Leyla's Story

- Learning from Experience

Lessons Learned from a Serious Case Review

Background to Report

In 2015, and whilst in the care of Sandwell Metropolitan Borough Council, Leyla[1] was seriously assaulted by a male perpetrator, who was subsequently arrested, charged and convicted.
At the time of this incident, Leyla was 12 years old.

The family came to increased notice early in 2013 following concerns about Leyla's older sibling's deteriorating relationship with their mother, Catherine[2]. Some 'Early Help' initial work was done with the family, but Leyla came to be voluntarily accommodated under Section 20 of the Children Act in March 2014 after assaulting her mother and siblings. There were a number of returns to the family environment and subsequent returns to the care of the local authority as relationships with their mother broke down.

In late 2014, information from school was received about Leyla which resulted in a multi-agency sexual exploitation (MASE) meeting being convened in respect of the child sexual exploitation (CSE) risks. Due to Leyla's continued association with inappropriate individuals, periods of going missing, Looked After status and other risk factors, they were deemed to be at high risk of CSE. A further referral to Children Social Care (CSC) was made early in 2015 regarding inappropriate behaviour. This was due to text messages of an inappropriate nature uncovered on Leyla's phone from an adult male known to the family. Following this, all three children were made subject to Child Protection Plans.
Leyla has been in Local Authority care consistently since 2015 and remained in care until early 2018.

A Serious Case Review was completed in September 2017 on behalf of Sandwell Safeguarding Children Board (SSCB) following the serious incident in 2015 involving Leyla.
The 2017 Review report listed the key events in the case and gave a series of recommendations based on documents relating to the case and information gathered from a Practitioners' Event in October 2016. Recommendations from the report and response to these recommendations can be found at the end of this briefing.

[1] *Leyla* and *Catherine* are pseudonyms chosen by them to protect their identity for publication
[2] See above

Learning points highlighted within the report are:

a) *Holistic assessment including all family members is required to provide an effective package of care.*
b) *The need for parenting assessments should be considered*
c) *Good record keeping is important to ensure good information sharing within the multi-agency team.*
d) *Regular supervision and support regarding case management for frontline staff is important to ensure high quality care.*
e) *Thresholds must be understood and consistently applied by all practitioners.*
f) *It is important to ensure good quality PEPs are included in LAC plans for children and young people.*
g) *Professionals should ensure that the voice of the child is obtained and clearly recorded in records and plans.*

The 2017 report did not, however, include the thoughts, wishes and feelings of Leyla or her mother, Catherine who were the key subjects of the report.

A Consultant Clinical Psychologist was commissioned to gather these thoughts and experiences to enable practitioners to learn what it feels like to be a child going through the social care system.

The consultant stated that:

"It is clear to me on reading the Serious Case Review that it should have from the outset included the views and feelings of *Leyla* and her mother and been written with a view to publication. The Serious Case Review itself points to the importance of listening to the voice of the child and yet does not bring this voice to the review process. Involving *Leyla* in this way had the potential to be extremely validating particularly in view of her expressed view (upon discharge from the CAMH service) that "no one is bothering with her" (Social Worker report, 11th January 2018).'

In agreement with Leyla, her family and safeguarding professionals, Sandwell Safeguarding Children Board has made the decision not to publish the 2017 report due to possible identification of Leyla or her family and the risks associated with this. However, after consulting with Leyla and her Mum, who were keen that agencies learned from their experiences, the following learning brief has been produced and will be used in further training.

'Please listen to me so that it doesn't happen to anyone else' **(*Leyla's Voice*)**

My learning points are:

- ***Involve Me***
- ***Understand Me***
- ***Don't Judge Me***
- ***Too Many Meetings and Plans***

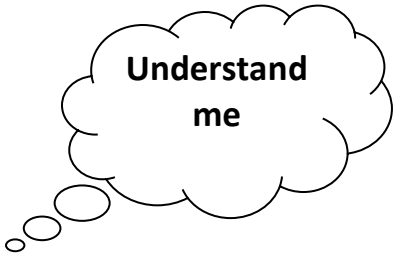
Leyla has said repeatedly that social workers involved in her care "never ever listened". In many ways she was trying to be heard through actions. Running away from placements was her way of communicating in the absence of having a formal voice in the decisions made about her.

Leyla recalls Looked After Children (LAC) Reviews as being forums where people "just made decisions for me". She did not feel involved and wonders if they chose not to involve her "because they probably thought I'd make stupid decisions".

Having a trusted friend or professional alongside her in such assessments and LAC Reviews would have made a positive difference and helped her to build trust in professionals.

Leyla and her mother feel the qualities needed to engender trust are:

- Being responsive
- Sorting things
- Actively listening
- Giving feedback
- Communicating clearly
- Don't make assumptions



Leyla and her mother believe had there been attempts to understand and involve them earlier, there could have been more helpful intervention.

"people jumped to conclusions…no-one asked me".

Leyla is clear that the main motivation for her seeking contact with others was due to loneliness, not because she was looking to be loved which is what she felt was "assumed" about her. This added to the already strong experience she had of people "**putting words into my mouth**" which led her to disengage further from the services being offered.

During early contact with CAMHS Catherine was told that Leyla, then aged 11, was presenting with "attachment disorder", they did not understand what this meant.

Catherine, instead of feeling helped by the diagnosis, recalls feeling judged and understood it to mean that "I didn't pick her (Leyla) up enough". It is important that when talking to children and families that assumptions around understanding are not made.

The Serious Case Review refers to Catherine disengaging from services. Catherine's view is that she "kept everything to (her)self" because she felt blamed and judged. She had a long struggle as a victim of domestic violence but does not think that this was ever considered in any meaningful way.

Catherine's experience of Children's Services at the time was that this was not considered and no help was offered to her in understanding and dealing with this. An offer of joint work with them both would have helped them to understand and repair their already fragile attachment relationship.

"They just come in, deal with what's going on, and go again".

In addition to not feeling involved in meetings about her, Leyla was clear that her contact with services led to "too many meetings" and little understanding on her part about the purpose of each meeting. She was "part of" (yet feeling not included in) LAC Health Assessments, LAC Reviews, School meetings, MASE meetings and CSE meetings to name but a few.

"there were so many different plans…they always changed. One minute I was going home, next I wasn't…so I just gave up and went along with it"

Catherine echoed this, saying:

"they used to tell her one thing…then move the goal posts the next day. She was passed from pillar to post".

Conclusion

Perhaps the most notable feature of Leyla's story as told through others' eyes is the marked absence of Leyla herself.

Leyla and Catherine feel sure that had there been earlier attempts to involve them both in ways that took account of both of their attachment insecurities and mistrust of professional systems, the outcome for them both could have been different. Leyla was left to "act out" her feelings through behaviour that became something to be managed rather than understood. Leyla feels strongly that she was seeking relief from feelings of desperation and loneliness through the very behaviours which then brought her harm.

Of note is that Leyla and Catherine are now recovering, and this process has been able to happen through the establishment of a key trusting relationship, that is the relationship with her personal advisor.

Leyla has articulated clearly that had she been able to access such a relationship and support earlier her outcomes may have been different.

Trust and active involvement require all of us who work to help children to "do with" rather than "do to".

For Leyla and Catherine this is hopefully the beginning of a different journey where they are active in their own stories and where they are partners and collaborators in a healing process.

Partners engaged with this further process have benefited from working in a different way with Leyla resulting in future to ensuring that the child's voice and experiences are at the forefront of their work.

Recommendations from the 2017 report and assurance from Children's Services on improvements that were made within the service following the original concern are listed below:

The service position updates below relate to progress made by October 2017 following the immediate response to this case. Further progress has been made since 2017 and the recommendations and learning from this case continue to inform ongoing improvements to services.

Recommendation 1: regular dip sample audits of LAC cases should be undertaken by LAC team managers to ensure good record keeping and planning is in place for individual cases.

Response and service position – Children and Families Service now undertakes a monthly audit cycle (which includes LAC TMs) and one third of the cases chosen for audit are LAC. The audit tool used by the service covers record keeping and planning for children.

Recommendation 2: The Corporate Parenting Board receive assurance that relevant background information about the child is available from the social worker when a LAC health assessment is undertaken.

Response and service position – The LAC Health Nurse chairs the Corporate Parenting Board Health and Wellbeing work stream, which is attended by the Group Head for LAC and the Group Head for Placements Provision. This work stream ensures that Health Assessment performance for children is discussed in detail. This includes how improvements can be made for LAC across the partnership. The service work collaboratively to hold a LAC Health surgery in the LAC Teams so individual children's health can be tracked, and where a child has a Health Care Plan, advice is offered to SWs to make sure that the children receive the right health support at the right time. In addition, the service has put in place a weekly meeting between LAC Health and LAC Business Support to ensure that all children who require health assessment, have one. This also ensures that consent is sought, and children's information is available for the health assessment appointment.

Recommendation 3: SSCB is assured that there is a clear care pathway for CAMHS support for children and young people with mental health needs placed outside the borough.

Response and service position - The Group Head for Placements Provision is working jointly with CAMHS on the s117 joint response to children who need CAMHS support. The s.117 agreement will include out of borough children.

Recommendation 4: SSCB is assured that systems are available to enable practitioners to demonstrate how CSE risks have been reduced.

Response and service position – the service have in place the CSE screening tool and risk assessment which enables practitioners to evidence how risk is being reduced for children. MASE meetings and minutes also evidence either reduced or heightened risk. There is a CSE workspace to ensure that collective themes and individuals are known and that this is considered at MASE meetings. The service improvement plan includes ensuring that the CSE issues identified at MASE meetings are seamlessly joined with the overall care plan for the child.

Recommendation 5: Assurance is received that the quality of out of area missing interviews for Looked After Children is of the same high level as those for in borough cases.

Response and service position – there is a process in place to manage the out of borough (OOB) children and their missing return interviews. The service improvement plan includes making sure that the process for OOB children is complied with, return interviews taking place, and accurate data being available. The service plan also includes ensuring that missing episodes are routinely being evidenced in the child's chronology.

Recommendation 6: A report on plans to improve placement options should be received by the Corporate Parenting Board.

Response and service position – This report 'Placement Strategy 2017 to 2020' is completed and includes placement options for children. This report will go to the Corporate Parenting Board on 30-10-17.

Recommendation 7: A report on plans to recruit, train and support local foster carers is received by the Corporate Parenting Board.

Response and service position – The service has in place a Fostering Marketing Plan for 2017 to 2018. The Plan outlines the approach to recruit, train and support additional foster carers in Sandwell and is underpinned by the LAC Placement Strategy. The Corporate Parenting Board (CPB) already receives quarterly data to consider in relation to children placed in foster care, and there is a plan for the Annual Fostering Report to be a future agenda item at the CPB.