A Serious Case Review

'Jaiden'

Final Overview Report

March 2016

Index

1 Introduction and context ... 3
- 1.1 Purpose and circumstances of the serious case review ... 3
- 1.2 Rationale for conducting the serious case review ... 3
- 1.3 The scope and methodology of the serious case review ... 4
- 1.4 Agencies who provided information to the serious case review ... 6
- 1.5 Membership of the case review team and access to expert advice ... 7
- 1.6 Family contribution to the serious case review ... 8
- 1.7 Cultural, ethnic, linguistic and religious identity of the family ... 10

2 Summary of contact and significant events between June 2013 & March 2015 12

3 Appraisal of professional practice in this case ... 19
- 3.1 Voice of the child and understanding a child's personal history ... 19
- 3.2 Delivery of early help before the onset of more protracted difficulties ... 21
- 3.3 Assessment ... 22
- 3.4 Missing from home ... 25
- 3.5 Recognising disguised resistance and the use of constructive authority .. 26
- 3.6 Multi-agency working ... 29
- 3.7 Use of team around the child (TAC) where children are at risk of significant harm ... 31

4 Analysis of key findings for learning and improvement ... 34
- 4.1 Cognitive influence and human bias in processing information and observation ... 35
- 4.2 Family and professional contact and interaction ... 37
- 4.3 Responses to information and incidents ... 38
- 4.4 Tools to support professional judgment and decision making ... 39
- 4.5 Management and agency to agency systems ... 42
- 4.6 Issues for the Stockport Safeguarding Children Board to consider in regard to learning and improvement ... 46
- 4.7 Recommendations ... 46
- 4.8 Issues for national policy ... 47

5 Appendix Professionals who participated in group discussions ... 48

1 Introduction and context

1.1 Purpose and circumstances of the serious case review

1. This serious case review examines, for the purpose of professional learning and the continuing improvement of services to safeguard children, the response of organisations and the appropriateness of professional support given to a 15 year old child who, for the purpose of this review, is referred to as Jaiden, and who died in March 2015 as a result of a road traffic accident.

2. The death of any child is distressing especially for family, friends and the professionals and carers who knew them. There is a particular tragedy that Jaiden had begun to overcome significant difficulties and adversities in recent months with the help and support of many different people.

3. The review has considered the extent and quality of professional contact and involvement from the June 2013 to March 2015 with Jaiden who had been looked after by the local authority for two almost consecutive periods from spring 2014. The arrangements were made in response to concerns about neglect, substance misuse, and persistent incidents of missing from home and the vulnerability of Jaiden to child sexual exploitation.

4. The task of the review is to establish what lessons are learned from the case for improving safeguarding services, to improve inter-agency working and to better safeguard and promote the welfare of children.

5. For the purpose of clarity the use of acronyms is kept to a minimum. Family members are referred to by their relationship to Jaiden such as mother, father, maternal or paternal grandparent for example. Jaiden was living with a foster carer in another part of Greater Manchester. Professionals are referred to by their roles such as CAMHS worker, GP, police officer or social worker for example.

1.2 Rationale for conducting the serious case review

6. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires local safeguarding children boards to undertake a review in accordance with the criteria and procedures that are set out in chapter four of *Working Together to Safeguard Children (2015*).

7. A Local Safeguarding Children Board should always undertake a serious case review when a child dies or has been seriously harmed and abuse or neglect is either known or is suspected *and* there is cause for concern as to the way the authority, the local safeguarding children board or other relevant persons have worked together.

8. The circumstances of Jaiden's death were discussed at a meeting of the serious case review consideration panel on the 1st July 2015. The panel agreed that a serious case review should be commissioned. The recommendation was ratified by the independent chair of the Stockport Safeguarding Children Board and the Department for Education, Ofsted and the National Panel of Independent Experts were notified of the decision.

1.3 The scope and methodology of the serious case review

9. The timescale agreed for the review is from June 2013, when Jaiden came to the attention of children's social care services up to the date of the fatal road traffic accident in March 2015. The review was conducted from the outset on the basis that the overview report would be published in full and without redactions.

10. The review was conducted in a way which:

    a) Recognises the complex circumstances in which professionals work together to safeguard children;

    b) Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did; identifying the contributory factors that influenced key events and decision making;

    c) Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than relying on hindsight analysis;

    d) Is transparent about the way data was collected and analysed and makes use of relevant research and case evidence to inform the findings.

11. The methodology uses elements of a systems learning review to inform the process of analysis designed to examine underlying factors that influence professional practice alongside features of an investigative review such as gathering of chronologies and key documentation from organisations that had significant contact or involvement with Jaiden. For example copies of assessments, care plans or agreements were examined. Agencies were not required to complete individual management reports although some were asked to provide written evidence in response to specific points of clarification where necessary.

12. The review comprised distinct stages beginning with identifying and briefing relevant services and practitioners, collating a chronology, facilitating discussions with practitioners and key managers, the provision and analysis of written documentation and the dissemination of key learning.

13. The conversations with practitioners who had direct contact or knowledge of Jaiden were facilitated by the lead reviewer and a member of the serious case review panel. The discussions involved adult and children's substance misuse practitioners, CAMHS, children's social care services, education (including the pupil referral unit), independent reviewing officers, police, services for young people, sexual health services, youth offender service and the provider of the foster carer placement. A list of the professionals is included as an appendix.

14. Understanding the case from the perspective of those involved allows their engagement in a reflective process, using their understanding to consolidate learning and development.

15. In addition to the input of information from practitioners the review sought information from the family as well as the foster carer who was looking after Jaiden.

16. The methodology provided;

    a) A framework to shift focus from just an investigation to a learning process;

    b) Involved family, staff and managers in a reflective review process by listening to their perception of events;

    c) Involved multi-agency practitioners in a reflective process to learn lessons;

    d) Focused on learning lessons as it relates to current practice;

    e) Focused on a wider systems approach to understand key factors, examining not only what happened but also why;

    f) Involved frontline staff and managers in understanding how and why processes fail and harness their experience in the action planning /change process;

    g) Provided independent oversight and involvement in the review process.

17. The serious case review panel was comprised of senior and specialist agency representatives to oversee the collation and analysis of information and outcomes of the review and reporting to the Stockport Safeguarding Children Board. The panel representation encompassed senior and specialist professionals from children's, criminal justice, education, health, and mental health and substance misuse organisations.

18. The review was co-ordinated by Peter Maddocks. He is an independent lead reviewer with appropriate experience and training and is the author of this report. He has over thirty-five years experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local authority services and of working in national inspection services as well as with the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council (HCPC). He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and statutory inspections in relation to safeguarding children. He has undertaken independent agency reviews and has provided independent overview reports to several local safeguarding children boards in England and Wales as well as worked on domestic homicide reviews for several community safety partnerships. He has not worked for any of the services contributing to this serious case review. He has undertaken training for overview authors and independent reviewers.

19. The overview report is the property of the Stockport Safeguarding Children Board as the commissioning board and is the final and public record when it is published.

1.4 Agencies who provided information to the serious case review

20. The following agencies have provided information and contributed to the serious case review:

    a) Bolton NHS Foundation Trust (BFT) provided information and participated in round table discussions regarding the provision of school nursing services, young people's substance misuse and sexual health services;

    b) Greater Manchester Police provided information and participated in round table discussions regarding contact primarily in relation to episodes of Jaiden missing from home, safeguarding referrals, crime and investigation of the circumstances of the fatal road traffic accident;

    c) Independent fostering agency that provided information and participated in round table discussions regarding the foster care placement in Bolton;

    d) School based professionals provided information and participated in round table discussions about arrangements and Jaiden's participation in education in Bolton and Stockport;

    e) Stockport children's services provided information and participated in round table discussions about social work services provided in regard to

safeguarding referrals and assessments and care planning and support of arrangements for Jaiden to be looked after;

f) Stockport Clinical Commissioning Group provided information about general practitioner medical services (GP);

g) Stockport independent reviewing officer services provided information and participated in round table discussions about child protection conferences, statutory looked after reviews and the local multi-agency sexual exploitation (MASE) framework and panel;

h) Youth Offending Services provided information and participated in round table discussions about support and supervision in relation to criminal justice in Bolton and Stockport;

21. Contact with and information from the family is described in section 1.7.

1.5 Membership of the case review team and access to expert advice

22. The case review team that oversaw this review comprised the following professional roles and organisations;

Business and performance manager	Stockport Safeguarding Children Board
Head of children's social care and Principal children's social worker	Children's Social Care
Deputy head of children's social care services	Children's Social Care
Head of safeguarding and learning	Safeguarding Children Unit
Business and performance manager	Bolton Safeguarding Children Board
Senior advisor for safeguarding in education	Safeguarding Children Unit
Service manager	Stockport's Integrated Children's Service
Team manager	Stockport's Integrated Children's Service
Deputy head of service	MOSAIC- Stockport's Integrated Children's Service

Drug and alcohol treatment lead/team manager	MOSAIC - Stockport's Integrated Children's Service
Operations manager	Bolton Youth Offending Service
Interim matron	Bridgwater Community Healthcare
Detective Inspector	Greater Manchester Police
Named nurse, safeguarding	Stockport NHS Foundation Trust
Designated nurse for looked after children	NHS Stockport Clinical Commissioning Group (CCG)
Named nurse, mental health	Pennine NHS Foundation Trust
Head of student services	Bolton Free School
Independent reviewer	(author of this report)
Professional support	
Administrative Coordinator	Stockport Safeguarding Children Board

23. The case review panel met on three occasions between September 2015 and February 2016. Members of the panel were also participants at the round table discussions that involved practitioners. The draft overview report was presented to an extraordinary meeting of the Stockport Safeguarding Children Board in February 2016.

1.6 Family contribution to the serious case review

24. Mother and father were informed of the serious case review at the outset and accepted an invitation to meet with the independent reviewer and the chair of the panel. Mother and father had separated at the end of 2014 and the meetings took place independently of each other.

25. Mother said that she felt let down by some of the professionals although reported that she had trusted the social worker who was working with Jaiden and the family in the months before and after Jaiden's death. Mother said that she felt this particular social worker had been more truthful and straight

with her and felt that he had more experience to draw upon. She felt that other social workers had befriended her but mother had felt betrayed when they had wanted Jaiden to be placed with a foster carer outside of Stockport.

26. Mother felt that she was given ‘silly’ strategies to manage Jaiden which did not work such as getting Jaiden out of bed in the morning. She did not feel that she was a bad mother but she had felt judged and could not see the point of doing the parenting classes for example.

27. Mother felt that concerns about risk to Jaiden were exaggerated and felt that Jaiden missing from home was made more of an issue than it needed to be. For example, she felt that they were compelled to make a report that Jaiden was missing when on some occasions Jaiden had returned late from being out and beyond the agreed time.

28. Mother had regular conversations with the foster carer. Mother felt that the foster carer had helped build mother’s confidence and mother felt that Jaiden was safe and that the foster carer was managing Jaiden’s behaviour and acknowledged that Jaiden was participating in education and attending health and YOS appointments more consistently.

29. Mother also described some of Jaiden’s early history. Mother explained that she met father after a very brief relationship with Jaiden’s biological father and realised that she had become pregnant after meeting father. Although she had always thought that father was not Jaiden’s biological father she had been open with him and he had accepted the possibility that he was not the biological father but had been a father to Jaiden since birth. It was when Jaiden had become a teenager (14) that mother felt that Jaiden should know for certain who the biological father was. A DNA test confirmed paternity was not with father. Jaiden had been very upset by this information.

30. Mother felt that the serious case review needed to look at how professionals communicate with parents and is an area explored later in the report. Being given the message that she was a bad parent along with father had switched them both off from engaging with much of the professional advice and help.

31. Mother acknowledged that Jaiden was in relationships with adults but was not convinced that it was Child Sexual Exploitation (CSE). Mother was aware that Jaiden was using drugs and had done so for several years. Mother thought that it had been being funded through shoplifting.

32. Father felt that professionals had an exaggerated concern about Jaiden who he believed had not been at risk of child sexual exploitation. He felt that Jaiden was a ‘typical teenager’. He never saw the point of Jaiden being looked after or being placed outside of Stockport. He felt that not much had changed for Jaiden. He had never wanted to agree to the placement but reluctantly went along with arrangements when faced with an ultimatum

when Jaiden was summoned to the youth court and was told that he and mother would lose all control if they did not consent to the arrangements. He felt that the exclusion from school was a significant turning point when things deteriorated very quickly for Jaiden. He felt that Jaiden was easily led and met other young people with their own difficulties after the exclusion and being placed in education other than at school.

33. Father felt that the youth court should have imposed firmer penalties; for example administering a 'short sharp shock' which he thought might have curbed Jaiden's behaviour. Father was dismissive of the parenting classes that were offered feeling that they offered very little that was of use to him or to mother. He felt the team around the child (TAC) meetings were far too focussed on recent events and not planning enough for the future. He felt that he, along with mother, were simply portrayed as poor parents. He felt that they were both being judged and blamed by professionals.

1.7 Cultural, ethnic, linguistic and religious identity of the family

34. Jaiden's family cultural and ethnic heritage is white British and English is their language. There is no record of a religious or cultural affiliation.

35. As a result of concerns about Jaiden's safety including child sexual exploitation, Jaiden was living with a foster carer in Bolton, who was also white British, from March 2014. Jaiden had regular contact with family which included for weekend stays. It was during one of those visits that Jaiden came to be in the motor vehicle that was involved in the fatal road traffic accident.

36. Prior to the foster placement, Jaiden lived with mother, father and younger sibling in a rented house where they had lived since 2011. Both mother and father have experienced significant periods of unemployment although mother has been in employment for several months while the review was taking place. There is a history of domestic and substance misuse and involvement by mental health services with father. Mother and father have separated. Jaiden was unaware that the father was not the biological father until 2013 when aged 14 years old. The biological father is serving a prison sentence. Father and biological father have both had contact with specialist substance misuse services.

37. Jaiden's family lived in one of the three most deprived districts in Stockport and which are amongst the five per cent most deprived areas in England according to the Index of Multiple Deprivation[1]. It is one of three priority areas for the local authority in improving language and learning skills for

[1]http://www.mystockport.org.uk/viewpage.aspx?c=page&page=GeographiesFAQ&cookieCheck=true&JScript=1

children before they start at primary school and supporting families that have the most complex needs.

2 Summary of contact and significant events between June 2013 and March 2015

38. Although the focus of the review covers just less than two years when Jaiden had come to the attention of statutory services because of safeguarding concerns there had been previous contact with statutory services over and above the routine provision to all children of universal education and health care services.

39. The police provided a history of domestic abuse involving mother and father. The police responded to 19 incidents between 2000 and June 2013. In May 2010 they arrested ten year old Jaiden for an assault on another young person. In July 2010 Jaiden, then aged 11 years old, was arrested for shoplifting and again for the same offence in August 2010.

40. Between April 2013 and March 2015 the police also dealt with 47 reports of Jaiden missing from home or from the foster placement. The incidents of missing included returning later than a pre-arranged time as well as occasions when Jaiden was missing for longer. The incidents were processed through a joint protocol that has since been developed further in response to revised guidance and standards.

41. Children's services also had historical involvement between October 2000 and April 2013. Initial assessments were completed by children's social care services in July 2001 and December 2001. Both resulted in no further action or involvement by social work services. Children's services have a record of eleven notifications of domestic abuse; fewer than the incidents dealt with by the police. As with the missing from home protocols mentioned in the previous paragraph, the arrangements for reporting domestic abuse involving children have also been subject of development in response to information from reviews, research and national inspections of services.

42. On the 11th June 2013 Jaiden was referred to the school-based specialist substance misuse practitioner following a three day exclusion for smoking cannabis.

42. An initial assessment completed by the substance misuse service on the 19th June 2013 recorded that Jaiden's self-reported primary substance was alcohol, claiming to consume around 20 units of alcohol (spirits) each weekend although Jaiden could exceed this. Jaiden described having consumed a litre of spirits, a half bottle of liquor, a bottle of wine and shots of other spirits in one session of drinking. There is no further information about what the 'one session' of apparently very hazardous drinking was. The practitioner recorded what they were told by J. Although there may be a query as to whether the quantities that were reported are factually correct it nonetheless was indicating a worrying level of substance misuse that was not apparently discussed in detail in multi-agency meetings.

43. Jaiden stated that mother and father were not aware of the drinking; again there is little information about how the reported level of Jaiden's drinking could be unknown to close family[2]. Jaiden reported having smoked cigarettes since ten years of age. Jaiden did not want help in stopping smoking or using alcohol. Jaiden described having recently found out that father was not the biological father.

44. Jaiden's behaviour and presentation at school had become problematical in year 9. Having not received any fixed term exclusions previously, Jaiden began to truant and did not comply with behaviour management strategies.

45. In June 2013 Jaiden was referred through the children's social care supporting families' pathway to the local YOS (youth offending service) for voluntary help and support although did not engage with this initiative at preventing a further escalation of difficulties and was closed by July 2013. YOS subsequently became involved on a statutory basis in October 2013 when Jaiden was convicted for a serious assault.

46. In July 2013 Jaiden came to the notice of children's social care services and police as being potentially vulnerable to child sexual exploitation (CSE). An adult male had been buying new clothes for Jaiden and paying for taxi journeys and was purchasing alcohol for Jaiden. Mother says that she and father had no knowledge of this at the time. A specialist CSE practitioner completed an assessment of risk and Jaiden was referred under the local multi-agency sexual exploitation (MASE) procedures for a discussion at the MASE panel.

47. Jaiden continued to be the subject of referrals about safeguarding concerns and was also convicted on the charge of assault and made subject of a referral order; when this was breached because of non-compliance a youth rehabilitation order[3] was imposed.

48. Jaiden saw the school based substance misuse worker in September 2013 at a 'catch up session'. Jaiden reported having experienced one occasion of complete lack of recall when under the influence of alcohol and or drugs. Jaiden said that the assault on another young person was the result of a loss

---

[2] The level of alcohol intake as reported and recorded stretches credibility and is disputed by mother who says she never saw Jaiden drunk. It is indisputable that Jaiden was using substances including alcohol and drugs.

[3] The Criminal Justice and Immigration Act 2008 came into force in November 2009 introducing the biggest legislative change for the youth justice system since the Crime and Disorder Act 1998. The *Scaled Approach* reflected in the youth rehabilitation order aims to reduce the likelihood of reoffending by tailoring the intensity of the intervention to the young person's assessed risks and needs identified using the Asset assessment tool, and by ensuring more effective management of risk of serious harm to others through the inclusion of any requirements seen to be necessary.

of control (although in reality it was a pre-planned assault). Jaiden agreed about the need to make changes and a referral to the young people's substance misuse service was completed.

49. Jaiden was referred to the local CAMHS (child and adolescent mental health service) by the GP in September 2013. The referral mentioned that Jaiden had recently been told by 'somebody' that father was not the biological father and that Jaiden was struggling to come to terms with this information (it was clarified during mother's discussion with the author of this report that she had instigated the process with the intention of Jaiden having certainty about who father was). Jaiden was described as struggling with anger, had recently been expelled from school (19th September 2013). There was no known history of suicidal ideation or self-harm. An assessment was initially offered in October 2013 but was subsequently postponed until early December 2013 and was again postponed to mid-December. Jaiden did not attend the appointment and CAMHS closed the case in January 2014.

50. In December 2013 the police used their police powers of protection (PPOP) when called to deal with an incident at the family home involving Jaiden having an argument with mother who was refusing to allow Jaiden back into the family home. Jaiden was returned home and children's social care services undertook an assessment and agreed that continuing support would be provided to Jaiden as a child in need (CIN). There were further incidents of Jaiden being reported missing from home and of aggressive behaviour at school.

51. In January 2014 Jaiden was one of several young people going to a property where alcohol and cannabis was being consumed. The householder was issued with a child abduction notice by the police[4].

52. In January 2014 the specialist young people's substance service completed a Tier 3 drug treatment assessment. Jaiden described having used alcohol since 12 years of age and by June 2013 was regularly binge drinking. By January 2014 Jaiden was regarded as becoming dependent upon cannabis and this was having an impact on Jaiden's mood, ability to focus and general mental health. Jaiden described feeling anxious, had low mood, memory loss, paranoia and a lack of concentration. Jaiden's consumption of alcohol had increased to 40 units per week at weekends but Jaiden asserted having not

---

[4] Child Abduction Warning Notices (CAWNs) are used to disrupt an adult's inappropriate association with a child or young person. Previously called 'Harbourer's Notices', a CAWN warns the adult that they have no permission to associate, contact or communicate with the young person, and that if they continue to do so then they may be arrested and prosecuted. There is no statutory or other legislative provision dealing specifically with the issue of CAWNs. Breach of a notice is NOT a criminal offence. These notices are simply part of an administrative process. If issued properly, they can provide evidence to support the prosecution of other criminal offences and/or to support civil proceedings such as ASBOs (anti-social behaviour orders), evictions or injunctions.

consumed alcohol for several weeks. Jaiden was smoking five or six cannabis joints a day. There was no further contact with the substance misuse service in Stockport and the case was closed in early April 2014 given the non-engagement.

53. In February 2014 Jaiden was found at another property having been missing for four days. Jaiden was returned home but almost immediately went missing again but was located at a friend's house by mother and father.

54. A MASE meeting discussed Jaiden on the 8th February 2014 who was considered to be at risk of CSE and was breaching the terms of the TAG curfew (wearing of an electronic tag) and going missing from home. Jaiden was believed to be consuming cannabis worth about £20 per day and was shoplifting and selling possessions to fund it. The MASE was advised that two male adults had been issued with child abduction notices.

55. Jaiden continued to be the subject of police reports and referrals to children's services regarding safeguarding concerns involving Jaiden going missing sometimes for several days.

56. On the 11th February 2014 Jaiden alleged being assaulted by mother and father. A MASE meeting on the 11th February 2014 agreed that an initial child protection conference was not required but that a 'care planning meeting' would be arranged. A strategy meeting took place on the 12th February 2014 involving the police and children's social care services. The strategy meeting was advised that Jaiden had reported on the 10th February 2014 having been assaulted by father and mother. The police had also been called by neighbours due to a loud argument taking place. The police were not aware of the earlier disclosure of an assault which had not been reported to them.

57. The meeting was told that Jaiden's behaviour was escalating with an increasing number of missing from home incidents and breaches in complying with the terms of the court imposed rehabilitation order. The police reported that parents were working with the police to reduce the addresses being visited by Jaiden. Mother and father were described as close to breaking point.

58. The strategy meeting agreed that children's social care services would speak with Jaiden about the allegation of assault when Jaiden returned home, that a care planning meeting would be convened to discuss 'alternative options and whether the risk to Jaiden remaining at home was too high'. Children's social care services would provide further information to the specialist police officers in the public protection and investigation unit (PPIU) and convene a further strategy meeting after Jaiden had been interviewed by social workers.

59. A legal planning meeting on the 18th February 2014 agreed that Jaiden should be looked after by the local authority due to the risk of harm. It was further agreed that this would be achieved without resorting to care proceedings.

60. Jaiden was arrested on the 27th February 2014 and mother and father were unwilling to agree to the proposed plan for Jaiden to be looked after by the local authority.

61. In early March 2014 Jaiden was charged with others for a racially aggravated public order offence which involved a threat of violence to a shopkeeper. Jaiden was also prosecuted for breaching the youth rehabilitation order.

62. On the 19th March 2014 an integrated placement and education panel (IPEP) expressed concern about the continued refusal of mother and father to agree to the plan for Jaiden to be looked after and recommended to consider escalation to legal gateway meeting; it was also agreed that the YOS would recommend to the court that Jaiden should live as directed by the local authority.

63. On the 20th March 2014 Jaiden attended at the youth court and a direction was made to live as directed by the local authority. Arrangements were made for Jaiden to be placed with a foster carer outside Stockport. The placement was provided by an independent fostering agency.

64. An initial child protection conference (ICPC) on the 27th March 2014 discussed the risk to Jaiden from CSE and the frequency and pattern of Jaiden going missing from home. There were concerns about Jaiden's consumption of cannabis. There were concerns that mother and father were no longer providing sufficient protection and were not co-operating sufficiently with the various organisations to keep Jaiden safe.

65. The ICPC agreed that because Jaiden had been placed with a foster carer and was now subject of statutory care planning and placement reviews that would be overseen by an independent reviewing officer there was not a requirement to have a child protection plan.

66. Jaiden continued to go missing from the foster placement often returning to Stockport. On other occasions Jaiden returned to the foster carer. Jaiden appeared to be adopting a more regular and healthy lifestyle though; was eating and sleeping more regularly for example and was attending education. Jaiden shared some concerns about the domestic abuse and drinking of alcohol by mother and father.

67. The police visited Jaiden to help encourage Jaiden to disclose any evidence in regard to CSE. A specialist nurse was also in contact with Jaiden to whom Jaiden also only provided very limited information.

68. On the 20th May 2014 Jaiden disclosed to the police having had a relationship with an adult. Jaiden had thought that the adult loved them although had subsequently realised that was not the case. Jaiden was not willing to disclose the name.

69. Jaiden was discussed at the MASE meeting on the 20th June 2014 which was told that Jaiden was doing well in the foster placement and was being allowed extended overnight contacts with family.

70. On the 27th June 2014 a second referral was made to the substance misuse service in Stockport. The referral advised that Jaiden had been returned to the care of mother and that Jaiden was already in breach of the court order, was using cannabis and was going missing from home. Appointments were offered to Jaiden who did not attend. The case was closed to the specialist substance misuse service in Stockport (Jaiden was in contact with the out of area specialist substance misuse service) in late October 2014 because Jaiden had returned to the foster placement. The YOS retained their involvement with Jaiden. This provided continuity and as such is good practice.

71. In July 2014 Jaiden was arrested for robbery. A male and female were attacked in the street by Jaiden and two others and a purse was stolen.

72. On the 1st August 2014 Jaiden was remanded and directed to live as directed by the local authority and was resentenced to the youth rehabilitation order on the 27th August 2014.

73. In September 2014 the youth offending service (YOS) in Stockport attempted to offer family parenting support with mother and father which was declined.

74. On the 12th November 2014 a looked after child (LAC) statutory review took place. There is not a record of the review discussing recent disclosures about Jaiden having sexual relations with an adult.

75. In December 2014 father took an overdose of over-the-counter medication and attempted to hang himself and was admitted to hospital as a voluntary patient under the mental health legislation for inpatient treatment. Whilst father was in the hospital a male adult visited the family home looking for father to secure settlement of a debt for crack cocaine. The male made implied threats that female members of the family would be raped if the debt was not settled. It emerged that the father had previously been attacked by several men looking for settlement of the debt but this had not been reported to the police or to any other agency. Mother disclosed that she had been trying to leave the relationship and that she was afraid of the father. She requested a housing transfer and her own tenancy.

76. By February 2015 mother and father had separated and they both acquired tenancies on separate properties in March 2015. In February 2015 the police

reported concerns that Jaiden whilst on agreed visits to Stockport was staying at a property in Stockport at weekends where drugs were being consumed and there was suspicion of CSE. The location of the property had not been identified and mother disputes that Jaiden was staying anywhere other than at home when on visits to Stockport. In the same month Jaiden was arrested for an assault on a female who Jaiden had been in an argument with regarding postings on a social networking website. The victim was not willing to make a formal complaint.

77. In March 2015 Jaiden was killed in a road traffic accident whilst having home contact in Stockport. The review does not investigate the circumstances of the accident. According to information provided to the review panel, Jaiden did not know the occupants of the car. The occupants were not known to services providing information to the review. In that respect there are not issues to examine in regard to professional action or decision making.

3 Appraisal of professional practice in this case

78. This chapter provides a critical appraisal that looks for the learning provided by the people who worked with Jaiden to help support continued improvement in working with vulnerable children and young people. The work is complex and it demands considerable emotional intelligence and resilience as well as the development of professional knowledge about a diversity of areas that involve different professional disciplines across education, health, criminal justice and social care services.

79. The tragic circumstances of Jaiden's death could not have been foreseen and therefore prevented by any of the professionals. Jaiden's death has been devastating for the family and for the people who worked with and cared for Jaiden.

80. Professionals had taken action to address concerns about Jaiden's safety and the risk from several different factors. Considerable progress had been achieved by Jaiden in the last months before the accident and shows great credit to Jaiden, the family despite some of their misgivings and the people who worked with and cared for Jaiden.

81. Professionals knew that Jaiden needed help and support and showed great determination in responding to Jaiden and had to overcome some very considerable opposition at times. There were occasions that individual professionals had to balance the interests of other children alongside deciding how to respond to Jaiden's presentation of need. An important example is the exclusion from school following the very serious assault on another student.

82. The key messages set out in this appraisal along with the findings in the final chapter are designed to support the work of empathetic and motivated professionals who are already committed to achieving good outcomes for children, some of whom are living in very adverse circumstances.

3.1 Voice of the child and understanding a child's personal history

83. Reviews such as this often describe how little is actually recorded or known about in regard to the views, wishes and feelings of a child or young person. A significant area of learning in this review is the extent to which important information was either unknown or not sufficiently understood about Jaiden until very recently and in spite of the effort of people trying to talk with Jaiden.

84. Young people face various internal and external barriers in being able to talk about their feelings or disclosing difficult information about themselves or about their circumstances. It is their behaviour that is often the means by

which they might reveal what they are experiencing, thinking, feeling or hoping for.

85. Appropriately trained, experienced and supported professionals who regularly work with children and young people who present with the more complex levels of needs and risk through behaviour will understand that it is often a manifestation of underlying difficulties and that these need to be the focus rather than just trying to prevent the behaviour or risk that are the symptoms of the child's deeper distress. Understanding the relevant history and context of young person is a fundamental aspect of that process.

86. Several professionals from different organisations and disciplines sought to establish a relationship with Jaiden and were often having to react to incidents that involved trying to keep Jaiden or other people safe. In the last weeks of Jaiden's life considerable progress had been achieved in reducing the incidents and level of risk that Jaiden presented and this makes the circumstances of Jaiden's death even more tragic and painful for all who knew and cared for Jaiden. Jaiden was attending education, was eating more regularly and generally complying with agreed boundaries such as coming home times. Jaiden was also opening up more although some of the concerns that Jaiden raised for example in regard to aspects of family life allegedly involving substance misuse for example had resulted in argument and disputed versions with mother and father.

87. Different professionals trying to help keep Jaiden safe faced great difficulty in achieving meaningful engagement from Jaiden or from mother and father. Some of the help was hampered by the perceived reluctance of Jaiden to comply with advice or guidance; there was also reluctance on the part of significant family adults to important issues such as being in agreement about arrangements for Jaiden to live with a foster carer and to be placed outside of Stockport. The source of the reluctance was not fully appreciated at the time.

88. There were significant factors associated with Jaiden's history. An example is the evidence of domestic abuse when Jaiden was very young; the implications for children's longer term emotional and psychological development are increasingly understood. This is not to suggest that this caused the tragic circumstances of Jaiden's death; the point being made is how to understand the internal world of the child more effectively and in this case there were significant adversities such as domestic abuse and substance abuse and mental health that are relevant to understanding how a child is interacting with other people. This was not really understood it seems until late 2014.

89. Finding a foster carer who had the skills, time and empathy was an important and positive development although introduced complications. Jaiden felt a conflict of emotions and a sense of responsibility to the younger sibling. Mother and father felt that they were being judged as failing to be able to

parent Jaiden effectively. Mother in particular found it difficult to see her child parented by a foster carer.

90. The foundations for optimal work with children and young people include having a good enough history that can identify significant factors and influences in regard to the child's development.

91. Important information that was only partially understood was Jaiden learning in adolescence that father was not the biological father of Jaiden but was the biological father of Jaiden's sibling. This had implications for Jaiden's sense of identity along with the other difficulties within the family associated with domestic abuse, mental health and substance misuse. Key people such as school teaching staff who were trying to respond to Jaiden's presentation of need in school were largely unaware of much of this family hinterland.

92. These factors and their influence on Jaiden did not appear to have been explored; at least there is no recorded evidence of assessment involving these factors until just before Jaiden died and that was work that was unfinished.

93. A review such as this should not try to second guess through hindsight what difference would have been made if there had been more knowledge and understanding about Jaiden's personal history. It does however open up a different perspective in regard to the incidents of missing from home or from placement for example. Jaiden was processing some very difficult personal information which coincided with other factors such as sexual development and coming into contact with adults who were seeking exploitative relationships with Jaiden.

94. When Jaiden moved to another area to live with a foster carer there were occasions, particularly during the first episode of being looked after, of Jaiden going missing from placement to return home. This was largely seen as the behaviour of an adolescent who wanted to back at home where there was less ability to manage Jaiden's behaviour rather than understanding other potential pull factors which probably included Jaiden feeling worried about what was happening at home and felt they had a responsible for example towards the younger sibling.

3.2 Delivery of early help before the onset of more protracted difficulties

95. The focus of this serious case review is from the summer of 2013 when Jaiden was seen to be increasingly at risk primarily in regard to child sexual exploitation.

96. Prior to 2013 there had been a longer history of contact for example in regard to domestic abuse by the police. There were assessments completed by children's social care and Jaiden had come to the attention of criminal

justice services in 2010. It is also apparent that school attendance was a concern and mother and father had been fined.

97. The first use of early help through a team around the child (TAC) was in the summer of 2013 when concerns about CSE were being identified and this broadly coincided with Jaiden's assault on another pupil that resulted in exclusion from school. Jaiden was a habitual user of cannabis.

98. With the benefit of hindsight, the significant earlier history had probably merited early help interventions such as through the common assessment framework (CAF). This falls outside the scope for this review for any detailed examination and it is acknowledged that at national and local levels there is a greater policy commitment to the benefit of early help. By the time that a preventative approach was tried in making the referral to YOS there was a reduced scope for Jaiden and family to engage. The purpose of the current early help framework is that children who may have indicators of vulnerability and additional need can be offered enhanced support along with their family at the earliest possible stage and is predicated on trying to offer help before difficulties become more entrenched or severe as they did in this case.

99. The permanent school exclusion in 2013 was a significant watershed for Jaiden. The decision to exclude Jaiden was reluctantly made by the school who had to balance the needs and safety of the victim who attended the same school and also take into account that the assault was very serious. Although there is no suggestion that the procedures applied in response to school attendance or to the assault were not legally compliant, there is scope to consider whether in responding to the behaviour of the pupil there was enough attention and capacity given to considering underlying factors for Jaiden's behaviour.

100. It is recognised that school attendance can improve for some pupils with the application of enforcement and behaviour management strategies. There are circumstances when the approach will not be effective when for example the circumstances of the pupil are more complex as in Jaiden's case. The point has already been made that the school were not aware of significant information about Jaiden. Although there were several different services in contact with Jaiden and the family, none were taking a lead responsibility and therefore people were largely working within professional silos.

3.3 Assessment

101. Up until March 2013 and the publication of the revised national guidance in *Working Together to Safeguard Children* all local authorities in England were expected to comply with a national framework for assessing children in need or at risk through a two stage assessment process that began with an initial assessment and could then be extended into a more detailed core

assessment when the needs of the child required more extensive involvement through specialist services such as a social worker.

102. From March 2013 it has been left to local areas to develop their own arrangements for the single assessment of children that should extend from early help through to statutory assessments associated with child protection plans, child in need or being looked after.

103. Jaiden was never the subject of a child protection plan but was looked after from spring 2014. Jaiden was a child in need prior to becoming looked after although it remains unclear whether this was ever explicitly agreed. There is an overlap on the local framework between children receiving help through a team around the child plan (TAC) and children who are definitely within the category of need and risk of statutory support.

104. This is not a matter of semantics. Legislation describes explicit arrangements and responsibilities in regard to children in need who are frequently at the cusp of being exposed to significant harm. They are a group of children where robust statutory assessment and plans need to be developed either to address preventable impairment of development or health or where there are vulnerabilities and adversities that could develop into risk of significant harm. It is also where statutory services are balancing and prioritising finite resources between children subject of child protection plans or are looked after alongside children in need who are not yet at that that threshold.

105. Jaiden was the subject of two initial assessments in 2001 which were in response to reports about domestic abuse via the police. Both of those assessments resulted in no further action. The reason for this is not analysed by this review as it falls outside the scoped timeline although it is acknowledged that the level of understanding about domestic abuse and the potential for harming children in the short and longer term should be better understood now than in 2001. The review is not in a position to make an evaluation of wider practice.

106. The initial assessment in June 2013 resulted in a TAC plan being recommended. The plan set objectives for Jaiden to attend school full time, that Jaiden would cease going missing from home, the family would agree times that Jaiden needed to be home by that Jaiden would meet with specialist substance misuse services and a referral was made to the MASE.

107. The other assessments that were completed were in regard to the risk of CSE and used a template developed by a specialist service and used across much of Greater Manchester until it was replaced by the current framework that was developed through *Project Phoenix* which was established across Greater Manchester in 2013 to coordinate and develop best practice in response to CSE.

108. The CSE checklist is not intended to provide a holistic and complete assessment of a child or young person's needs or circumstances. It was designed with the purpose of providing a single framework through which judgements can be made as to whether an individual child or young person is at low, medium or high risk of CSE. It is not a screening tool either in regard to CSE specifically or more generally in regard to need and risk to a child. The tool is used when professionals have evidence or information that could indicate a child or young person is at risk of CSE.

109. A score of 41-60 indicates high risk from CSE, 21-40 indicates a medium risk and 10-20 indicates low risk. The tool is intended to be completed by a specialist worker.

110. The tool is designed to support judgements about risk to a child or young person and also contributes to intelligence and data collation to assist in targeting interventions to identify and prosecute perpetrators and raise awareness and protection for particularly vulnerable groups or areas.

111. Unless it is explicitly understood that the CSE toolkit is not a holistic assessment of a child or a young person there is a risk of the tool being misapplied in supporting interventions beyond immediate risk assessment and its amelioration.

112. There are other factors that can contribute to potentially misleading judgements. The tool is susceptible to the cognitive and human bias of whoever is completing the assessment. In this case most of the CSE assessments placed Jaiden at the higher end of medium risk in regard to CSE. A CSE assessment in September 2013 scored Jaiden at 17 less than a month after another had scored 38.

113. Jaiden was a habitual user of cannabis; some reports say that Jaiden was using £20 worth of cannabis a day. Jaiden was also using other substances which were disclosed to specialist substance misuse practitioners.

114. Some gaps in information sharing reflected different ethics in regard to how sensitive disclosures about behaviours such as substance misuse are shared. The level of detail that is recorded by some individual substance misuse practitioners is not captured in the records of multi-agency discussion and formal documentation. Some specialist professionals particularly after Jaiden moved out of Stockport were not involved in the statutory planning and review arrangements for Jaiden. They were also working with very little history about Jaiden.

115. A comprehensive and holistic assessment should have been completed as part of the arrangements for Jaiden to be looked after. It was not although a Social Work Assessment was commenced on the 16th December 2013 and

used to inform decision making. A decision by the initial child protection conference in March 2014 decided not to implement a child protection plan. That decision was largely influenced by knowing that Jaiden was already looked after by the local authority and in itself is not an unreasonable decision although does not address the robustness or otherwise of the assessment or plan.

116. The referral to MASE was an acknowledgement that Jaiden was at risk and that action was required by local services to safeguard Jaiden. The MASE is not designed to provide detailed case management and is not a substitute for using the statutory framework for child protection, child in need or looked after arrangements. There were occasions when a referral to MASE was seen effectively as a substitute for conducting a strategy meeting or convening a child protection conference. It suggests that there was not a clear enough focus on ensuring that Jaiden was the focus of developing an individual plan that included securing a robust enough assessment and coordinated multi-agency work.

117. The reliance on the TAC left services such as the police along with primary services such as the GP outside any system of information sharing and planning. The TAC relied on a cohort of core professionals who for much of the time were reacting or ‘fire-fighting’ in response to incidents or information.

3.4 Missing from home

118. A child who goes missing from home or from a care placement is recognised as representing a significant safeguarding concern both in regards to the immediate circumstances under which the child left home as well as possibly being a signifier of other underlying factors. The police along with the social work services across Greater Manchester work to a framework of policy and protocols that have been significantly extended. This was already in-hand prior to the review and incorporates the recent learning from national and local work in regard to children going missing from home, care and/or education.

119. At the heart of the framework is a process for making informed and proportionate judgements in response to reports of missing from home which describe an escalation of response describing meetings and plans that will be initiated where a child or young person is persistently missing.

120. An important function of the meetings is to identify any push/pull factors associated with the incidents of going missing from home or care. Comment has already been made regarding the absence of information about some of the push/pull factors for Jaiden leaving home or placement. There is one reference to a trigger plan throughout the 47 episodes recorded during the time frame for the review.

3.5 Recognising disguised resistance and the use of constructive authority

121. Considerable effort was given to working with the consent and agreement of Jaiden's mother and father. Having the support and co-operation of significant family members in addressing the needs and risks of a child at risk of significant harm is a preferable position compared to a more authoritative strategy so long as the co-operation is not disguising the opposite.

122. The work of serious case reviews has consistently revealed the importance of professionals being able to distinguish between families who are genuinely engaged in a necessary process of change and intervention and those that are resistant to professional concern and interventions.

123. The evidence of research and from reviews of practice identify three broad types of uncooperative behaviour.

    a) Hostile and threatening behaviour; which produces damaging effects, physically or emotionally, in other people including professionals;
    b) Non-compliant behaviour; involves proactively sabotaging efforts to bring about change or alternatively passively disengaging;
    c) Disguised compliance (manifested as disguised resistance); involves significant adults in a child's parenting and care not admitting to their lack of commitment to change but working subversively to undermine the process.

124. The types of behaviour are not entirely or necessarily exclusive from each other in their use by resistant adults although the first two behaviours are more explicit and discernible. Accepting the need for change in response to concerns about significant harm to a child is often a complex journey. Tony Morrison (2006)[5] adapted Prochaska and Di Clemente's (1984)[6] model of change by describing seven sequential elements of motivation, which, he argued, are necessary for genuine and lasting change to begin:

    a) I accept there is a problem;
    b) I have some responsibility for the problem;
    c) I have some discomfort about the impact, not only on myself, but also on my children;
    d) I believe things must change;
    e) I can be part of the solution;
    f) I can make choices about how I address the issues;

---

[5] Morrison, T. (2006) *Staff supervision in social care: making a real difference for staff and service users,* third edn, Brighton: Pavilion.

[6] Prochaska, J.O. and DiClemente, C.C. (1984) *The transtheoretical approach: crossing traditional boundaries of therapy*, Homewood, IL: Dow Jones-Irwin.

g) I can see the first steps to making the change/can work with others to help me.

125. Father in particular remains unconvinced that Jaiden was at risk of CSE and felt that Jaiden's behaviour was within the boundaries of adolescent development. He also felt that he could counter and control any perceived threat by for example looking for Jaiden. He and mother were both particularly opposed to suggestions for Jaiden to be looked after and were not persuaded that working on parenting strategies for example was worthwhile. The history of domestic abuse, mental health and substance misuse had not featured with any great clarity in professional enquiries and work with Jaiden. The complications associated with perpetrator and victim behaviour where domestic abuse is a factor were not explored. The focus was often on Jaiden going missing, use of substances and aggressive behaviour.

126. Parental non-acceptance of the stages identified by Morrison produces different forms of resistance and, indeed, even parents within one household may respond differently to accusations of maltreatment. In several works, Bentovim (1987[7] and 2004[8]) argues that parents' failure to take responsibility for their children's maltreatment, their dismissal of the need for treatment, their failure to recognise their children's needs and the maintenance of insecure or ambivalent parent and child attachments are all key indicators of a poor prognosis in regard to a diagnosis that a child has or is at risk of significant harm.

127. To complicate matters considerably, parents may say that they accept the need for change, and can even appear motivated towards that end, whereas, in reality, they are actually opposed or indifferent.

128. Reluctance and resistance may surface, for example, when a parent is encouraged to develop new ways of relating to their children, when they feel threatened that their partners may be perceived to be risk factors in their lives or there are concerns about their capacity to exert sufficient appropriate influence to change and modify a child's behaviour.

129. They may retreat into 'disguised compliance', by only focusing on relatively 'safe' matters and may even subtly disrupt progress by being superficially 'co-operative, set unrealistic goals and then use them as an excuse for not moving forward….' (Egan 2002[9]). Equally, they may refuse to take part fully, either actively or passively, in an apparently though superficially agreed plan

---

[7] Bentovim, A., Elton, A. and Tranter, M. (1987) 'Prognosis for rehabilitation after abuse', Adoption and fostering, vol 11, no 1, pp 26–31.

[8] Bentovim, A. (2004*) 'Working with abusing families: general issues and a systemic perspective'*, Journal of family psychotherapy, vol 15, no 1/2, pp 119–135.

[9] Egan, G. (2002*) 'The skilled helper: a problem management and opportunity development approach to helping*', seventh edn, Pacific Grove, CA: Brooks/Cole.

of action, or as in this case when they feel there is no other option. Resentfully and belligerently appearing to sabotage interventions may, however, overshadow more powerful feelings of self-doubt. In this case there is evidence of the plans for Jaiden being the focus of a great deal of resistance and arguably were undermined on more than one occasion.

130. An additional explanation for parental reluctance or resistance is the possibility (or perception) that the professionals' assessment and involvement has included poor practice that can include inaccurate assessment, inadequate preparation, sporadic or episodic professional involvement or even disrespectful relationships. In this case mother and father could not describe where an assessment had been completed and they both felt that professionals had listened to what they regard as false accusations about drug use made by Jaiden.

131. An important foundation is first understanding the significance of parental resistance, recognising its manifestation, and having the ability to at least try to identify the source and nature of the resistance and then develop appropriate strategies.

132. As part of the process it is of course fundamental to understand who has legally defined status in relation to children. In this case father was assumed to have equal legal status to mother. It remains unclear to the author if that is the case[10]. Father was certainly regarded as having a parental relationship with Jaiden.

133. The issue of parental responsibility had particular significance in regard to the discussions about plans for Jaiden to be looked after by the local authority. Discussions about making arrangements for Jaiden to be looked after were first discussed in mid-February 2014 and were opposed persistently until Jaiden appeared in court in late March 2014 on public order offences and breach of a previous youth rehabilitation order.

134. Mother and father reluctantly agreed to Jaiden being placed with a foster carer outside of Stockport. They describe it as being given no choice by the professionals at the youth court.

135. The placement ended in late June 2014 much against the advice and judgement of children's social care services. They felt they had no choice other than to accede to Jaiden and mother and father's determination for Jaiden to return home because they had no share in parental responsibility for Jaiden. There had been several unplanned visits to home. Jaiden had been

---

[10] An unmarried father can only get legal responsibility for his child in one of three ways: jointly registering the birth of the child with the mother (from 1st December 2003), getting a parental responsibility agreement with the mother or getting a parental responsibility order from a court.

successfully attending a pupil referral unit (PRU) and engaging with a local specialist substance misuse service.

136. The return home lasted just over a month before Jaiden had again been summoned for breach of the youth rehabilitation order. The court remanded Jaiden into the care of the local authority. A local authority residence requirement was attached to the youth rehabilitation order which was to last until February 2015.

137. The local authority practitioners did consider using a public law outline procedure at the legal planning meeting held on the 18th February 2014. However it was concluded, following legal advice that Jaiden could be accommodated without care proceedings. However, given the reluctant agreement to Jaiden being placed with a foster carer it would have still been worthwhile considering what would happen if and when consent was withdrawn either in regard to the placement in general or on specific matters such as contact arrangements and returning to Stockport.

138. The value of the public law outline procedure is that it provides a structure for highlighting concerns about a child, encourages a discussion with adults who have the care and parental responsibility for the child about why the local authority is considering seeking more control and the steps that they plan to take. It should allow discussion about why a parent might be reluctant or unable to take required action and should emphasise that it is not a case of winning complete control or authority over a child but does give the local authority shared parental responsibility that it can then use to support plans in the interest of the child.

139. It is not apparent that the nature of parental resistance was fully understood, there was limited opportunity taken to identify the reasons for mother's and father's opposition to Jaiden becoming looked after. There was insufficient understanding about the push/pull factors that had an influence on Jaiden.

140. By choosing to use the youth court proceedings the local authority never achieved parental responsibility thereby limiting its legal powers to influence arrangements and left the mother and father resentful. However, it needs to be acknowledged that the professionals who felt that Jaiden needed to be looked after and away from Stockport achieved this objective at least in the short term.

141. The father continues to feel the placement was unnecessary and unhelpful. Mother has acknowledged that the foster carer provided good care of Jaiden and was able to support Jaiden in attending education.

3.6 Multi-agency working

142. Jaiden was the subject of more than 29 multi agency meetings between June 2013 and March 2015. Of these, nine were TAC meetings plus two others that were referred to as case planning meetings that were held when Jaiden was living at home and four were statutory looked after reviews. There were six discussions at the MASE and seven at the integrated placement and education panel. There was one child protection conference. There were additional meetings associated with school exclusion. There were also strategy discussions on at least two occasions between the police and children's social care services.

143. The recital of the number of formal meetings that discussed Jaiden illustrates the amount of discussion that was taking place. In addition there were many more contacts by telephone and email between the various core professionals. All of this represented a considerable logistical challenge to the social workers in particular who were servicing most of the meetings.

144. Many of the meetings were reacting to the latest incidents such as missing from home, being in breach of orders or agreements.

145. The meetings did not involve a consistent core membership. Some of this arose because of work reallocation but some of it also reflected different professionals being focussed on different aspects of Jaiden's circumstances as well as being in different geographical locations. Some involved participation by Jaiden and mother and father, others did not. Different information was discussed. None appeared to have a comprehensive overview of information or capacity to coordinate and had limited influence in the management of risk.

146. The decision by the child protection conference in March 2014 to not implement a child protection plan was largely predicated on the fact that Jaiden was looked after. The minutes of the conference refer to Jaiden being monitored through the TAC process rather than drawing particular attention to the statutory framework and requirements governing assessment, planning and reviewing arrangements for a looked after child or making an explicit statement about how risk was to be addressed. Discussion at the conference may have been more substantial than was captured in the written record.

147. The LAC reviews did not involve significant services who were in contact with Jaiden. This included the specialist substance misuse service. It did not re-engage any of the CAMHS professionals.

148. Important information remained hidden from multi agency discussion. The extent of substance misuse was not fully reflected in records of assessment and plans. Some specialist workers were not invited to meetings such as the looked after child reviews. Some specialist substance misuse workers discussed the dilemmas they felt in balancing complex duties and

responsibilities in regard to confidentiality, and encouraging a young person such as Jaiden to use the service and engage. The lack of progress made in involving CAMHS was not reflected in a multi-agency meeting's plan. The meetings under the missing from home processes were not incorporated into multi-agency TAC plans.

149. Jaiden's placement outside Stockport was made without alerting the local CSE team.

150. Jaiden's first period of care was supported with education provision from a PRU. The arrangement worked well but ended when Jaiden and family insisted on a return to Stockport in June 2014. When that arrangement broke down and Jaiden returned to the foster carer the placement at the PRU was no longer available. No other alternative were offered by the home local authority and it was left to the social worker to locate appropriate provision. This was not achieved for several weeks.

3.7 Use of team around the child (TAC) where children are at risk of significant harm

151. Since March 2013 local authorities have been responsible for developing their own single assessment arrangements for children. The revised arrangements abolished the distinction between initial and core assessments and put an emphasis on developing early help for children and young people requiring services.

152. Stockport in line with many other local authorities has a legacy of pathways that describe four levels of need and the corresponding frameworks of services intended to provide the most appropriate help. Level 1 describes universal services that move through escalating levels of need at 2 and 3 that are described as additional or complex needs and can be met through a TAC plan that under legacy arrangements would have been informed by the common assessment framework (CAF).

153. Level 4 is the highest level of intervention focused on children or young people at risk of significant harm and will require the involvement of specialist services such as a qualified local authority social worker. These are children and young people whose circumstances and needs come within the scope of section 17 or section 47 of the Children Act 1989 which define a child in need and describe particular responsibilities and duties that are supported through national guidance and secondary legislation for safeguarding children from significant harm.

154. The level of intervention can be escalated and de-escalated according to the changing circumstances of a child. For example a child with their family may be receiving help through a CAF/early help plan but the level of risk or actual

harm may require a referral and involvement of social work services through a child protection plan.

155. Conversely, it is good practice that when for example a child protection conference steps down a child protection plan that there are arrangements for continuing advice and help in place through a TAC. This is often referred to as a step down plan and reflects a de-escalation of involvement particularly from specialist and statutory services.

156. There are important distinctions underlying the different levels of intervention. The lower levels of intervention rely on an approach that puts families at the forefront of developing plans and carrying arrangements forward with the advice, help and support of appropriate people and services. In the event of families not having the capacity or motivation to take appropriate action, an escalation should signify a change in approach that sees a move to more assertive and authoritative involvement.

157. The underlying principles of the TAC (Team Around the Child) model are described in local procedures:

    a) The child's needs must come first;
    b) The child's welfare is everyone's responsibility;
    c) All organisations must work together for the benefit of the child;
    d) The parents'/carers' rights must be considered and inform the process;
    e) The TAC should be ‘owned’ and driven by the child and their parents/carers.

158. The TAC remained the preferred model for work with Jaiden and family up until Jaiden was placed with a foster carer in March 2014 and was then subject of looked after children legislation and regulations that prescribe planning and review arrangements. Most of the TAC plans from June 2013 recited similar objectives for Jaiden to remain in education fulltime and to cease going missing from home.

159. By February 2014 there was a clear difference of view between mother and father who were unconvinced about the level of risk to Jaiden and the view of professionals who increasingly were looking to alternative approaches involving the use of a placement outside Stockport. Neither Jaiden nor mother or father was willing to engage with CAMHS, substance misuse or sexual health services. Jaiden consistently breached the rehabilitation order.

160. CSE risk assessments that recorded significant risk to Jaiden were referred to the MASE who in turn relied on the TAC to monitor ongoing risk. The police were also using other powers such as serving child abduction notices on adults who Jaiden was associating with. The MASE meeting in February 2014 recommended that a child protection conference was not required as

an appropriate TAC was already in place. The TAC had been consistently unable to achieve any meaningful change or engagement.

161. When a child protection conference was convened Jaiden had already become looked after and therefore reliance was given to the LAC processes addressing the risk factors.

162. The decision not to escalate the intervention from a TAC meant that apart from through the MASE, the police were never parties to detailed discussion of risk and the development of plans for Jaiden. The use of TAC provided ambivalent messages to father and mother about the level of professionals concerns.

163. Giving a formal signal of moving to a child protection plan would have been a clear signal of intent and could have generated opportunities for all relevant agencies to be party to plans to address Jaiden's circumstances. The use of a child protection plan should also have prompted consideration as to whether the local authority had sufficient legal authority to carry forward the agreed plans for addressing risk in the face of ongoing parental opposition.

4 Analysis of key findings for learning and improvement

164. Any meaningful analysis of the complex human interactions and the decision making processes that are involved in multiagency work with vulnerable children and troubled families, needs to understand why things happen and the extent to which the local systems (people, work processes, organisational arrangements) help or hinder effective work locally within 'the tunnel'[11].

165. It is a cruel irony that significant progress was achieved especially after Jaiden returned to the foster care placement in August 2014. Jaiden was participating in education. Jaiden's use of alcohol and drugs was reduced and Jaiden was engaging with specialist services. Jaiden had already committed to remaining with the foster carer for several more months in order to make further progress. It is therefore appropriate to give credit to the care and skills that were demonstrated by many people in Stockport and elsewhere and to acknowledge the quality of care provided by the foster carer who was able to establish a relationship with Jaiden from the outset when Jaiden was at a very low point. The placement was achieved and supported through the co-operation of several different professionals who often went beyond the required standards and expectations.

166. The purpose of the review is to address learning. In that spirit there are aspects of this case that provide insight in regard to how professionals respond to older children at risk.

167. This chapter sets out the key findings designed to offer challenge and reflection for the local safeguarding children board and partners. A recommendation is made where a specific issue should be addressed through targeted and SMART action.

168. The key findings are framed using a systems based typology developed by SCIE to identify some of the underlying patterns that appear to be significant for wider local practice:

    a) Cognitive influence and human bias in processing information and observations;
    b) Family and professional contact and interaction;
    c) Responses to significant incidents and information;
    d) Tools and frameworks to support professional judgment and practice;

---

[11] View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people's assessments and actions, the review team try to attain the perspective of the people who were there at the time, their decisions were based on what they saw on the inside of the tunnel; not on what happens to be known today through the benefit of hindsight.

e) Management and agency to agency systems.

169. The remainder of this report aims to use this particular case to reflect on what this reveals about gaps or areas for further development in the local systems for vulnerable children and young people.

170. In providing the recommendations, reflections and challenges to the Stockport Safeguarding Children Board there is an expectation that there will be a formal response to the key findings in regard to the following:

a) An indication as to whether the Stockport Safeguarding Children Board accepts the findings;
b) Information as to how the Stockport Safeguarding Children Board will take any particular findings forward;
c) Information about who is best placed to lead on any particular activity;
d) An indication of the timescales for responding to the findings;
e) Information about how and when it will be reported.

171. The Stockport Safeguarding Children Board will determine how this information is managed and communicated to the relevant stakeholders. The formal response should form part of the publication of the serious case review.

4.1 Cognitive influence and human bias in processing information and observation

Perceiving standard safeguarding processes as suitable for responding to risk with older children; influence of differential and age related biases in processing significance of risk to older children; encouraging and developing opportunities for children to seek self-help; understanding barriers that prevent children accepting advice and help and why they turn to peers whom they feel will understand their circumstances; recognising and understanding resistance and the factors that contribute to resistant mind-sets and behaviour; identifying and understanding the significance of push/pull factors that influence child and adult behaviour;

172. There were complex influences in regard to how Jaiden's behaviour and interaction with other people was processed that reflected the multi-faceted nature of Jaiden's interaction with people at home, community and with professionals. This applied in regard to behaviour presented at school, the repeated incidents of missing from home, the use of alcohol and drugs, the use of violence and the sexually exploitative relationships.

173. Hindsight can seriously mislead in regards to what information should have been processed differently and more quickly at the time of the events happening but professionals generally were largely unaware of significant background and history and were often 'working in the moment'.

174. Some of this can be associated with an age related bias when professionals are processing information and observations about older children. It was manifested in the inconsistent grading of risk recorded in two different CSE assessments within weeks of each other. Adolescence can be regarded as a time of testing boundaries. They can be regarded as more resilient and capable of looking after themselves and taking responsibility and if they behave badly a common understanding is that as part of growing up they need to be held to account because they should know the consequences between different behaviours and they can exercise choice.

175. Although this is an important part of promoting appropriate socialisation with children and young people through them learning that there are consequences that arise from anti-social attitudes and behaviour, strategies that are primarily behaviour focussed are less likely to succeed if there are underlying needs and deficits to be addressed. It also misses an understanding that for some children who have cognitive deficits arising from their upbringing, environment or other factors, they will face greater problems processing the usual learning processes that work well enough for many children who have not had the level of adverse circumstances. It is for this reason that effective assessment is important as a method for understanding children and how they function in, and relate to, the environment around them.

176. Further complications arise when the young person is seen to be putting them self at risk and is exacerbating the likelihood of harm such as going missing or associating with adults who seek to exploit them or with peers who have anti-social lifestyles. Simplistically stated, this can be seen superficially as ‘wilful’ and ‘poor’ behaviour in the absence of any context. This assertion is not an argument for any behaviour to be acceptable or excused out-of-hand but rather inviting more careful reflection about how information is processed about children.

177. Jaiden’s behaviour triggered responses that were not successful enough in identifying various underlying factors which included Jaiden’s home circumstances or exploring how they had a cognitive impact. Jaiden disclosed clearer information after becoming looked after for the second time in September 2014 that provided a better insight about aspects of their behaviour. Push factors included the use of substances in the household, domestic abuse and pull factors that caused Jaiden to be so reluctant to be looked after which centred on concerns about the younger sibling.

178. Young people, particularly in adolescence, do not easily ask for help and are more likely to talk with their peers who they instinctively feel will understand them better. There were concerns that Jaiden was seeking out peers who had their own difficulties; some of this may have been Jaiden seeking out young people who might have a better insight about the problems that Jaiden was processing. An unintended consequence of Jaiden being permanently

excluded from school was a greater exposure to other young people who were also living with significant levels of vulnerability and social challenge.

179. Other cognitive factors related to the mind-set that developed in regard to father and mother. Although they were described as co-operating with professionals there is evidence that they had difficulty accepting the concerns that professionals had in regard to Jaiden. The discussion in February 2014 about moving Jaiden out of Stockport was resisted by father and mother. The basis of their resistance was not explored. They both described feeling that they were losing control and that they were being judged as being bad parents. This was an influential factor in their resistance to other suggested strategies such as parenting support. It was compounded by not acquiring a level of legal authority that could deal with the withdrawal of agreements for example in regard to the first placement with the foster carer.

4.2 Family and professional contact and interaction

Locating current events and information in longer term narratives about children's development; negative impact of judgmental intervention; use of authority; resistance disguised as compliance;

180. An initial assessment in July 2013 following a referral from school and centred on the immediate concerns about child sexual exploitation (CSE). A further assessment was completed in December 2013 by a trainee social worker who had experience in working with young people vulnerable to CSE. There were three CSE specific assessments. A third and final social work assessment was started in early 2015 although was not complete when Jaiden died.

181. The last assessment includes the greatest detail of family history which includes reference to drug use by father and the family having moved home on four occasions. The assessment does not include any information about domestic abuse.

182. The appraisal of practice in earlier parts of this report includes a summary of research in regard to resistant behaviour. A significant issue for father and mother was their sense of being the subject of judgemental advice and intervention.

183. Ferguson describes the importance of professionals having time to develop relationships with families in order to know what is really happening and also refers to professional practice needing to use 'good authority'[12]. It is an approach that seeks to know what is truly happening in a child's life, avoid a

---

[12] Ferguson, H. (2011) *Child Protection Practice*. Palgrave Macmillan.

dynamic of blame and display empathy and respect but are prepared to use their professional and legal authority when it is required.

184. Confident practitioners who are clear with families about their role, are able to demonstrate important qualities such as empathy and respect, and are honest about processes and can show a readiness to use processes when there is not an alternative are less likely to be accused of acting in bad faith.

185. An important example in this particular case was the manner in which the absence of agreement about Jaiden becoming looked after was never resolved. The plan was achieved by giving mother and father an ultimatum which left them resentful; the voluntary basis upon which the plan was predicated did not have the engagement of either adult and gave no greater legal powers to the local authority.

186. The reliance on a voluntary arrangement, in the face of continuing opposition from mother and father, to make the placement of Jaiden with a foster carer outside of Stockport limited the ability of the local authority in particular to exercise control over arrangements including contact and ultimately the return home. Credit is however given to the professionals who were party to the arrangements for Jaiden to be placed with a foster carer; they created a clear structure of supervision and activity that had not been achieved previously.

4.3 Responses to information and incidents

Children dealing with information that feels traumatic to them; missing from home; permanent exclusion being managed as risk to a child; confidentiality contributing to gaps in information sharing.

187. The escalation of concerns in 2013 coincided with Jaiden becoming aware that father was not the biological father. There was an absence of apparent curiosity among professionals about the significance of this information for Jaiden. Very little was recorded about the circumstances under which Jaiden became aware of it or about Jaiden's response to the information. Mother feels that it caused Jaiden to question all relationships within the family. The identification of significant men in children's lives is a recurring theme in serious case reviews.

188. The assault that led to Jaiden being permanently excluded was pre-meditated and involved prolonged coercion and control of the victim who was a little older than Jaiden. Although detailed work was undertaken by the YOS in preparing a pre-sentence report that involved consulting with other professionals it remained the only multi-agency assessment of record in regard to the circumstances of the offence. It has not been routine practice for a copy of such an assessment as conducted by YOS to be circulated with other relevant professionals. In the interest of avoiding unnecessary duplication and promoting good rigour, managers have discussed extending

the circulation of such assessments subject to any rules operating around court processes.

189. Similarly when the permanent exclusion took place which complied with legal and procedural standards and requirements, there was no explicit multi-agency assessment in response to the likely escalation of vulnerability with the withdrawal of the school placement. The school had represented an important source of support to Jaiden and father and mother both commented on the significance.

190. There was limited multi-agency assessment recorded in response to the instances of Jaiden going missing from home although were logged at meetings of the MASE and at TAC meetings. It is apparent that there were push and pull factors contributing to the incidents that were not clearly enough recognised. The implementation of revised arrangements that are being overseen by an operational manager is providing fresh impetus and rigour.

191. Some specialist practitioners discussed the dilemmas they face in working with children who are disclosing information such as substance misuse and sexual health. They express concerns that if children and young people did not feel they have absolute assurance about what will be done with information in regard to third party referrals to other services it will discourage young people to use those services. Similar dilemmas were raised in regard to counselling services operating in mainstream services such as school. Specialist substance misuse workers who were not notified about the LAC reviews were in receipt of information about Jaiden consuming alcohol, amphetamines, cannabis, cocaine and MDMA (ecstasy). The substance misuse had significance in terms of its association with CSE, the implications for Jaiden's mental and physical health.

192. Specialist workers will understand that the consumption of such a cocktail of substances has immediate and longer term implications for a young person. The LAC reviews do not record any information regarding the substance misuse or its significance as regards shorter and longer term risk to Jaiden's mental and physical health.

193. It was evident that for some parts of adult and children's specialist services, that there is a dilemma to share what is perceived to be confidential client information about issues such as substance misuse. Some of this reflects a concern that young vulnerable clients will withdraw or not use a service.

4.4 Tools to support professional judgment and decision making

Achieving appropriate levels of assessment that triangulates and has sufficient theoretically informed perspective; use of public law outline; clarity about use of TAC and MASE in cases of higher risk; use of child protection conferences and plans

194. The importance of assessment to identify the needs of children and the nature of vulnerability is a recurring theme in serious case reviews. National guidance encourages assessments to be dynamic and to be updated which analyses and responds to changing needs and risk. The same guidance refers specifically to circumstances where children become looked after; the assessment should be the baseline against which decisions in regard to children returning home should be evaluated.

195. The delegation of responsibility to local areas for developing assessment arrangements requires local determination about how this fundamental activity is now completed in local areas.

196. An effective child assessment can identify the significant people in the child's life and their relationships and the child's sources of security and support along with evidence of trauma such as the loss of a significant person or relationship. Tools such as ecomaps can be a useful in exploring the history of the individual child and of their family but there is no evidence of this in Jaiden's assessment. The narrative should be written as the child's story as much as possible and describe significant (good and bad) events and the impact it has had on the child including previous agency contact.

197. An effective assessment is not just the recording of a narrative account of concerns but provides an analytical examination of the respective areas of risk, the strengths of the child's family and the resilience of the child them self. There should be an understanding about the respective factors that can be an indicator of increased vulnerability alongside other factors that can be identified as potential sources of protection as they relate the child's developmental needs, the parenting capacity of relevant adults and the family and general environment.

198. In this case for example, the family were seen to be a protective factor without exploring and understanding enough about the sources of vulnerability in regard to issues such as substance misuse, crime, domestic abuse and mental health. This is not to say that they did not have any protective factors or that they did not care about Jaiden.

199. The quality and significance of the child's development, the identification of significant people (for good or otherwise) in the child's life and understanding the factors that have had an adverse effect on a child's development and behaviour need to be explored.

200. A starting point for the assessment has to be securing a sufficiently complete narrative about the history of the child and family which should include the personal history of significant adults taking responsibility for caring or parenting. There were gaps in the narrative for Jaiden that have already been commented upon.

201. The point has already been made that an assessment cannot just be a narrative. It requires professionals to analyse the significance of information that is collated (and the significance of any information that is not available or cannot be verified). In this case the revelation about Jaiden's paternity was significant. The nature of Jaiden's offence of assault was significant; Jaiden described it as being a loss of control although the facts suggest that it was not loss of control that was the driving factor. Jaiden's use of substances was also significant as contributing to risk, escalating or disinhibiting behaviour at critical moments and in regard to emotional and physical health.

202. Family history that includes substance misuse, domestic abuse and mental health are factors that will have significance for the development of a child. The quality and nature of attachment is significant in regard to implications for mental and physical health and contributing to cognitive functioning and decision making.

203. In developing an insight into the level and nature of risk there has to be an exploration of what protective factors or sources of resilience can be identified alongside the factors that indicate vulnerability for a child.

204. For example, research indicates that older children with good attachment, good self-esteem and a good relationship with a sibling combined with a higher IQ will indicate higher levels of resilience compared to another child. In this case the assessments do not reveal this sort of information and there are limited prompts for the practitioners to explore this within the template used for assessment.

205. Similarly, parental history of domestic abuse, significant substance misuse, chronic psychiatric illness, isolation, experience of being abused as child, were looked after and had multiple placements or are fearful of the stigma or suspicious of statutory contact are contra indicators to consider alongside protective factors that include positive social support, a positive parental childhood, good parental health (mental and physical), education including workplace qualification and stable employment. The assessments do not provide sufficient information on these factors and the template provides little prompting to do so.

206. Family and environmental factors that are significant in regard to indicators of vulnerability include a run-down neighbourhood, a poor relationship with school, poor social support, poverty and social isolation. The factors in regard to protection and resilience include a committed adult for the child, a good school experience, strong community and good services and support. The assessments do not provide sufficient information about these factors and the template provides little prompting to do so.

207. The formats for collating and presenting assessments need to encourage practitioners to develop both a sufficiently comprehensive narrative and to

also provide a structure for analysing the information. The point being made here is whether practitioners regard the type of assessment that was completed for Jaiden as the type that is expected by local arrangements and if so does it assist them in carrying out complex judgments and actions and help them make enough sense of how to most effectively help a child?

208. The use of assessment frameworks has been the subject of academic commentary and evidence suggesting that professional practice might be more prone to error under this type of 'apparatus'. The increased recording requirements introduced with the integrated care system and national assessment framework under a previous government and no longer a national arrangement, together with associated templates and timescales was widely seen as ill-suited to the task of complex work of safeguarding children, and could provide the latent conditions for error by encouraging premature categorisations or judgements.

209. The use of law is an essential part of social work practice. Understanding the circumstances under which a voluntary partnership between adults who have care responsibilities for a vulnerable child is not working effectively enough also demands professional confidence in knowing how to access and use the legal system. The legal gateway framework needs to be sufficiently understood by all social workers and supervisors. Professionals who have less contact with the court are inevitably going to be less confident about using the legal system.

210. A conundrum at the heart of the case is that although the MASE framework was used effectively to highlight risk factors in regard to CSE and there was evidence of multi-agency working through the TAC there were important areas of need and risk that were not well enough understood and Jaiden was never explicitly helped through the child in need or child protection frameworks.

211. The MASE was never designed to provide a mechanism for detailed case assessment and risk management. There may have been a degree of function creep in regard to both TAC and the MASE. Neither are frameworks for the management of individual cases involving risk of significant harm to a child.

4.5 Management and agency to agency systems

Assessment informing key practice and decision making; access to supervision in completing assessments; notification of vulnerable children placed in another area; supporting external placements including access to education; independent oversight and professional support on case management; importance of consistency for independent reviewing officer arrangements in regard to children's cases.

212. The absence of a recorded statutory assessment of Jaiden's circumstances during key periods of contact and intervention have been highlighted. It

limited the opportunity to develop better insights for the practitioners who were working with considerable determination to keep Jaiden safe.

213. Arguably, the decision to hold the case management of Jaiden's circumstances at the level of a TAC (team around the child) may have blurred the clearer distinction that Jaiden was a child in need and was also clearly a child at risk (in regard to the MASE discussions) and therefore should have triggered a statutory child assessment. The decision in early 2014 that Jaiden's needs could not be appropriately met whilst living at home was a clear moment when a statutory assessment should have been started.

214. The point that assessments were not worked on and do not feature more clearly in Jaiden's circumstances is not about procedural compliance or whether there is enough policy guidance. The more useful reflection is what value and purpose is given to the task of statutory assessment. Is it seen as completing templates of information or is it seen as a mechanism for collating and developing insights to support judgements and decision making? Do practitioners have the time and capacity to take on that type of professional task?

215. A similar point can be made about the templates that should be routinely completed by police and social care in regard to the incidents of children going missing from home and care. If systems are in place managers have to provide the leadership to their workforce in regard to the purpose and value and ensure that there is appropriate capacity to complete these professional tasks as well as the professional supervision and oversight.

216. The people providing direct support and supervision to practitioners working directly with children and families are crucial to the delivery of good services to children. The role of professional supervision is an important means by which social care practitioners in particular are able to develop sufficiently robust statutory child assessments. The supervision should provide the means by which the 'working out' of the assessment's analysis is checked and supports appropriate conclusions and recommendations that address the circumstances and needs of the child. Statutory child assessment is complex and demanding work and practitioners are often working with data and information that is opaque and often contradictory and families can seek to hide significant information especially if they fear the consequences of statutory services becoming aware.

217. Practice supervisors need to have the time and the emotional and cognitive capacity to ensure that practitioners are supported in achieving sufficiently rigorous assessments that are appropriate and proportionate to a child's circumstances. The task of practice supervision needs to offer challenge and reflection and be informed by a framework. Supervision needs to be able to evaluate whether a child's assessment is coherent in telling the child's story in enough detail and whether it provides sufficient analysis about the needs

of the child as well as risk they are exposed to from external factors as well as from their own behaviour and interaction.

218. Supervisors need to be able to confirm that evidence has been triangulated in enough detail through observation, collating what is declared or reported by the adult and checking history/third party information to highlight significant consistencies and contradictions for example for the purpose of analytical insight and understanding. Supervisors should be able to confirm and provide evidence that the assessment contains clear enough conclusions and judgments about what needs to change in regard to the child's circumstances.

219. The assessment should be able to show proper reasoning of all relevant factors and that the assessment has given each appropriate weight and attention. The assessment supervisor needs to be able to consider the reliability and alternatives about any views and or contradictory or opaque evidence. Supervision should check that there is enough evidence of consulting the child, any relevant adults with a significant relationship as well as having input from other professionals. The assessment should consider any areas where there is disagreement for example between professionals and a parent. If a plan is reliant on co-operation it is important to establish the extent to which this is sufficient in achieving outcomes for the child and also to consider how factors such as disguised resistance have been examined and taken into account. The assessment should acknowledge any lack of experience or expertise and its impact on the assessment.

220. The assessment supervision should acknowledge any factors that have influenced the quality of the assessment such as workload or access to specialist or other advice. The assessment supervision should acknowledge the lack of any information from the family or from a relevant third party and its impact on the assessment. The assessment supervision should be clear as to whether any conclusion is provisional and if so, can it identify what is required to make it final such as access to any further expert advice or legal advice.

221. The notification of Jaiden being placed in another area did not notify the local CSE team. The routine notifications to statutory agencies were completed and the CSE team is a multiagency police and local authority service. There was also a lack of clarity about arrangements for Jaiden accessing specialist substance misuse services in regard to involvement in LAC reviewing. The social worker completed all the relevant movement forms and therefore it appears that a check on the expectations and requirements of respective systems is what is required rather than regarding this as any individual failing to do their job adequately.

222. Changes in regard to missing from home arrangements have been highlighted in the report. Other changes made by the police ensure that where child

sexual exploitation is a factor that the level of risk is graded high and is managed with a commensurate level of priority through the use of gold meetings.

223. When Jaiden returned to the foster care placement in August 2014 there was no longer a place at the pupil referral unit and Stockport were advised there were no education placements available. It was left to the social worker and their manager to seek out alternative arrangements.

224. The arrangements for children to be looked after by the local authority is subject of primary legislation supported by regulations and statutory guidance. The principle source of guidance is *The Children Act 1989 guidance and regulations Volume 2: care planning, placement and case review.*

225. In regard to children placed out of authority the guidance refers to the role of the nominated officer ensuring arrangements meet the needs of the child and also describes the particular role of the Virtual School Head and of specialist health professionals such as the designated nurse for looked after children.

226. The issues highlighted in regard to the notification regarding CSE and the gaps in coordinating education and specialist substance advice and support indicate that an audit of current policy and practice in regard to out of area placements is completed against the relevant national legislation and guidance.

227. The value of ensuring consistency in respect of the independent reviewing officer is already recognised in local as well as national standards. In this case, the allocation of Jaiden's placement was through a duty IRO system. The allocation occurred when one officer had left the service and there was a reallocation of workload responsibilities for other officers. The manager of the service is confident that the more usual capacity of the service ensures that children have a consistent independent reviewing officer allocated.

228. The allocation of an independent reviewing officer when a child is looked after is the subject of detailed regulations and guidance. At the heart of the statutory arrangements is ensuring that the independent reviewing officer is in a position to challenge as well as to support the work of professionals responsible for the ongoing case management. This includes consulting the independent reviewing officer in the event of significant new developments or a need to significantly change a plan agreed at a review for example. In this case, partly perhaps because of the reallocation when Jaiden was looked after for a second time there was not the level of consultation with the reviewing officer that is required in regulation and guidance.

229. The logistics of co-ordinating large multi-agency teams of professionals working with a child and their family are highlighted in this review. There are

several examples of individual professionals seeking contact with other relevant people and there was a good level of contact by email, telephone as well as in formal and semi-formal meetings. Services such as YOS worked to provide continuity alongside other staff. The work of individual specialist practitioners presented some with dilemmas in how to first all achieve engagement with older children and to also be in a position to share significant information for the purpose of highlighting risk.

4.6 Issues for the Stockport Safeguarding Children Board to consider in regard to learning and improvement

230. Individual services will use the review as an opportunity to examine other aspects of policy, practice or processes in responding to vulnerable children and will be implementing action plans that will be monitored by a sub-group of the Stockport Safeguarding Children Board.

4.7 Recommendations

1. The Stockport Safeguarding Children Board should ensure that the systems for notifying another local area about a child being placed in to their district includes information about specific issues of vulnerability associated with child sexual exploitation and that any specialist services such as child exploitation teams are alerted.

2. The Stockport Safeguarding Children Board should ensure, through the Director of Children's Services, that the regional strategic lead officers for vulnerable children discuss the adequacy of reciprocal arrangements between local authorities in Greater Manchester for the placement of children between areas. (This is to clarify the extent to which they explicitly address the provision of educational, health and relevant specialist services in compliance with relevant regulation and national guidance and the role of nominated officers and Virtual School Heads in each area). The Director of Children's Services should report back to the Stockport Safeguarding Children Board.

3. The Stockport Safeguarding Children Board should consider whether further work is required on ensuring that any child referred to the MASE has their circumstances case managed at appropriate thresholds within the local levels of need policy document and the associated assessment framework.

4. The Stockport Safeguarding Children Board should refer this overview report to the relevant subgroup to confirm whether or not any further changes are required in regard to the revised protocols for children missing from care, home and/or education. This should also include consideration of the work by the secondary panel for inclusion.

5. The Stockport Safeguarding Children Board, in consultation with the Director of Children's Services should consider whether there is learning and improvement to be applied to local arrangements for the assessment of children in need, at risk or looked after and its relationship with arrangements for early help and MASE.

6. The Stockport Safeguarding Children Board should consider if further work on the application and understanding of confidentiality and information sharing protocols is indicated by the findings of this review.

231. The following challenges invite further consideration by the Stockport Safeguarding Children Board to determine if any further learning and improvement is required.

   1. What additional learning can be developed in regard to:
      a) the issues of disguised resistance;
      b) the application and use of the public law outline;
      c) responding to the non-engagement of families and the associated closure of professional involvement; and
      d) ensuring that the role of independent reviewing officers is fully recognised in monitoring the performance of the local authority in regard to children who are subject of statutory reviews or child protection conferences.

4.8 Issues for national policy

232. The serious case review has identified the following issues relating to national guidance, policy and professional frameworks.

   1. Local areas ensuring that children being placed by another local authority are provided with suitable services that include education and health.

5 Appendix Professionals who participated in group discussions

Substance Misuse Worker	Bridgewater Community Healthcare
Specialist Drug Support Worker, Mosaic	Stockport Integrated Children's Service
Social Work Treatment Team, Mosaic	Stockport Integrated Children's Service
Mental Health Practitioner, Youth Offending Service	Stockport Integrated Children's Service
Service Manager Specialist Service	Pennine Care NHS Foundation Trust
Drug Worker Specialist Service	Pennine Care NHS Foundation Trust
Teaching and Learning Coordinator, Virtual School	Stockport Integrated Children's Service
Manager, Services for Young People	Stockport Integrated Children's Service
Head teacher x 2	Two schools
Team Manager	Bolton EXIT Team
Social Worker	Stockport Children's Social Care
Social Worker	Stockport Children's Social Care
Social Worker	Stockport Children's Social Care
Team Manager	Stockport Children's Social Care
Senior Nurse Adolescent Health	Bolton NHS Foundation Trust
YOS Officer, Youth Offending Service	Stockport Integrated Children's Service
Independent Reviewing Officer	Stockport Safeguarding Children Unit
Independent Reviewing Officer	Stockport Safeguarding Children Unit
Independent Reviewing Officer	Stockport Safeguarding Children Unit
Quality Manager	Parallel Parents
Foster Care Development Worker	Parallel Parents
Registered Manager	Parallel Parents
Support Worker	Parallel Parents
Foster Care Development Manager & Area Manager	Parallel Parents
Foster Carer	Parallel Parents