%) of the looked after population was aged 10- 17<sup>xxiv</sup>. Once in care this age group tends to stay longer and have multiple placement breakdowns, and these young people can oscillate between home and care<sup>xxv</sup>. Unsurprisingly, this leads to poor long term outcomes, which are characterised by the potential for sexual exploitation, involvement in crime, poor mental health, reduced life chances, poor health and wellbeing and a higher risk of experiencing difficulties in the future parenting task and role.
- 3.8.3 This all points to the need for action to consider how best to meet the needs and improve the circumstances for these often troubled young people. Part of this action has been to try and improve family relationships with a specific focus on services to prevent family breakdown, often known as "edge of care" services. Nationally there is no one way of delivering these services, and there has been a proliferation of methodological and theoretical approaches<sup>xxvi xxvii</sup>.
- 3.8.4 The evidence suggests that adopting a holistic family approach is essential. Alongside this there needs to be a good quality assessment to understand in detail the nature of the problems to be addressed, a good analysis of the causal pathways, with a focus on past and present difficulties, and clear aims and goals and areas of change for all members of the family. It is essential that services do not collude with parental conceptualisations that the young person is the only problem (see Finding 3), but also to be empathetic to the complexities of parenting troubled young people.

- 3.8.5 In a national themed review of “edge of care” services by Ofsted (2011)<sup>xxviii</sup> family engagement was considered a critical factor and was found to be difficult to achieve where there was a lack of warmth or empathy for children and young people.
- 3.8.6 Where parents do not engage with those services designed to support them, it is almost inevitable that family breakdown will occur. It is essential that professionals are proactive in reviewing progress and do not wait to take appropriate action. Far too often it is parents who signal that they can no longer cope and ask for young people to come into care- the lack of professional action appears unintentionally to provide opportunities for parents to very publicly reject or abandon their young people, with attendant consequences for already complex attachment histories.
- 3.8.7 In this situation agencies are placed in a difficult position; they must take action to safeguard the young person. This risks colluding with the parental perception that the young person is unmanageable, and is the problem, and it can imply that it is acceptable to give up your responsibility as a parent. This requires careful thought about how these situations are to be managed, if we are to promote a young person-centered process which minimises the potential for re-traumatising vulnerable young people.

#### **How did it manifest in this case?**

- 3.8.8 Extensive support was provided to Olivia, sibling 3, father and mother. Father engaged inconsistently and mother did not engage at all; neither acknowledged that they might need to make changes to improve family life generally or specifically for Olivia. The constant changing of arrangements about where both girls were living made it difficult for them to make use of the services designed to provide them with support.
- 3.8.9 Olivia was always very clear that her family were important to her. Her history was that of change and fragmentation, with a number of moves in her formative years when she was aged 6/7 years old. She did not see her mother for five years and was unaware of having younger siblings. She was devastated when her father asked for her to come into care. This was in the context that he could not manage her, despite not having taken advantage of the services offered to help with exactly this. This public rejection was likely to have impacted negatively on her already fractured self-esteem and self-worth. Effective work was done to find an appropriate placement and to build a plan of contact and a route home. This finding asks the question if nationally and locally we are exerting enough challenge at this critical time for young people in what often may become a long, and sometimes fragmented, care history.

### **How do we know it is an underlying issue and not something unique to this case?**

3.8.10 The review team recognised that this was a routine and complex dilemma that they regularly faced when working with vulnerable adolescents with complex needs. The research evidence suggest that this age group is more likely to become subject to voluntary accommodation in a crisis and the Care Inquiry has highlighted the significance of managing these crises well for the future care needs of young people.. This was an issue we saw in the lives of both girls subject to review.

### **How widespread and prevalent is it?**

3.8.11 Nationally young people are the largest group in care; in 2015 almost half (45%) of the looked after population was aged 10- 17<sup>xxix</sup>. Once in care this age groups tends to stay longer, have multiple placement breakdowns and these young people can oscillate between home and care<sup>xxx</sup>.

### **Why does it matter?**

*High-quality relationships matter more than anything else for children in or on the edge of care ... the quality and continuity of relationships, ... promotes and enhances.*

3.8.12 The Care inquiry<sup>xxxi</sup> highlights the importance of all young people having a sense of security, continuity, commitment and identity through childhood and beyond In this context family are important, relationships are important and attachments are important. The breakdown of family relationships is a critical moment for young people and if they are to be able to build resilience into their future as adults and to form new relationships they need to understand that they are not wholly responsible for family breakdown, and that services are prepared to challenge what is felt by the young person to be rejection and abandonment.

#### **Finding 4**

##### **Questions for the Board to consider**

- How will the Board seek assurance that interventions designed to enable children and young people to remain in their families are appropriately child centred and are planned, implemented and monitored to provide the best possible outcomes for those children and young people?

**3.9 Finding 5: There is a disjoint between both children’s and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.**

3.9.1 This Finding focuses on the importance of good working relationships and information sharing across the Community Safety Partnership (CSP) and services responsible for safeguarding children.

3.9.2 This is important because there are increasing concerns regarding the narrow focus of safeguarding nationally on young people being at risk of harm from their families or alternative caregivers. There is increasing recognition that young people as they develop spend increasing amounts of time with their peers, their school, and the community and public environments, independently of adult supervision. For some young people this leaves them at risk of abuse and exploitation and currently this is appropriately the focus of much policy and practice attention.

3.9.3 Less is known in research terms in the context of safeguarding about the risks that young people pose to others in the community, whether this is called peer abuse, teenage relationship abuse, harmful sexual behaviours, or serious youth violence, or involves sexual bullying and exploiting those who are vulnerable in the community. This is a significant safeguarding issue and clear systems and processes need to be in place to address these concerns, map young people and their connections and consider how existing fora can address these concerns. The University of Bedford have produced a recent toolkit that aims to support practitioners to recognise how social environments and extra-familial relationships are relevant to safeguarding adolescents.

**How did this manifest in the case?**

3.9.4 Olivia was briefly known to the PCCOs for what they described as low level concerns regarding misbehaviour and harassment around some shops. She was never subject to an anti-social notification. However, she was often missing overnight, frequently with peers, and therefore vulnerable and the group was a potential risk to others. There is no evidence that the groups Olivia were involved with anti-social behaviour, although when she took a young person out from the children’s home in November 2014 there was evidence Olivia and peers were drinking and during this incident another young person was injured. There was also concern that Olivia and Yasmine were alleged to have been involved in the theft of a mobile phone; something they disputed.

3.9.5 There was never any evidence that Olivia had any contact with Carol, or was at her home. There was evidence that Carol was harassed by young people, who asked her to buy alcohol, and used her house as a place to drink and smoke. Despite this, this finding needs to question the safeguarding system more broadly about what information should child welfare agencies have from those agencies providing community safety services which could improve the circumstances and safety of vulnerable young people and what information should agencies providing community safety services have from child welfare agencies to improve community safety.

#### **How do we know it is an underlying issue?**

3.9.6 This is a national issue and there is national research about the threats to vulnerable young people when they are unsupervised in the community with their peers. There is emerging evidence that these young people can also pose a risk to their peers and vulnerable members of the community. Locally the Review Team confirmed that they were not always well informed about the work of the role and range of community safety services and their work with vulnerable young people did not always make connections with this team. The Review Team also reflected on the focus in child welfare on the vulnerability of young people, particularly girls, without there always being a focus on risks they might pose to others. This risk could be harassment, bullying, stealing and anti-social behaviour more generally.

3.9.7 There has been work undertaken already locally to improve the two way communication between the agencies, and to make use of the community safety services. It is important that this progress continues if children and young people are to be protected from harm, and if we are to recognise the potential risks young people in the community might pose to their peers and vulnerable adults.

#### **Finding 5**

##### **Questions for the Board to consider**

- How can Hartlepool Safeguarding Children Board (HSCB) work in partnership with Teeswide Safeguarding Adults Board (TSAB) and the Community Safety Partnership to ensure that the development work currently being undertaken by the Community Safety Strategic Partnership strengthens the links for both adults and children?

## 4. APPENDICES

### 4.1. Methodology and Process of the Review – Appendix 1

4.1.1 This review has used the SCIE Learning Together model – a ‘systems’ approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and child protection work (Munro, 2005; Fish et al, 2009).

1. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.
2. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.
3. The basic principles – the ‘methodological heart’ of the Learning Together model – are in line with the systems principles outlined in Working Together 2013:
  - Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the ‘view from the tunnel’). What was influencing and guiding their work?
  - Provide adequate explanations – appraise and explain decisions, actions, in- actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
  - Move from individual instance to the general significance – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency safeguarding system.
  - Produce findings and questions for the Board to consider.
  - Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

4.1.2 Typology of underlying patterns: To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

4.1.3 Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

4.1.4 Anatomy of a finding: For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency local safeguarding children board?

## 4.2 References – Appendix 2

---

- <sup>i</sup> Department for Education (2013) Working Together to Safeguard Children
- <sup>ii</sup> Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report: London. Department for Education.
- <sup>iii</sup> Mike Stein and Lesley Hicks (2010), *Neglect Matters: a multi-agency guide for professionals working together on behalf of teenagers*, London, Department of Children, Schools and Families.
- <sup>iv</sup> Rawes P (2016) Troubled Teens: A study of the links between parenting and adolescent neglect; London. The Children Society
- <sup>v</sup> Hanson, E and Holmes, D. (2014) That Difficult Age: Developing a more effective response to risks in adolescence; Research in Practice and ADCS
- <sup>vi</sup> Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report: London. Department for Education
- <sup>vii</sup> Ofsted (2011) Ages of concern: learning lessons from serious case reviews
- <sup>viii</sup> Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report: London. Department for Education.
- <sup>ix</sup> Ofsted (2011) Ages of concern: learning lessons from serious case reviews
- <sup>x</sup> Hanson, E and Holmes, D. (2014) That Difficult Age: Developing a more effective response to risks in adolescence; Research in Practice and ADCS
- <sup>xi</sup> Research in Practice (2014) Risk Taking adolescents and child protection.  
<http://sscb.safeguardingsomerset.org.uk/wp-content/uploads/2016/06/CSE-Risk-taking-adolescents-and-child-protection.pdf>
- <sup>xii</sup> Research in Practice (2014) Risk Taking adolescents and child protection.  
<http://sscb.safeguardingsomerset.org.uk/wp-content/uploads/2016/06/CSE-Risk-taking-adolescents-and-child-protection.pdf>
- <sup>xiii</sup> Mike Stein and Lesley Hicks (2010), *Neglect Matters: a multi-agency guide for professionals working together on behalf of teenagers*, London, Department of Children, Schools and Families.

---

<sup>xiv</sup> Mike Stein and Lesley Hicks (2010), *Neglect Matters: a multi-agency guide for professionals working together on behalf of teenagers*, London, Department of Children, Schools and Families.

<sup>xv</sup> Hanson, E and Holmes, D. (2014) *That Difficult Age: Developing a more effective response to risks in adolescence*; Research in Practice and ADCS

<sup>xvi</sup> Barlow, J. and Schrader McMillan, A. (2010) *Safeguarding children from emotional maltreatment: what works?* London: Jessica Kingsley.

<sup>xvii</sup> Gavin, H. (2011) Sticks and stones may break my bones: the effects of emotional abuse. *Journal of Aggression Maltreatment and Trauma*, 20(5): 503-529.

<sup>xviii</sup> Barlow, J. and Schrader McMillan, A. (2010) *Safeguarding children from emotional maltreatment: what works?* London: Jessica Kingsley.

<sup>xix</sup> Munro E (2011) *The Munro Review of Child Protection: Final Report A child-centred system*: Department for Education

<sup>xx</sup> Ofsted (2011) *Edging away from care – how services successfully prevent young people entering care*

<sup>xxi</sup> <https://www.unicef.org.uk/what-we-do/un-convention-child-rights>

<sup>xxii</sup> <http://www.legislation.gov.uk/ukpga/1998/42/contents>

<sup>xxiii</sup> <http://www.legislation.gov.uk/ukpga/1989/41/contents>

<sup>xxiv</sup> Department for Education (2014) *Rethinking support for adolescents in or on the edge of care*.

<sup>xxv</sup> Department for Education (2014) *Rethinking support for adolescents in or on the edge of care*.

<sup>xxvi</sup> C4EO (2010) *Edge of Care Evidence Pack*. Accessed at [http://archive.c4eo.org.uk/costeffectiveness/files/edge\\_of\\_care\\_evidence\\_pack.pdf](http://archive.c4eo.org.uk/costeffectiveness/files/edge_of_care_evidence_pack.pdf)

<sup>xxvii</sup> [https://ipc.brookes.ac.uk/publications/Rapid\\_Research\\_Review\\_relating\\_to\\_Edge\\_of\\_Care\\_July\\_2015.pdf](https://ipc.brookes.ac.uk/publications/Rapid_Research_Review_relating_to_Edge_of_Care_July_2015.pdf)

<sup>xxviii</sup> Ofsted (2011) *Edging away from care – how services successfully prevent young people entering care*. Manchester

---

<sup>xxix</sup> Ofsted (2011) Edging away from care – how services successfully prevent young people entering care

<sup>xxx</sup> Ofsted (2011) Edging away from care – how services successfully prevent young people entering care

<sup>xxxi</sup> [https://www.frg.org.uk/images/Policy\\_Papers/care-inquiry-full-report-april-2013.pdf](https://www.frg.org.uk/images/Policy_Papers/care-inquiry-full-report-april-2013.pdf)