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Child Safeguarding Practice Review

Charlie

REVIEW REPORT

**Agreed by the Pan-Dorset Safeguarding
Children Partnership on 1st February 2023,
Published 23rd May 2023**

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1 Introduction to the case and summary of the learning from this review

- 1.1 This Child Safeguarding Practice Review (CSPR) is in respect of an 18-year-old adult to be known as Charlie. Charlie was diagnosed with High Functioning Autism¹ and “likely” to meet the Generalised Anxiety Disorder² criteria in March 2015 by a Private Psychologist. Although this review focuses on Charlie’s life between October 2019 - February 2022 when Charlie was a child and transitioning to adult services, it will also provide a background of information known before the scoped period.
- 1.2 The learning identified from this review includes:
- Children and young people who have a primary diagnosis of autism who also have significant and complex care needs
 - Children and young people transitioning from children to adult-focused services.
 - Legal Planning for children and young people with disabilities and complex needs.
 - Children and young people who display a rapid deterioration in interaction with others.

2 Process

- 2.1 The Pan Dorset Safeguarding Children Partnership (PDSCP) recognised the potential to learn lessons from this review regarding the way that agencies work together to safeguard children³. It was agreed that this CSPR would be undertaken using a systems theory methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time avoiding hindsight bias. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the learning from the case within their agency. Then practitioners, managers and agency safeguarding leads come together for learning events. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the events⁴. Further interviews were arranged when issues requiring clarification were identified.

¹ High-functioning autism generally refers to autistic people who have significantly developed language and independent living skills. What is high-functioning autism? Medical News Today reviewed by N Greene, PsyD — By Z Villines — Updated on October 31, 2021

² Generalized anxiety disorder is a persistent state of heightened anxiety and apprehension characterized by excessive worrying, fear, and dread. Generalized Anxiety Disorder in Children and Adolescents. By J Elia, MD, Nemours/A.I. DuPont Hospital for Children Last full review/revision Apr 2021 | Content last modified Sep 2022

³ The Chair of the PDSCP agreed the CSPR following a Rapid Review and advice from the National Panel, the lead reviewer was appointed, the terms of reference were agreed, agency reports were requested, and two events were held to engage with staff in October and November 2022. The reviewer is Robin Harper-Coulson, an independent safeguarding consultant. He is independent of PDSCP and its partner agencies.

⁴ The same group then came together again to study and debate the first draft of the CSPR report. Later drafts are also commented on by all of those involved and making a vital contribution to the learning and conclusions of the review

- 2.2 It was agreed that the CSPR would consider in detail the period from October 2019 up until February 2022. Detailed family information will not be disclosed in this report⁵, only the information that is relevant to the learning established during this review.
- 2.3 Family engagement is required within the systems model of review. However, in this review, this was not initially seen as appropriate due to ongoing legal intervention. This situation changed following advice from Adult Social Care and Mother was informed of the review and invited to contribute to its findings. However, the legal processes may delay publication. It is important that this learning can be embedded before publication. Following advice from organisations involved in the case the planned conversations with Charlie did not take place, as Charlie was assessed as not having capacity and may have been distressed by any planned attempts at communicating.
- 2.4 The PDSCP Business Manager and reviewer met with Charlie's Mother and she was reassured PDSCP were providing confidentiality to her family by protecting Charlie's and the family's identity. She was also able to share her views on Charlie and wanted the reader to be aware that Charlie was a young adult with a logical mind, interests and a good sense of humour, not just a case or subject. Charlie, she believes has very controlling behaviour and has mental health needs, although the focus has been primarily on Charlie's learning needs. Mother also commented that Charlie does not cope well with change and this is why the late deterioration occurred moving from primary to secondary education.

3 Family structure

- 3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Charlie
Mother of Charlie	Mother
Father of Charlie	Father
Siblings of Charlie	Siblings

- 3.2 To protect the families and Charlie's identity a non-binary name has been used as an alias, with titles used for the family relationships and no geographical locations identified within the Bournemouth, Christchurch and Poole (BCP) boundaries.

4 The background before the scoped period

- 4.1 Concerns were first raised about Charlie's presentation at the age of eleven by Education following a Professionals Meeting. Charlie had been absent from school due to laryngitis for two weeks. It is reported by Education that Charlie returned to primary education following a rapid deterioration with a noticeable change in Charlie's presentation. When meeting Mother at the school gate, Charlie's behaviour changed to not verbalising words and being unable to walk and needing their Mother to assist walking. Charlie was observed placing themselves in one of Mother's child-minding pushchairs as they were having difficulty walking. The discrepancies between the school's assessment of Charlie and to Mother's assessment of Charlie were striking. Discussions with the Local Authority Designated Officer (LADO) took place due to Mother being a child minder. Mother shortly after closed her child-minding business. At this time an early help assessment should have been considered.
- 4.2 When Charlie moved to High School on a part-time basis, they noted no significant concerns. This was contrary to what Mother was reporting regarding Charlie's presentation and behaviour at home. Charlie was seen by a Paediatric Neurologist in 2016 for an MRI and this confirmed that no neurological

⁵ Statutory Guidance expects full publication of CSPR reports, unless there are serious reasons why this would not be appropriate, If they consider it inappropriate to publish the report, they must publish any information about the improvements that could be made following the review.

abnormality was found, although there were some changes these were not seen as of consequence. The MRI was repeated in 2019 and the same findings were reported.

- 4.3 In 2016, a professionals meeting took place and it was reported that Charlie was being neglected and had regressed in their behaviour and started to show traits of obsessive-compulsive disorder (OCD) and ritualistic behaviour. Charlie was said to be soiling at home, but the school saw no evidence of this. Charlie's Mother appeared not to be utilising the support on offer and was said to be encouraging dependency of Charlie on herself. It was reported that Charlie's Mother was not supporting Charlie to attend education. Charlie was reported in school as softly spoken and described as timid; however, Charlie was able to engage with peers and teachers and move independently around the school.
- 4.4 Charlie's mother commented that one key area that she believed would have improved the service's involvement with Charlie, was the knowledge professionals had about autism and how to best manage this. She was very clear that Charlie had shutdowns where this lack of knowledge in her view caused a misinterpretation of her actions and Charlie's development.
- 4.5 In February 2017 reports of extensive historical domestic abuse by Father against Mother were made. Father had assaulted Mother after consuming large amounts of alcohol. Charlie and their siblings were made the subject of CP plans. Mother commented that this had an impact on Charlie's functioning, with comments at the time such as Daddy's drunk and Daddy's noisy. Mother said Charlie was scared by the noise. Mother undertook the Freedom Programme⁶, and stated she should have left Charlie's father much earlier.
- 4.6 On 1 April 2019, the BCP Councils merged into a single Unitary Authority. Followed within 6 months by a merger of the two NHS Trusts that managed Poole Hospital and the Royal Bournemouth and Christchurch Hospitals forming University Hospitals Dorset NHS Foundation Trust (UHD). These complex re-organisations and restructuring of services Charlie was accessing were described by the professionals at the learning event as significant to the learning for this review.

5 Key episodes

- 5.1 The time under review has been divided into three 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family.
- 5.2 As the episodes are key from a practice perspective rather than to the history of the child, they will not form a complete history, but will summarise the relevant activities that occurred, and are a brief outline of the information that informed the review.

Key episodes ⁷
1. From 30 June 2019, before re-referral to 20 April 2020 when the Hospital-based residential assessment unit ⁸ (Residential Unit 1) closed because of the Covid-19 pandemic
2. From the 21 April 2020 when a Review Child Protection Conference was held, Charlie continued to remain on a Child Protection Plan, to the 28 April 2021 agreement to apply to the Court of Protection (CoP)
3. From 30 July 2021 application to the CoP and subsequent delays until February 2022, when Charlie was admitted to the hospital

⁶ <https://www.freedomprogramme.co.uk/> The Freedom Programme examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help them to make sense of and understand what has happened to them, instead of the whole experience just feeling like a horrible mess. The Freedom Programme also describes in detail how children are affected by being exposed to this kind of abuse and very importantly how their lives are improved when the abuse is removed.

⁷ The impact of covid will be a theme throughout

⁸ Residential Unit 1 provides a homely and welcoming environment in order to support, care and manage children's physical, psychological, educational and social needs from the ages of 0 to 16 years.

Key episode 1: (30 June 2019, before re-referral to 20 April 2020 when the Hospital-based residential assessment unit (Residential Unit 1) closed because of the Covid-19 pandemic)

- 5.1 On 19 June 2019, an interagency referral was made to Children's Social Care (CSC) by the Child and Adolescent Mental Health Services (CAMHS) within Dorset Healthcare University NHS Foundation Trust (DHCUT)⁹ due to concerns about Charlie's declining presentation. By August 2019 the situation had deteriorated to Charlie receiving personal care from their Mother whilst asleep. CAMHS professionals wanted to assess Charlie's needs away from the family home in Residential Unit 1 as it had in-house services such as psychiatrists, psychologists, clinical staff, and education provisions, Mother did not consent to this move as she believed that this would neither meet Charlie's needs or interests. In September 2019 Special educational needs and disabilities (SEND) team recorded that Mother agreed for Charlie to be admitted to Residential Unit 1 for assessment. Within 3 days SEND received a request to Electively Home Educate (EHE) Charlie from Mother. CAMHS advised they could not support the request to EHE Charlie, as EHE would add further pressure to the family. The admission to Residential Unit 1 did not progress as Mother did not want Charlie to be admitted to Residential Unit 1. She commented she wanted to try CSC interventions first. There should have been a consideration of early help at this stage to provide support to Charlie, siblings and family.
- 5.2 On 1 December 2019, a BCP CSC Practice Audit was undertaken which identified that there was a delay in the case being allocated. On 24 December the case was transferred to an SW in the CHAD¹⁰ team. The SW's role was specific to supporting Charlie and the family with Charlie's disability-related needs and supporting the transition to Residential Unit 1. Mother stated she did not consider the placement necessary. The CHAD SW visited the family home for the first time on 9 January 2020 and escalated concerns immediately, including that Charlie would spend days in the lounge under a blanket, Charlie was not attending school or having social interactions, and sitting in soiled clothes. Charlie was reliant on Mother and had not been out of the family home since August 2019.
- 5.3 In January 2020, the Police received allegations of sexual abuse from siblings in different Police areas. This led to an Initial Child Protection Conference (ICPC) and the arrest of the Father. The criminal action threshold for the prosecution was not met so there was no further Police action. Father moved out of the family home and Mother later disclosed further historic domestic violence and did not exclude the possibility of Charlie being sexually abused by father. A CHAD Family Practitioner (FP), started working with Charlie and the family (two or three times weekly) to build relationships and seek to support Charlie to engage to seek an understanding of Charlie's wishes and feelings. There was unanimous agreement that Charlie should be placed on a CPP under the category of Neglect, as there were concerns that Charlie's lifestyle is limited and they are not getting the social interaction or personal care that is required. There was recognition from the Independent Reviewing Officer (IRO) that an *'effort has been made to try and capture the child's lived experience but that this has been difficult due to the level of communication and the child's presentation. Capturing the child's voice has proved to be difficult in this situation'*. Charlie's Parents did not attend this conference, but received the minutes. Some key professionals from UHD were also not in attendance, including Safeguarding Children NHS Team named professionals and the Consultant Paediatrician but received the minutes.
- 5.4 On 7 February 2020 CAMHS team was clear that Charlie's needs were beyond what could be met in the community. This was agreed upon by the Dorset Clinical Commissioning Group (CCG), however, due to the Covid-19 pandemic Residential Unit, 1 closed. As such, Charlie did not enter Residential Unit 1, remaining in their Mother's care until 1 February 2022.
- 5.5 The Covid-19 pandemic had an impact on visiting and establishing the safety of vulnerable children and

⁹ Dorset HealthCare is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care. We are the biggest provider of healthcare in Dorset, and our services continually evolve and develop to meet the needs of the local community.

¹⁰ <https://www.bcppartnershipacademy.co.uk/our-teams/child-health-disability-team>

young people. BCP introduced a protocol that vulnerable children and young people living in the community who are either Children in Need or have a CPP must be seen by their SW every week. The CHAD SW and FP continued to visit Charlie at home wearing PPE. Garden visits took place with Mother by the SW and CAMHS worker to reinforce the strategies recommended by CAMHS. On occasions Mother considered that she may be Covid-19 positive a visit took place on the doorstep and Charlie was able to mobilise, as Mother refused entry to the property despite workers wearing gloves, masks, aprons and visors. Some virtual visits also took place. Charlie was seen under the blanket during these when Mother would remove the blanket briefly.

Key episode 2: (21 April 2020 Review Child Protection Conference (RCPC) was held, Charlie continued to remain on a Child Protection Plan (CPP), to 28 April 2021 agreement to apply to CoP.

- 6.1 The RCPC was held on 21 April 2020. Charlie remained on a CPP. There was a focus on Residential Unit 1 reopening and for the funding to be in place, alongside Charlie's basic health needs, hygiene, and the plan to seek an assessment away from the family home in a specialised unit.
- 6.2 A joint home visit was made by the CHAD SW and CAMHS on 22 May 2020. They spoke with Mother regarding behavioural strategies that needed to be employed to make Charlie aware of the day/night by pulling the curtains in the morning, using Picture Exchange Communication Systems (PECS) to indicate a choice, visual timetables and calendars. The expectation was these needed to be used routinely and consistently to achieve any progress. These strategies had been put in place when CAMHS first became involved but were strengthened through this visit. The CHAD FP's role was extended to support Mother in implementing the autism strategies for Charlie in the home. Mother refused entry to the home due to fear of COVID-19 infection although workers were wearing gloves, masks, visors and aprons.
- 6.3 Charlie was not brought to attend the pre-assessment at Residential Unit 1 on 9 June 2020. Mother informed the Duty SW that Charlie was not prepared for the assessment. Mother declined support from the CHAD Duty SW to take Charlie out, and refused to allow Charlie to be seen. Later on, the same day, a joint home visit was undertaken by CAMHS and the CHAD SW. Charlie came to the doorway and appeared to walk with a slightly bent spine, communicating by making noises and gestures rather than words, appearing slightly cross-eyed and appearing underweight. The workers were unable to assess Charlie's capacity to make decisions due to refused access by Mother, whom the professionals believed was acting in a hostile manner. A further Strategy Meeting was held at Dorset MASH. There were multi-agency concerns around parental engagement, non-compliance with CPP, the presenting health and wellbeing of Charlie and the lack of progress and opportunities for Charlie and the wellbeing of Charlie's carers. A s.47 enquiry was agreed with a Health assessment at UHD. A further health assessment at UHD was arranged for 22 June 2020, but Charlie was unable to attend this appointment safely. Charlie was distressed, kicking, hitting, and shouting and the SW decided to halt the attempt. At this point, the SW requested CAMHS undertook a physical health assessment of Charlie as this was a requirement from CSC Legal Advisors. CAMHS explained the reasons were not able to undertake a safeguarding health assessment as their medical knowledge and expertise were predominately within mental health needs and they would have not been able to undertake a safeguarding health assessment. CAMHS, signposted CSC to the appropriate process for this, so that any medical assessment would be suitable for legal proceedings. The family's GP visited to undertake an observation of Charlie's health two days later and the advice was that there was no reason to indicate Charlie was unwell organically.
- 6.4 In July 2020 Mother gave consent to prepare for adulthood (PfA) referral, having previously refused this many times. The CHAD FP offered to support her with advice in the home and a log was to be kept daily. Mother was informed that Social Care would begin Legal proceedings if consistency was not shown. Mother's views were the behavioural strategies provided did not meet Charlie's specific needs or understanding and that as an example, taking photographs of food didn't support Charlie to make a choice, but Charlie would attempt to eat the photograph. In August 2020 autism-experienced

carers from an independent care agency (ICA) started going into the family home. The carers were arranged as Mother had indicated that she would agree to Charlie being changed out of soiled clothes. Mother undertook all the care herself. Mother refused to leave the house for some respite while leaving carers to look after Charlie.

- 6.5 On 27 August 2020, Public Law Outline¹¹ (PLO) proceedings were started due lack of progress with the CP plan and Charlie's care not being managed in the home. Later on, 14 September 2021, CSC instructed a Consultant Chartered Clinical Psychologist (CCCP) to undertake a psychological assessment of Charlie and Mother.
- 6.6 By September 2020 there was a high volume of professionals attending the family home offering the following support, Weekly Child Protection Monitoring Visits by CHAD Social Workers, 3 x times per week support for behaviours from CHAD FP, Home Tutoring Monday – Friday mornings, CAMHS reviews, Carers from an Independent Care Agency (ICA) attending Monday- Friday, afternoons and Parenting Assessor visiting 1-2 times per week. In December 2020, Mother requested a break from the ICA carers for the Christmas celebrations. Mother refused to have this reinstated until 1 June 2021. CAMHS were requested to provide an itemisation of all strategies and advice supplied to the Mother and Father during the time of involvement. Mother stated to CAMHS she had only tried these strategies once.
- 6.7 The CCCP, on 21 January 2021 completed reports on both Mother and Charlie as part of the PLO process. This was delayed as a result of the CCCP's personal health. Later in January, the CHAD SW made a referral to CAMHS ID (Intellectual Disability Team) as Charlie was identified by CCCP's assessment to have lower cognitive ability than previously assessed and therefore CAMHS ID threshold was met.
- 6.8 Charlie moved on 2 February 2021 to an area on the landing and refused to move or stand up. A core group meeting was held on 8 February 2021 and the PLO process was closed, due to no threshold for removal, as Mother was cooperating with the Child Protection Plan (CPP). Charlie remained on a CCP alongside CSC searching for skilled autism carers to work with Charlie and potentially offer respite care. A Mental Capacity Assessment was discussed and the means of assessing capacity by using autism strategies. Guidance was provided by BCP Legal team about an application to the Court of Protection.

Key episode 3: From 30 July 2021 application to CoP and subsequent delays until February 2022, when Charlie was admitted to the hospital

- 7.1 A Letter before proceedings was issued to Mother on 19 July 2021. With an initial hearing before the CoP on 31 August 2021. The CCCP was instructed to provide a further assessment of Charlie as an addendum to the original assessment. The CHAD team, CAMHS ID and PfA team were meeting or communicating daily about the progress of the case and Charlie's welfare during the delays in the CoP, due to the Covid-19 pandemic. Charlie's mother explained that CSC and ASC did provide some support to her during this period through Acceptance and Commitment Therapy (ACT)¹². She believed that this was supporting her and was making a difference and the therapist wanted to continue. However, BCP had only funded six sessions and this came to an end.
- 7.2 On 22 September 2021, the CoP ordered a 'Round the Table meeting' to seek to agree on a care plan for Charlie. Mother remained of the opinion that Charlie should reside at home in her care which conflicted with the professionals' views, this was supported by Charlie's Official Solicitor. The CCCP amended report did not support a move for Charlie to residential care and recommended therapeutic services in the community. The Final contested hearing was set for 20 December 2021. Some key professionals were not available for this date, so it was re-scheduled. The Judge recommended that

¹¹ The Public Law Outline (PLO) sets out the duties that local authorities have when taking a case to court

¹² <https://www.talkingchange.nhs.uk/acceptance-commitment-therapy-act> The aim of ACT is to maximise your potential for a rich, full and meaningful life. Developing mindfulness skills to deal with painful thoughts and feelings effectively – in such a way that they have much less impact and influence.

Mother consider a 12-week assessment period at Residential Unit 2¹³.

- 7.3 On 16 January 2022, Mother instructed her solicitor to accept the placement at Residential Unit 2 but requested that the hearing the following day continued. This CoP hearing was condensed into one morning as a result of Mothers agreement to residential care. Charlie was made the subject of an order to reside at Residential Unit 2 from February 2022, Charlie at an RCPC became a child in care under the Children Act 1989, Section 20. On the same day, Charlie moved to Residential Unit 2 in a supported move. On 4 February 2022 Residential Unit 2 informed CSC of concerns that Charlie was refusing to eat or drink. They further sought medical advice from the GP who advised to weigh Charlie's incontinence pads, with ongoing advice sought on 10 February 2022, a Nurse Practitioner attended Residential Unit 2 to assess Charlie and recommended hospital admittance. On 11 February 2022, Charlie was admitted to University Hospital Southampton (UHS) needing acute care as a result of malnutrition and dehydration supported by carers from residential Unit 2.

8 Analysis by theme and learning

Theme
Monitoring the progress of plans and quality of practice
Legal Intervention application and progress
Organisational culture and leadership for good outcomes
Escalation, Dissent, and raising concerns
Understanding Professional Roles and responsibilities
Diagnostic Overshadowing
Response to potential Sexual Abuse and Trauma
The child's voice
Reluctant and Sporadic Compliance

8.1 Monitoring the progress of plans and quality of practice.

- 8.2 All conferences took place within the required timescales. However, there was a significant turnover of Child Protection Conference Chairpersons (CPCC) following the merger of BCP into a Unitary Authority, the Ofsted inspection on 6 December 2021.¹⁴ This impacted the morale of the IRO service with many CPCCs leaving and difficulties in recruiting. In Charlie's life, this meant there were two CPCCs during the timescale of the key episodes.
- 8.3 Critical thinking and challenge were absent at the beginning of the child protection process and the impact of domestic abuse on Charlie and alleged sexual abuse by Charlie's siblings was not considered in depth especially given that Charlie has additional needs¹⁵.
- 8.4 The Father was absent in the CP process and this limited professional views of the Father despite there being allegations of historical domestic abuse and Charlie's siblings alleging that they were sexually abused by their Father. Although no further action was taken by the Police due to lack of evidence, the CPCC did not raise the need for an updated risk assessment to be undertaken of Father and also Mother to look at her ability to protect, although these were undertaken by the CHAD SW. Domestic abuse

¹³ Residential Unit 2 supports men and women of various ages with severe learning disabilities, autism and associated complex needs.

¹⁴ Inspection of Bournemouth, Christchurch and Poole local authority children's services <https://files.ofsted.gov.uk/v1/file/50177455>

¹⁵ Franklin, A., Bradley, L. and Brady, G. (2019) 'Effectiveness of services for sexually abused children and young people. Report 3: Perspectives of service users with learning difficulties or experience of care' comments on the invisibility of disabled children and young people within child sexual abuse services. Services in this study reported not receiving referrals for young people with learning disabilities/difficulties, despite the fact that they know that they face greater risk of sexual abuse.

work was offered to Mother, but there is no evidence of any work being offered or undertaken with Father who was the perpetrator. No consideration was given as to whether Mother's over-protectiveness was to protect Charlie from the Father. This was eventually identified as a concern by the second CPCC although much later in the child protection process¹⁶.

- 8.5 Not all child protection conferences were quorate but went ahead. Parents did not attend some of the meetings and there is no evidence of any follow-up by the chair with other agencies or parents. Mid-point reviews were also absent from the file. Having these meetings would have aided the CPCC to have a clearer oversight of Charlie and the progress of work.
- 8.6 The focus of support and services provided by agencies seemed to focus mainly on Charlie's abilities being the focus of service provision. This meant that Charlie's abilities became the issue rather than concerns such as Mother's behaviour and allegations of historical domestic/sexual abuse against Father which seemed to fade into the background. The obstacles and concerns that mother was presenting were not fully addressed and mother appeared to be keeping professionals at arm's length, meaning access to Charlie and professionals' ability to assess and build a relationship with Charlie was difficult. The absence of Charlie's voice in assessments and the CP process meant there was an unassessed risk. This response to changing risk is something that should have been challenged earlier on by the first CPCC who should also have considered the history of this family and the length of time children's services had been involved with no positive impact or outcome for Charlie as a result.
- 8.7 Legal advice should have been recommended earlier on by the CPCC. There were many opportunities for both CPCCs to escalate their concerns (Pan-Dorset Multi-agency Escalation Policy) due to the lack of progression and change for Charlie. This was reviewed by the Senior leadership involvement in a case discussion which agreed with the current plan and pursued the legal intervention within the CoP. It also declined a suggestion to seek a bespoke placement to care for, promote Charlie's welfare and enable a medical assessment.
- 8.8 CPPs were too optimistic and, in some areas, superficial, with limited contingency planning. The plans did not tackle the lack of change for Charlie. A CPP should not continue for two years especially when a child or young person has already been subject to a plan before. Additional to the drift and delay due to Covid-19, there was further drift and delay in this case that could have been avoided.
- 8.9 The impact of Covid-19 did play a part and the first placement that had been identified for Charlie was unable to provide this care due to closing due to Covid-19. The Placement Commissioning Service were searching locally, regionally and nationally for a suitable placement that could meet Charlie's needs without success. RCPs should have taken place more frequently in Charlie's case. However, the fact that this has to happen should indicate to the CPCC that further action needs to be taken to safeguard Charlie.
- 8.10 There is no evidence of the CPCC being told of Mother or Father's employment as a person in a position of trust. BCP LADO has no evidence of any contact being made to discuss Mother's position of trust as a child minder. The CHAD team were contacted by the IRO service in May 2022 to notify them of Father's assault conviction. The CHAD team worked with the adult's allegations officer, but this was communicated to the LADO, as the Father may have also had contact with children and young people within that position of trust.
- 8.11 Both CPCCs, in their minutes, refer to Charlie's Mother as wanting what is best for Charlie. Whilst there is a need for all professionals to highlight the positives to a parent as well as what needs to change, there is also a need to be open and honest with a parent whose actions continue to raise concerns and impact their child. From reading the minutes of the meetings, sporadic and reluctant compliance was present and there were occasions when Mother appeared to control situations. For example, when

¹⁶ The Social Care Institute of Excellence (SCIE) addresses 'Men and male caregivers' in their Working Together with Parents e-learning module 3. They highlight a number of different but connected issues emerging from reviews in relation to men in families: • the dearth of information about men in most serious case reviews • the failure to take men into account in an assessment • rigid or fixed thinking about men as 'all good' or 'all bad' • the threat posed by men to workers

she refused visits to take place due to professionals having to wear masks which she said would cause Charlie distress. Mother also asked for the child in-care meeting to be incorporated within another professional meeting which was agreed upon by the social work team without consultation with the IRO or CPCC. Mother believes that the professional network did not want to work with her or listen to what she was saying.

- 8.12 Parents did not always attend CPCC's, at the ICPC neither parent attended which was the same for the last CP conference. Father's views were sought, but he should have been offered separate time from Mother to attend the conferences. There is ongoing work to improve the response to working with Fathers, and 'Practice Fundamentals' development sessions are now arranged in working with Fathers.
- 8.13 The second CPCC did a case allocation review, although this was around 6 weeks after the case was allocated. The review did identify the seriousness of matters and noted that legal proceedings should already have been initiated and Charlie should have been removed from Mother's care. The CPCC identified that throughout the involvement of children's services and health, no in-depth assessments or mental health assessments had been completed with Mother.
- 8.14 There have been significant changes in the IRO service since February 2022. The new Service Manager for IRO, CPC and LADO has implemented a service improvement plan concerning the Ofsted inspection report, subsequent focussed and monitoring visits. The improvements include,
- CPCCs have been reminded of the need for conferences to be quorate and include relevant key people who are significant in the child's life and who will help progress the child protection process.
 - There has been a change made to the case management system (Mosaic) so that the IRO and CPCC footprint and recording of mid-point reviews can be monitored more robustly by managers.
 - Work with the IRO service has been undertaken around mid-point reviews and the need for these to take place. Practice learning is discussed in team meetings and good examples are given as well as learning.
 - IRO team managers are now required to use data in supervision with an IRO and review any child or young person who has been the subject of a CP plan for more than 9 months. IROs and CPCCs are requested to use the formal Multi-Agency Escalation Policy to raise concerns about drift or delay. Any cases of concern are brought to the attention of the IRO service manager in weekly management meetings.
 - It is not clear from the file if there was any consideration given to a consultation with LADO given parents were both at some point in a position of trust or if this was discussed with parents. Although referred to adult services, the BCP LADO has no records of any consultation in respect of Mother and only in May became aware of Father's position of trust and his assault conviction.
 - Weekly monitoring is in place with IROs and CPCCs to further monitor visits to children, mid-point reviews and referrals/allocation of an advocate in a child's life.
 - The first CPCCs should have been more robust in the CP process and considered the history of the family when making recommendations at the ICPC. The LA seeking legal advice should have been recommended earlier at the first RCPC. The plan should not have continued for two years when no change or improvement for Charlie had been evidenced. Charlie's CP plan needed to be more robust with clear timescales and meaningful and realistic actions that should have been managed better by the CPCCs and other professionals.
- 8.15 There is learning for CPCC's managers also around tracking CP cases where a child is on a repeat CPP or this has continued beyond the 9-month RCPC. At the point of reallocation, the IRO manager who was tasked with reallocating the previous CPCC cases should have identified the delay and lack of

change for Charlie and instructed the new CPCC to raise a Multi-Agency Escalation. This should also have been raised with the IRO /CP service.

- 8.16 The CPCC's footprints on Charlie's file were limited. There is other email evidence of the second CPCC liaising with the social work team and raising his concerns. These emails were not on Charlie's file. A Multi-Agency Escalation should have been formally raised on numerous occasions by any multi-agency partner. In particular when Charlie's placement at Residential Unit 1 did not go ahead, when the situation for Charlie did not improve by the first RCPC (given that Charlie had been on a CP plan before) and when there was a delay in the application to the CoP and Charlie remained at home in mother's care.
- 8.17 The CPCCs did not identify or appropriately challenge the obstructions that Mother was presenting, or the sporadic and reluctant compliance by Mother. Their view of Mother was too optimistic and at times, not based on the reality of the situation for Charlie. Concerns around Father, domestic abuse and sexual abuse were not fully assessed or recognised which meant that the trauma likely to have been experienced by Charlie was not addressed. Covid-19 added to the difficulties in engaging with Charlie and Mother. Mother's behaviour was at times rationalised due to circumstances such as Covid-19. Information from Mother was sometimes accepted by the CPCCs and other professionals rather than investigating further.
- 8.18 Charlie's Mother's views of the case review progress were that the decision-making meetings were poor, with a lot of being spoken at rather than with. The chairperson tried to listen, but she believed the outcome was a foregone conclusion.

8.19 Learning: Monitoring the progress of plans and quality of practice

1. There needs to be an improved approach by professionals when it is identified that the person who we are working with is in a position of trust.
2. On occasions, case conferences were held which were not quorate. Some apologies were received in relation to members of the CPP being Covid positive or impacted on by the raised levels of working during the pandemic. To determine quoracy, there should be sufficient agencies present to enable safe decisions to be made. Conferences were mainly attended by children's services and other agencies were absent, such as police and health. In Charlie's case, all relevant health services, both Mental Health and Physical Health must attend CP conferences, which was not always the case.
3. There is a need to update or review risk assessments if there is a change in circumstances, risks or needs.
4. Both CPCCs or any other professional did not escalate this through the Multi-Agency Escalation Policy due to the lack of progression and change for Charlie. Child protection plans were too optimistic and, in some areas, superficial and there were limited contingency plans. The CP did not tackle the lack of change for Charlie.
5. A CP plan should not continue for two years especially when a child or young person has already been subject to a plan before. There was drift and delay in this case that could have been avoided.
6. CPCCs should further develop knowledge of reluctant and sporadic compliance and should be able to recognise this early on and as well as being aware of what actions to take when this is suspected. Work around professional curiosity should also be undertaken.
7. Father's views were sought, but he should have been offered separate time from Mother to attend the conferences.

Single Agency Recommendations, Monitoring the progress of plans and quality of practice

Children's Social Care:

1. CSC will provide assurance to the BCP PDSCP that disguised compliance and being able to recognise this early and as well as being aware of what actions to take when sporadic and reluctant or disguised compliance is suspected is embedded in training.
2. CSC will monitor attendance at CP Conferences to ensure conferences are quorate with sufficient agencies present to enable safe decisions to be made, escalation should be made immediately to the senior management and assurance should be made to the BCP - PDSCP when sharing the annual report of the IRO, Safeguarding and LADO annual report.
3. CSC will be aware of the need to meet with parents separately when there are disputes, or when one partner is a risk to the other, assurance should be made to the BCP - PDSCP when sharing the annual report of the IRO, Safeguarding and LADO annual report.
4. CSC will share their IRO/LADO annual report with the BCP – PDSCP setting out the progress of CCP, the functioning of the IRO Service and any quality issues.
5. CSC should ensure that the guidance Standards for Enabling Participation of Children and Young People in Child Protection Conferences, is followed in CPCs.

All Acute Health Services

1. All acute services will review the role of Safeguarding Professional's and their role in attending and providing their expertise and knowledge to child protection conferences.
2. Once this review is undertaken oversight and assurance should be provided to the PDSCP.

Multi-agency Recommendations

Recommendation 1: All Organisations and professionals must follow the PDSCP Policy on Child Protection Conferences Procedures, including guidance about when to attend Child Protection Conferences as set out in the Policy. The PDSCP must send the guidance to agencies to distribute and link it to the learning to give context for the rationale.

Recommendation 2: The PDSCP must develop a seven-minute guide to ensure that the role of the LADO is understood by all partner organisations and relevant organisations. The PDSCP should ensure the LADOs functions are built into existing multi-agency training. This should also include information regarding working with adults who may be parents or carers who are involved with children's services and who are in a position of trust.

Legal Intervention application and progress

- 9.1 Many professionals at the learning event voiced their concerns about why a legal intervention was not pursued in Charlie's case. They highlighted the lack of change in Charlie's circumstances and the timescales of intervention.
- 9.2 On 24 June 2020 at a Care and Resource Panel Review meeting, BCP Legal services advised that CSC would rarely make applications for 16-year-olds, but believed this should be considered. It was agreed that the threshold for PLO and a Care Order was met. It was also agreed highlighted that CSC could apply for a Child Assessment Order if Mother did not agree to CSC's care plan under PLO.
- 9.3 This was followed up by the CHAD SW on 30 June 2020 when she received Legal Services which advised the threshold for PLO was not met. This was at odds with the previous legal advice
- 9.4 This was identified by Ofsted in November 2020 focused visit to BCP Children's Services on 13 October 2020, which stated *"The failure of managers to provide appropriate oversight of the pre-proceedings*

stage of the Public Law Outline (PLO) results in children remaining for too long in unsafe situations".¹⁷

- 9.5 This situation has improved since November 2020 in the most recent monitoring visit undertaken on 4 and 5 October 2022, Ofsted identified *"When risks escalate to the point of using the pre-proceedings process under the Public Law Outline (PLO), work is carried out under the clear and organised oversight of a service manager who understands the work and children's needs very well. A clear and closely maintained tracker is used to monitor progress for children effectively"*¹⁸.
- 9.6 The Professional Meeting agreed that a court application for a Child Assessment Order¹⁹ would be fruitless. For the following reasons:
- Residential Unit 1 did not believe they can complete it in timescale, and other provisions were not admitting new patients due to Covid-19.
 - CAMHS stated its role was mental health rather the physical health, so could not provide a safeguarding health assessment that was appropriate for Court.
 - The order can only be granted for 7 days, and it was believed that any assessment would take longer, due to Charlie's needs
 - Although many options were considered no other provision was identified that could undertake the health assessment.
- 9.7 In August 2020 BCP issued a Letter Before Proceedings under the PLO, highlighting their concerns and what Mother could do to improve things, setting out the concerns that the LA has about Charlie and the things that have been done to try to help the family. The PLO was reviewed monthly following the issuing of the letter.
- 9.8 At a Legal Gateway meeting on 29 January 2021, the significant delay in the legal process was due to CCCP's report being overdue due to illness and the parenting assessor being off due to ill health. The parenting assessment was significantly delayed as the assessor wanted sight of the CCCP's report before concluding her report. This was not sent to the parenting assessor until January 2021.
- 9.9 The CCCP's assessment did not assist in legal planning for Charlie as the recommendations made had been tried in the past. The assessment made no suggestions of how the recommendation of respite and community-based services could be achieved given Charlie has not left the family home for 2 years. This was challenged by the Legal Service's asking the CCCP to respond to further questions to assist in planning for Charlie.
- 9.10 At this time Charlie was 17 in 6 weeks and therefore the opportunity to seek an Interim Care Order (ICO) was lost. Also, without a recommendation of removal from home in the CCCP's assessment, it would be very unlikely to secure removal and an ICO at home would serve no purpose for Charlie.
- 9.11 It was agreed that the case needed to remain in PLO until the CCCP replied to our further questions and the parenting assessment was complete²⁰. The CHAD team continued to seek an assessment unit that would agree to assess Charlie identified and then make an application for an Assessment Order. Without this provision identified the CHAD team continued to work with Mother to identify a respite provision and support Charlie to access this provision through a transition to the PfA Team.
- 9.12 On 8 February 2021, the PLO was discontinued. By this time Charlie had been on PLO Pre-Proceedings since August 2020, this should not go on longer than 16 weeks.²¹ This was a significant delay in the

¹⁷ <https://files.ofsted.gov.uk/v1/file/50156980>

¹⁸ <https://files.ofsted.gov.uk/v1/file/50197985>

¹⁹ Child Assessment Orders, Section 43 is the opening section of Part V of the Children Act 1989, entitled "Protection of Children".

²⁰ Recently published Best practice guidance: Support for and work with families prior to court proceedings March 2021, Public Law Working Group suggests that "the purpose of the PLO pre proceedings process is to be a genuine opportunity to work closely with families by offering help and support to address their recognised needs in a bid to negate the need to issue care proceedings".

²¹ In 2014, the revised PLO was published (Family Procedure Rules, Practice Direction 12A). Revised statutory guidance (DfE, 2014)

progress of the PLO Pre-Proceedings work. Charlie remained subject to a CPP and The Multi-Agency team continued to work with Mother and Siblings for the best outcomes for Charlie.

- 9.13 On 27 April 2021 at a Local Area Protocol meeting held under the Care, Education and Treatment Reviews (CETR) process. Mother commented that she believed Charlie had deteriorated since the family had lost a lot of support. This view was disputed by professionals and further legal advice was requested. The legal advice confirmed there was sufficient evidence to make a welfare application to the CoP. CHAD and Adult Services Transitions Team SWs met to complete the Transition plan for the CoP, with parallel planning continuing with BCP legal for welfare application to the CoP.
- 9.14 At a legal meeting in June 2021, the following actions were agreed upon, to source a residential placement/suitable placement, including a transition plan to move Charlie from the landing to the identified placement, Also a care plan will be provided that can be lodged with the CoP setting out how Charlie will be cared for. Also, the present statement will be updated to set out the reasons why the application is being made and to encompass the views of the health professionals as to why an acute hospital or admission to a psychiatric unit is not appropriate. If no placement has been identified within 7 days an application will be made to the CoP to authorise the present deprivation of liberty.
- 9.15 The CCCP's report was completed by 12 September 2021. He stated that he questioned why Mother could not continue to provide care in the family home, if she was compliant and he did not support the move. Given this Mother submitted her statement saying she would not consider a trial period at Residential Unit 2.
- 9.16 A round table meeting was held at the direction of the court on 22 September 2021 to respond to some questions from Mother and the Official Solicitor. Further information was requested from the CCCP and to prevent further delay, he was invited to the meeting. The CoP hearing was held on 5 October 2021. The Judge suggested a trial period at Residential Unit 2. Mother agreed to a placement but not at Residential Unit 2.
- 9.17 A full hearing was listed for 20 December 2021, but the Judge did not have any availability and the final hearing did not go ahead until 17 January 2022 in the CoP. The Judge instructed the move from the family home to Residential Unit 2, which was planned and took place on 1 February 2022.
- 9.18 There was a significant delay in the legal intervention and progress of Charlie's case, The initial advice from BCP legal service was that the threshold for PLO and ICO was made on 24 June 2020. Charlie finally moved into residential Unit 2 shortly after 17 January 2022, which was a period of 1 year and 30 weeks. This delay was for a variety of reasons. Changing legal advice from BCP Legal Services, delays caused by long-term sickness to the parenting assessor and the CCCP. Then following these delays in the CoP due to Covid-19 and capacity issues.

9.23 Learning: Legal Intervention, application and progress

- 9.19 Cases for 16 and 17-year-olds that lack capacity should not be dealt with using The Children Act 1989 legislation and processes, they should be directed to The Court of Protection.
- 9.20 Delays in the progress of the legal case impacted Charlie's deterioration and access to full-time carers.
- 9.21 The minimal level of knowledge concerning the CoP and PLO in services that work for children and their families identified within written records, discussion and templates for this CSPR is significant.
- 9.22 The Practice Guidance Safeguarding Disabled Children was published in 2009 this guidance is significantly out of date. Although legislation is in place through Children and Families Act 2014 Part 3. It does not give the guidance required for this vulnerable group of children and young people.

which included a pre-proceedings flow chart, starting with the initial referral of the family to children's social care. This flow chart, for the first time, included a suggested time limit on the formal pre-proceedings process of 12-16 weeks (Annex A, DfE, 2014).

- 9.23 Furthermore, the Pan-Dorset Safeguarding Children Partnership (SCP) Policies and Procedures Manual Safeguarding Disabled Children section also requires improvement to ensure it provides in-depth guidance to all professionals and volunteers when working with this group of children and young people, including the Legal aspects of capacity and consent in children and young people with a disability.
- 9.24 The impact Covid had on the progress of the CoP timescales also was significant. The Judge tried to reduce delay through the round-the-table meeting and invited the CCCP to this meeting to gain the required information to complete their report.
- 9.25 The CCCP's report commissioned by BCP repeated already attempted interventions that had not been successful earlier in Charlie's life and did not consider available resources.

Single Agency Recommendations

Children's Social Care

6. The Director of Children's Services in BCP should ensure that the PLO processes are being conducted within 16 weeks and that delays and risks are addressed immediately.

BCP Legal Team

- 1 The BCP Legal Team should develop guidance on PLO pre-proceedings and the use of PLO and the application to the Court of Protection for 16- and 17-year-old vulnerable young people. This should be presented to the PDSCP and Children's services so this guidance is available for partners and Social Workers through the PDSCP website and the children's service manual, so that there is a better understanding of a process which becomes integral to many safeguarding cases in which partners are involved.
- 2 The BCP Legal team should monitor the timescales for PLO Pre-proceedings work, ensuring this remains within the 16-week timescale.

Multi Agency Recommendations

Recommendation 3: The PDSCP should write to HM Government highlighting that the Practice Guidance Safeguarding Disabled Children was published in 2009. This guidance is significantly out of date. Although legislation is in place through Children and Families Act 2014 Part 3 does not give the guidance required for this vulnerable group of children and young people.

Recommendation 4: The PDSCP should ensure the Pan-Dorset Safeguarding Children Partnership (SCP) Policies and Procedures Manual Safeguarding Disabled Children section is reviewed with the support of Tri.x in light of this CSPR to ensure it provides in-depth guidance to all professionals and volunteers when working with this group of children and young people. This should include the legal aspects of capacity and consent in children and young people with a disability and diagnostic overshadowing to ensure that safeguarding concerns do not become invisible due to the child's disability.

10.0. Organisational culture and leadership for good outcomes

- 10.1 During the learning event, the participants highlighted the move to a Unitary Authority named BCP Council and the merger of two Health Trusts into the University Dorset NHS Foundation Trust, with both restructured organisations embarking on a programme of integration and transformation.
- 10.2 The learning event participants spoke about the retention of staff during this time in BCP CSC as low with many senior managers, Social Workers leaving BCP. Also, following the publication of the Ofsted Inspection, Monitoring and focussed visits recruitment of experienced local professionals into teams was exceedingly difficult. The learning event said that children were being left too long in places of risk and opportunities to seek management guidance and/or support were limited due to this turnover and restructure of BCP CSC.

- 10.3 In the most recent monitoring visit undertaken on 4 and 5 October 2022, it was identified that *“Child protection conference decisions are inconsistent. While high staff turnover has played a part in this, the absence of a sufficiently robust frontline management approach in this area has had a greater impact. The subsequent child protection plans are either generic or place too much emphasis on actions and tasks rather than impact and change”*²².
- 10.4 The CHAD team explained at the time of Charlie’s allocation to their team, Charlie did not meet their threshold criteria, but due to them knowing Charlie and no other team was available, they felt under pressure to take on the case.
- 10.5 CAMHS also stated that they were going to close their oversight of the case as Charlie did not meet their criteria, but retained case responsibility as they were unsure who would take on the case if they closed it. Closing the case was also at odds with the Thrive Model²³ in working with difficult complex cases.

10.10 Learning: Organisational culture and leadership for good outcomes

- 10.11 At the learning event, it was discussed that there were two centres for medical assessments for children in Dorset, one with criteria of up to 16 and the other under 18 which provides a different level of service provision in Dorset/BCP area. These differences in accessibility and service provision should be reviewed by the DICB working with the Acute NHS Trusts in the area.
- 10.12 Since the CSC inspection, there have been significant improvements in management identified by Ofsted in the Monitoring Visit on the 4 and 5 October 2022, highlighting
- Concerted effort to put right structures in place to make the improvements necessary
 - Children’s Services Senior Management Team understands areas for improvement/ Corporate support to continue under current financial pressures
 - More timely decisions and actions
 - Sensible and sustainable plan in place to provide better quality services for children
 - Making steady progress – we are where Ofsted expect the service to be at this stage
 - Quality of SW is improving – however more to do before children receive consistently good services.
 - Staff are increasingly confident at tackling risk for the most vulnerable

Single Agency Recommendations

Children’s Social Care

7. The Director of Children’s Services in BCP should continue to share the BCP Improvement Plan with the PDSCP for information.

NHS Dorset Integrated Care Board (DICB)

1. DICB should lead a review of safeguarding paediatric services in their area working in partnership with all Health Trusts that provide safeguarding paediatric services. To ensure all Health Trusts in the Dorset and BCP areas that provide safeguarding paediatric services are deployed effectively to meet service requirements and local health needs across the area they serve.

²² <https://files.ofsted.gov.uk/v1/file/50197985>

²³ THRIVE is an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and families which conceptualises need in five categories or needs based groups:

11.0 Escalation, Dissent, and raising concerns

- 11.1 At the learning event and in their single agency report template the participants and authors mentioned the Pan-Dorset Multi-agency Escalation Policy numerous times. However, during the Key Episodes, this was never implemented. The Policy drafted in 2019 remains current and the view was that it was to be used to escalate concerns about CSC, rather than between any safeguarding partner. The policy is clear that is to set expectations and pathways for managing differences of professional opinions in the child's best interest. It has a focus on resolving multiagency safeguarding challenges, and the policy can be used between any agencies working to safeguard children.
- 11.2 The policy sets out the principles of professional challenge and escalation. Stating the use of professional challenge and escalation is expected and promoted in multiagency working to enable children (including young people) to be safeguarded effectively. The child's welfare and safety are paramount. The Pan-Dorset Multi-Agency Safeguarding Policies and Procedures Manual provides detail of expected practice and this should be referenced by practitioners in their challenges and escalations.
- 11.3 The lack of use of escalation, and dissent in core groups and CP conferences is clear as were professional differences of opinions in the learning event and individual interviews. The use of the escalation process was seen to be negative by the professionals involved in the case, rather than in progressing the case by providing an opportunity to promote the child's welfare.
- 11.4 There was a lack of challenge by the first CP chair and partly by the second CP chair who both should have applied the Multi-agency Escalation Policy process due to there being no change for Charlie and no professional being able to find out what life was like for Charlie. The fact that there was no change for Charlie for the length of the CP plan was enough for the Multi-agency Escalation Policy process to be implemented at many stages of the process. Also, during the CP conferences, there were no incidents of dissent where an agency does not agree with a decision or recommendation made at a child protection conference, their professional dissent will be recorded in the record of the conference
- 11.5 There were numerous examples where the use of the Pan-Dorset Multi-agency Escalation Policy was considered but not implemented by professionals These examples included the Police decision not to interview Charlie either as a potential victim of or witness to sexual abuse, lack of progress in the case, difficulties in information sharing, professional disagreement about a referral to ID CAMHS, delay in legal intervention, and the commissioning of a medical assessment of Charlie.

11.6 Learning: Escalation, Dissent, and raising concerns

- 11.7 The Pan-Dorset Multi-agency Escalation Policy and dissent process were not well understood by the multi-agency partners involved in this case or its role in promoting the welfare of children. This was further identified in the PDSCP CSPA "Iris 2021", In the learning event the feedback from the professionals involved in the case was it was a mechanism to raise concerns or a complaint process about CSC. Following "Iris 2021 para 25 Page 50" assurance was provided that *"Dorset Council has added that it has further strengthened its escalation policy since the summer of 2020"* This CSPA recommends that the PDSCP ensures that this policy is now understood by partners.

Multi-Agency Recommendation

Recommendation 5: The PDSCP should develop a seven-minute guide on the Pan-Dorset Multi-agency Escalation Policy and ensure training and supervision includes the use of the guide to confirm that all partners understand, are well versed and empowered to use this Policy.

12.0 Understanding Professional Roles and responsibilities

- 12.1 In the single agency templates and learning event, many professionals and agencies used generic titles for organisations such as “Health” “Local Authority” and “Children’s Social Care” without understanding the multiple professional teams specialising in specific arenas in that organisation²⁴.
- 12.2 An example of this is the use of the term “health” when recording case details involving CAMHS. It was clear that CAMHS was identified as the responsible “Health” agency and CHAD as the “Local Authority”.
- 12.3 A named person from UHD at the CPRC to agree with Charlie’s admission into the hospital for a medical assessment could have supported the discussion about a potential safeguarding paediatric assessment before the day of admission and may have avoided a subsequent refusal to accept the admission as there was no medical emergency.
- 12.4 The health assessment given Charlie’s needs was undertaken later in the case by University Hospital Southampton (UHS). They describe it as a complex situation, where ethics and the law were unclear. Charlie had to be given a general anaesthetic to gain Charlie’s height and weight. Careful planning should have been agreed upon at the case conference or strategy discussion to agree on a way forward to gain this medical assessment.
- 12.5 Following this refusal of admission as it was not in Charlie’s best interests the Family GP attempted to assess Charlie in the family home. However, Charlie became distressed and began kicking and grabbing Mother's hair. It was agreed at a health focussed meeting, which included the UHD staff, Paediatric safeguarding consultants and the GP agreed that Charlie did not need to be admitted into Hospital and the health assessment could be undertaken in the community. It is not clear if CSC were involved in this meeting. However, the GP reported that Charlie had good muscle tone as Charlie was able to kick out at him from below the blankets.
- 12.6 The role of the acute medical specialists and paediatricians, in this case, working alongside CAMHS should have been in place and although invited to CP conferences did not attend and minutes were sent as requested.
- 12.7 CSC was identified by professionals at the learning event as being responsible for the delay in seeking legal intervention in Charlie’s case. This was not the case as legal intervention was pursued through legal advice and the threshold was not met due to the Mothers engagement with services and the CCCP’s report which suggested community-based respite care and community-based services rather than a move to residential care.

12.8 Learning: Understanding Professional Roles and responsibilities

- 12.9 The need for a Child to have a safeguarding health assessment, in this case, was significant, CSC stated they were concerned about Charlie’s health, lack of mobility, not being changed from soiled clothing until asleep and how this impacted skin integrity. They also required information about weight and hydration, as this was unknown.
- 12.10 Although CAMHS were the consistent health partners and supported Charlie’s case., there was a need for them to be supported by Acute Services from UHD. It is important that a child who has been placed on a CPP for neglect with the potential to have been the victim or witness to sexual abuse be able to access a safeguarding health assessment.
- 12.11 So that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the

²⁴ This was also identified in an earlier CSPR “River May 2022” in which at Para 5.14 This review has highlighted that some practitioners required a greater and deeper understanding about the roles and responsibilities of colleagues in other agencies or with other client groups (adults or children).

role they should play and the role of other practitioners. They should be aware of and comply with, the published arrangements set out by the PDSCP. Working Together 2018²⁵ This was identified in the PDSCP CSPP “River May 22” and this review also identifies the need for professionals to be aware of each other roles and legal and statutory responsibilities.

Single Agency Recommendations

NHS Dorset Integrated Care Board (DICB)

2. The DICB should lead a review of the agreed safeguarding paediatric pathway to ensure that children with disabilities / complex presentations who live in the BCP area who require a health assessment due to concerns about their welfare due to alleged or potential abuse are able to access medical health assessments. This pathway should be presented to the PDSCP for ratification and entered into the PDSCP Multi-Agency Procedures.
3. The DICB review will also consider the policy of no home visits, or ambulance support for safeguarding paediatric investigations. The review needs to consider if this policy needs to change to include flexible support for cases where it involves children with disabilities to ensure they can access these services

Multi-Agency Recommendations

Recommendation 6: All partners should ensure that their staff and teams are aware of the diversity of organisations in relevant agencies and partner organisations, moving away from generic terms such as Local Authority or Health. This recommendation was also made in the Local Child Safeguarding Practice Review “River” 2022. The BCP - PDSCP should coordinate the development a briefing document to explain the role and responsibilities of agencies and organisations. Existing PDSCP training should provide the opportunity to discuss individual roles and responsibilities to break down stereotypes and myths.

13.0 Diagnostic Overshadowing.

- 13.1 Charlie’s complex needs impacted the progress of this case. The focus seemed to be on Charlie and ASD being the problem rather than the situation where Charlie may have been the subject or witness to Sexual abuse or domestic violence and was placed on a CPP for Neglect for two years.
- 13.2 Stalker et al, 2015 highlight how practitioners can lose sight of the child (and abuse) due to overly focused attention on impairment. As they state: *“signs of abuse could be attributed to aspects of a child's impairment and thus go unrecognized. This applied to both physical signs such as injury and changes in a child's behaviour denoting distress”*.²⁶
- 13.3 The Pre-Assessment meeting at Residential Unit 1 was attended by Mother, but not Charlie who was reported to have refused to come. The majority of the assessment was from Mother’s information as Charlie was not present. The Clinic letter summarised that the professionals who assessed Charlie did not feel able to decide on whether Charlie could come in for admission as they needed to understand Charlie’s response to being in the environment.
- 13.4 The Police in the learning event stated that they had not interviewed Charlie as communication was not possible and it may have caused Charlie distress. Police Dorset have an intermediary service to assist children and young people with their communication and involvement with the criminal justice system. But access to this provision is not timely. We know from recent research that *“Access to justice via thorough police investigations and criminal proceedings was rarely an outcome for disabled children and young people. They were often perceived as unreliable witnesses especially if they had communication needs. Disablism appeared to affect practice, with little evidence that access needs were met or*

²⁵ Working Together 2018 Introduction para 17

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

²⁶ 9. Stalker, K., Taylor, J., Fry, D. and Stewart, A. (2015). "A study of disabled children and child protection in Scotland—A hidden group?" Children and Youth Services Review 56: 126-134

*adjustments made”.*²⁷

- 13.5 At the meeting called to discuss this admission and subsequent lack of admission, there were concerns about how Charlie would react and present in a busy ward and uncertainties on how Charlie may be distressed by the hospital environment due to Charlie’s ASD needs, also worries about inflicting further trauma. As we now know Charlie was hospitalised in 2022, seriously ill. It was reported that Charlie did well while on the sideward at UHS, although this was a challenge for the hospital staff.
- 13.6 In 2020, in discussions with UHD safeguarding paediatricians, the CHAD SW was told that safeguarding paediatricians do not complete house visits, an ambulance won’t be offered for transport, and sedation won’t be offered. If the child can be brought in, they will undertake an assessment, otherwise, they can’t provide a service. The case then became Primary Care and the GP’s responsibility with limitations in what services and assessments they can undertake.
- 13.7 The focus of support and services provided by various agencies seemed to focus mainly on Charlie being the difficulty. It felt that Charlie became the issue rather than concerns such as Mother’s behaviour and allegations of historical domestic/sexual abuse against Father which seemed to fade into the background. This was at odds with CAMHS’s view that diagnostic overshadowing appears to have been a factor from other agencies outside of CAMHS who over-relied on CAMHS to provide support for Charlie’s needs, despite them being clear they had exhausted all their pathways.
- 13.8 In Charlie’s records by UHD on 11 June 2021; CSC requested for Charlie to have a medical assessment (including blood tests, weight, and skin check) to exclude underlying medical causes for the behavioural deterioration. The GP wanted to discuss this, having spoken to adult medicine who did not feel that admission to an acute hospital for basic medical assessment was appropriate or in Charlie’s best interests. The UHD staff agreed that there needs to be further discussion with all parties regarding how Charlie can be supported currently and how any basic assessment of health can be undertaken, agreeing that Charlie will need significant mental health/behavioural support to be able to tolerate examination etc. but disagreeing that there is a need for a ‘child protection medical’ - as per the acute medical team, as bringing Charlie into the hospital would be very difficult.

13.9 **Learning: Diagnostic Overshadowing**

- 13.10 A full health assessment was requested on numerous occasions, by BCP Legal Team, and at the CAMHS CETR (Care, Education and Treatment Review meeting)
- 13.11 Concerning admission into UHD. UHD may need to review that some rooms are available and suitably adapted to admit children with special needs for emergency treatment. The latest research shows increasing numbers of children are now born on the ASD spectrum²⁸. These children will get ill and are at an increased risk of abuse due to their disabilities.
- 13.12 Concerning UHD safeguarding paediatric services and medicals, the policy of no home visits, or ambulance support. UHD needs to consider if this policy needs to be reviewed to consider flexible support for cases where it involves children with disabilities to ensure they can access these services.
- 13.13 CAMHS stated *“The physical deterioration and wellbeing of Charlie was recognised. Had a medical review taken place sooner Charlie may not have required admission to the hospital following the transfer to Residential Unit 2”*. This was supported by UHS medical team who explained the BMI level and dehydration levels would not have occurred in the short timescale that Charlie was resident in Residential Unit 2.

²⁷ UK Social Work Practice in Safeguarding Disabled Children and Young People A qualitative systematic review June 2022 Franklin et al.

²⁸ Roman-Urrestarazu, R et al. Association of Race/Ethnicity and Social Disadvantage With Autism Prevalence in 7 Million School Children in England. JAMA Paediatrics; 29 March 2021; DOI: 10.1001/jamapediatrics.2021.0054
<https://www.ncl.ac.uk/press/articles/archive/2021/03/autismratesincrease/>

Single Agency Recommendations

NHS Dorset Integrated Care Board (DICB)

1. DICB should lead a review of safeguarding paediatric services in their area working in partnership with all Health Trusts that provide safeguarding paediatric services. To ensure all Health Trusts in the Dorset and BCP areas that provide safeguarding paediatric services are deployed effectively to meet service requirements and local health needs across the area they serve.
2. The DICB should lead a review of the agreed safeguarding paediatric pathway to ensure that children with disabilities / complex presentations who live in the BCP area who require a health assessment due to concerns about their welfare due to alleged or potential abuse are able to access medical health assessments. This pathway should be presented to the PDSCP for ratification and entered into the PDSCP Multi-Agency Procedures.
3. The DICB review will also consider the policy of no home visits, or ambulance support for safeguarding paediatric investigations. The review needs to consider if this policy needs to change to include flexible support for cases where it involves children with disabilities to ensure they can access these services.

Dorset Police

1. Dorset Police should provide assurance to the PDSCP that children with disabilities in Dorset that need to have an intermediary to assist their communication and involvement with the criminal justice system are offered this service to ensure that their access needs were met or adjustments made.

Children's Social Care

8. CSC should ensure where there is a medical diagnosis offered as an explanation for the presenting features of neglect, all aspects of the child's health and well-being should continue to be considered to avoid the potential for diagnostic overshadowing.

14 Response to potential Sexual Abuse and Trauma

- 14.1 Charlie's siblings made separate allegations of sexual abuse against their Father. The siblings and Mother commented that they could not rule out Charlie also being abused. Charlie was not interviewed by the Police at this time and this would be in Charlie's best interests due to ASD and concerns about distress. The CAMHS professional felt this was a mistake and raised her concerns but did not formally challenge this decision. The use of the Pan Dorset Escalation Policy would have enabled decisions to be reviewed and provided an opportunity for Charlie's voice to be heard. Charlie was not offered a paediatric safeguarding medical.
- 14.2 The s.47 threshold was met, and Father was arrested. The actions from this meeting included formal police interviews for the siblings and safety plans made. Father moved out of the family home following his arrest and never returned, Police took no further action due to lack of evidence. Father met with the social worker in February 2020 to deny all allegations and following this he made the decision not to have any further communication with children's social care, stating clearly in his email *"I do not want to be included in your updates/meetings etc"*.
- 14.3 Although no further action was taken by the Police due to lack of evidence, the CP chair did not raise the need for a thorough risk assessment to be undertaken of Father and also Mother to look at her ability to protect. Domestic abuse work was offered to Mother, but there is no evidence of any work being offered or undertaken with father who was the perpetrator. There was a lack of acknowledgement of the impact domestic abuse and possible sexual abuse had on Charlie. No consideration was given as to whether Mother's over-protectiveness was to protect Charlie from Father.

- 14.4 The research and evidence around child sexual abuse (CSA) and the symptoms and behaviours that a child may exhibit are well documented. Behavioural concerns include bladder and bowel changes, mutism, and eating disorders to name just a few. These three concerns are documented clearly within the records for Charlie.
- 14.5 *Studies also indicate that disabled children's risk of abuse varies according to impairment type, with having a mental or learning disability, communication impairment or behavioural difficulty being more strongly associated with maltreatment (Sullivan and Knutson, 2000; Spencer et al, 2006; Jones et al, 2012). Young people with learning disabilities have also been identified as at increased risk of sexual abuse (Spencer et al, 2006).*
- 14.6 The focus of support and services provided by various agencies seemed to focus mainly on Charlie being the difficulty. It felt that Charlie became the issue rather than concerns such as Mother's behaviour and allegations of historical domestic/sexual abuse against Father which seemed to fade into the background.
- 14.7 **Learning: Response to potential sexual abuse and trauma**
- 14.8 Many professionals do not understand that children with disabilities may be victims of sexual abuse. Often, signs and indicators of potential sexual abuse in children with disabilities go unrecognised or are dismissed as being part of their disability. Often the Thresholds document or Pan Dorset Continuum of Need does not provide clear guidance on children with disabilities. Professionals need to understand what the disability means for the child and their usual functioning. How does this impact their communication and sensory needs, how does this impact how they respond and make sense of information? They may be displaying signs that result from their condition, but this needs to be properly assessed rather than assumed.
- 14.9 There was a wide range of expertise available to multi-agency professionals to help them understand Charlie's needs, and communication style and to advise on the best way of maximising this. Charlie was non-verbal, but signs and indicators that are not expressed verbally could be considered. This needs to be a core requirement of strategy meetings/discussions regarding children with some form of disability so that those needs are discussed. The Centre of Expertise on Child Sexual Abuse has developed Signs and Indicators: A template for identifying and recording concerns of child sexual abuse.²⁹ This template may assist in the identification of non-verbal signs and indicators for children and young people who have suffered child sexual abuse.
- 14.10 The Police need to consider the use of Registered intermediaries for any child, but particular consideration should be given when the child is young or disabled. Officers must take into account the use of an intermediary when planning interviews with children.

Multi-Agency Recommendations

Recommendation 7: The PDSCP should signpost in the PDSCP procedural Manual, the Centre of Expertise on Child Sexual Abuse's [Signs and Indicators: A template for identifying and recording concerns of child sexual abuse](https://www.csacentre.org.uk/documents/signs-and-indicators-a-template-for-identifying-and-recording-concerns-of-child-sexual-abuse1/). This template may assist in the identification of non-verbal signs and indicators for children and young people who have suffered child sexual abuse.

Recommendation 8: The BCP - PDSCP should review the current training in Child Sexual Abuse. Ensuring that when professionals are working with a disabled children who are the victims of or witness of sexual abuse the course highlights the increased risk these children are living with due to a broad range of disability.

²⁹ <https://www.csacentre.org.uk/documents/signs-and-indicators-a-template-for-identifying-and-recording-concerns-of-child-sexual-abuse1/>

15 The child's voice

- 15.1 Charlie has been the subject of two CPP's and a brief period of being a looked-after child before Charlie's 18th birthday. At one meeting there were 18 professionals from different agencies and still no one could engage fully with or find out what life was like for Charlie. The CPCC's should have made it their priority to speak with and find ways to engage Charlie.
- 15.2 The voice of Charlie in the child protection process was absent. There is no evidence that either CPCC made attempts to visit Charlie or communicate via other ways. There were comments about Charlie playing video games so the chair could have attempted to use technology to initiate contact with Charlie which would have been a start to building a relationship. The lack of Charlie's voice in the CP process meant there was unassessed risk and gaps in assessments which meant the CP process was not safeguarding Charlie. Charlie was allocated an advocate but there is no evidence of the CPCC speaking with the advocate or Charlie's views being represented in the CP process by an advocate.
- 15.3 On 14 January 2020, the CHAD FP, started working with Charlie and the family (two or three times weekly) to build relationships and attempt to get Charlie to engage to seek an understanding of Charlie's wishes and feelings.
- 15.4 There was recognition from the IRO that *"effort has been made to try and capture the child's lived experience, but that this has been difficult due to the level of communication and the child's presentation. Capturing the child's voice has proved to be difficult in this situation"*. However, the IRO stated that *"Other agencies were helpful in the conference and were able to offer some insight into what Charlie's life is like and the risks and concerns currently in place, particularly professionals from CAMHS"*.
- 15.5 Charlie's needs were reviewed regularly by CAMHS, and actions were added which were based on professional knowledge and experience. Charlie was unable to verbalise words but was able to demonstrate displeasure by shh'ing, shouting and kicking. At times it was not possible to communicate directly with Charlie in any meaningful way, or indeed gain access to even have sight of Charlie.
- 15.6 The CCCP commented. *"Charlie offered only very infrequent, sporadic eye contact which could be described as fleeting, with no social interest shown in me"*. The psychologist was also asked whether Charlie was Gillick Competent, responding no, explaining Charlie's understanding is that the overall test of Gillick competency is one of a child being able to give consent if they fully understand the (medical) treatment that is proposed and if a child has sufficient understanding and intelligence to understand fully what is proposed. Charlie does not have this full and sufficient understanding of any changes that might be proposed for intervention. He went on to state, even if one would apply the Mental Capacity Act 1987 and 2005 test of mental capacity, Charlie would not be likely to be seen as having sufficient mental capacity to independently take decisions. Issues around advantages, disadvantages and potential long-term implications are not likely to be understood and processed with good understanding. Charlie is not likely to understand risks, implications and any consequences that may arise from any decision.

15.7 Learning: The child's voice

- 15.8 Following the CCCP's view of Charlie's ability to consent, give views and independently make decisions. Charlie's ability to contribute information about needs and wishes also seems fraught with difficulties. It is clear from the IRO's comments that professionals all attempted to communicate with Charlie with very limited or no success. The FP from the CHAD team who had developed a relationship with Charlie was allowed to press buttons to restart videos or reset the device, commenting he believed that Charlie was not able to contribute and provide professionals with a view of needs and wishes.
- 15.9 However, since the case improvements have been made and weekly monitoring is in place with IROs to further monitor visits to children, mid-point reviews and referrals/allocation of an advocate in a child's life.
- 15.10 Further learning regarding the numbers of professionals involved and Mother being used as a proxy for Charlie's, views and perspectives is highlighted by Taylor et al, (2016) *"talk of losing sight of the*

*child due to perceptions that the number of services that would potentially be involved with disabled children was highlighted as a safety net. They argue that this must not lead to complacency in safeguarding practice. This reliance on others for protecting disabled children was also seen to extend to reliance upon parents or carers to understand what the child was communicating, or even using them as a proxy for the child's perspective, which in some cases could render the child vulnerable"*³⁰.

Multi-Agency

Recommendation 9:

All relevant agencies should ensure their workers are aware of the vulnerabilities of children who have a disability and are electively mute or non-verbal.

Recommendation 10: The BCP- PDSCP should develop an easy-to-follow guide based on the Centre of Expertise on Child Sexual Abuse template <https://www.csacentre.org.uk/documents/signs-and-indicators-a-template-for-identifying-and-recording-concerns-of-child-sexual-abuse1/> setting out how electively mute or non-verbal children can communicate through written information, changes to their behaviour or through interaction with objects. This should be assessed alongside the behaviours of others providing care for the child. The BCP- PDSCP should seek assurance that this is embedded into practice through supervision and training

16 Reluctant and Sporadic Compliance

- 16.1 Mother's views on processes and actions changed repeatedly and how this impacted on Charlie's care was remarked on through the learning event and the organisation's single agency reports for this review. There were many instances when this occurred. This in many reviews is often termed disguised compliance. In this case, the Mothers choices were not hidden and were often clearly verbally shared. Organisations and individual workers explained how this impacted the progress of the plan and in many situations delayed progress. Mother also provided a different response to individual professionals changing her opinion regularly. An example of this is the work of the DHCUT Bladder and Continence service. This service worked closely with Mother and Charlie, providing support and strategies to mum for Charlie from May 2019. They were very flexible in their approach and Mother was supported to communicate with the service and was able to request continence supplies and pads. During a home visit by CAMHS in October 2020 Mother commented that she had no support with continence issues and had no 'supplies' to manage this. Records reviewed show that the Bladder and Continence Service had spoken with Mother on 24 September 2020.
- 16.2 On 9 June 2020, Charlie was booked for a pre-assessment appointment at Residential Unit 1, but Mother went on her own as she felt that Charlie was not ready. Mother refused the support of the CHAD Duty Social Worker to support getting Charlie to Residential Unit 1 and refused to allow access to Charlie. Mother attended the Residential Unit 1 pre-assessment appointment on her own, meaning the clinicians were not able to see and assess Charlie. In response to this, a strategy meeting was held on 12 June 2020. A further meeting took place in which it was identified that Residential Unit 1 was not able to meet Charlie's needs.
- 16.3 A review of the PLO was held on 29 October 2020 with an agreement that a final meeting would be held in December when the expert report was received. At this stage, Mother was informed that she had not adopted CAMHS recommendations or embedded them in her approach to Charlie and that a lot of things seemed to have got in the way of her achieving this e.g., tiredness, lateness, and wanting to make sure Charlie had food; or lack of confidence in the CAMHS approach. Mother objected to this, saying symbols had been used a lot.

³⁰ Taylor, J., et al. (2016). "Disabled Children and the Child Protection System: A Cause for Concern." Child Abuse Review 25(1): 60-73

16.5 Learning: Reluctant and Sporadic Compliance

- It is uncertain if Mother compliance was due to distinct choices, to disrupt the care planning for Charlie or was due to the stress and fatigue caused by the demands and fatigue of caring for a child with complex needs.
- Initial Child Protection Conference report of 30 January 2020 comments “Historically Mother has and continues to feel accused by the professionals of being a bad mother and in some way contributing to her child’s presentations. This makes her quite distrusting of professionals and wary of their intentions, questions, comments and advice.”
- Given the need to understand and respond to the reluctant and sporadic compliance, it is important the professional at the Core group and CP Conference involved maintain a robust multi-agency chronology, recording evidence about what is happening and sharing this with involved professionals. This was also a recommendation from a previous review “Ashley” 2020³¹.

Multi-Agency Recommendation

Recommendation 11: The BCP - PDSCP will provide a multi-agency chronology template and protocol to review children where they have been subject to a child protection plan on a number of occasions and have complex needs. This will be in line with the multi-agency chronology template and protocol under development by PDSCP following the Learning Review “Ashley” 2020.

17 Conclusion and recommendations

- 17.1 Charlie has a diagnosis with High Functioning Autism and “likely” to meet the Generalised Anxiety Disorder and was in Mother’s Care. Charlie had been known to CSC since in 2015. There was reported domestic abuse in February 2017 which was found to be extensive historical domestic abuse by Father against Mother. In January 2020 Charlie’s sibling disclosed being sexually abused by Father which started from the age of 4 or 5. Another older Sibling also disclosed being sexually abused. More historical domestic abuse was reported by mother after this. Mother did not exclude the possibility of Charlie being sexually abused by father. Throughout CSC involvement, Mother did not engage fully and obstructed professionals from undertaking assessments which meant that Charlie did not receive the required support and services. The legal intervention was started under the PLO and high-level intervention was put in place. This was in place for a period of 1 year and 30 weeks, with Charlie, eventually moving into a specialist unit as an adult after intervention by the CoP.
- 17.2 The context of the case includes a structural re-organisation of three Local Authority areas into a single Unitary Authority. Also, the merger of two Health Trusts to a single Trust system.
- 17.3 The Covid-19 pandemic impacted the progress of the case due to the closure of services, lockdown, shielding, restrictions on new admissions and delays in legal processes. Although BCP CSC put into place processes for children on CPP to be seen weekly in person. The response to Covid-19 allowed parents who are hard to engage with to avoid professional contact. In this case professional rigor and persistence were required so that Charlie’s needs continued to be met despite the challenges of working during a pandemic.

17.4 Good Practice

- 17.5 Good practice has also been identified in this case both in the agency reports and during discussions with the professionals involved in the case. They include:

³¹Pan Dorset Safeguarding Children Partnership, Local Child Safeguarding Learning Review, Ashley 2020

June 2022 Recommendation j. The Pan Dorset Safeguarding Children Partnership should develop a multiagency chronology template and protocol for use in certain circumstances to support informed decision making by all partner safeguarding agencies when working with complex situations

- CAMHS provided consistent support to promote Charlie's welfare and needs. They were a constant support and at times lead agency when the case was closed to CSC.
- UHS from the start of admission demonstrated good working together with adult and children services within the hospital. Charlie was treated within adult environments as initially it was deemed more clinically appropriate. A wide range of professionals all worked together to meet all of Charlie's needs, and all recognised Charlie's status as a child. This teamwork then provide support until Charlie was 18 years of age and transitioned into sole adult hospital care. The safeguarding team within UHS have a dedicated Transition Safeguarding service. This enabled and supported a consistency of care and communication for Charlie as the transition to adult services occurred at 18.
- Residential Unit 2 regular communication was maintained throughout and up to the admission to the hospital and this was done with a very detailed plan. During the emergency hospital admission Residential Unit 2 provided a carer to work with Charlie in UHS to provide consistent care.
- This family have had the opportunity to have continuity of care within the GP practice. They all have access to GPs that know them well. The GPs provided late visits and good multi-agency working.
- The timeliness of CP conferences was good, and all conferences took place within the required timescales.
- There was excellent joint working between the CSC CHAD Team and the ASC PfA Social workers and teams, at the point of case transition and beyond.
- The second CP chair raised concerns with the social worker and team manager about the delays in the CoP process via email and Charlie remaining at home.
- There was extensive agency involvement and various expert assessments were undertaken.
- Full MDT approach to decision making and preparing for adulthood led by Children's Social Care and excellent joint working with adult and children's services.
- The best possible solutions could not be achieved using The Children Act 1989, therefore processes within The Mental Health Act 1983 and The Mental Capacity Act 2005 were explored, resulting in a Court of Protection hearing.
- CSC tried to gain access to a range of provisions – initially Residential Unit 1, then Residential Unit 2, seeking provisions that could provide Charlie with a medical assessment.
- The SEND team sought a resolution regarding education by providing a home education service for Charlie in the home environment.

Multi-Agency Recommendation for linked to identified learning

Recommendation 12: The PDSCP should write to the Department of Education and Ofsted about the challenge in finding placements for children with ASD, and the need for flexible bespoke packages of accommodation, care and support for these children that are based on the child's needs and are not provision-led. They should be specifically asked to review the registration requirement for bespoke placements to ensure they can provide support in a timely way.

Recommendation 13

The issues raised in this CSPR relating to Covid-19 should be presented to the National Covid Inquiry by the PDSCP.

18 Appendices

Appendix 1 Multi-agency Recommendations.

Recommendation 1:

All Organisations and professionals must follow the PDSCP Policy on Child Protection Conferences Procedures, including guidance about when to attend Child Protection Conferences as set out in the Policy. The PDSCP must send the guidance to agencies to distribute and link it to the learning to give context for the rationale.

Recommendation 2:

The PDSCP must develop a seven-minute guide to ensure that the role of the LADO is understood by all partner organisations and relevant organisations. The PDSCP should ensure the LADOs functions are built into existing multi-agency training. This should also include information regarding working with adults who may be parents or carers who are involved with children's services and who are in a position of trust.

Recommendation 3:

The PDSCP should write to HM Government highlighting that the Practice Guidance Safeguarding Disabled Children was published in 2009. This guidance is significantly out of date. Although legislation is in place through Children and Families Act 2014 Part 3 does not give the guidance required for this vulnerable group of children and young people.

Recommendation 4:

The PDSCP should ensure the Pan-Dorset Safeguarding Children Partnership (SCP) Policies and Procedures Manual Safeguarding Disabled Children section is reviewed with the support of Tri.x in light of this CSPR to ensure it provides in-depth guidance to all professionals and volunteers when working with this group of children and young people. This should include the legal aspects of capacity and consent in children and young people with a disability and diagnostic overshadowing to ensure that safeguarding concerns do not become invisible due to the child's disability.

Recommendation 5:

The PDSCP should develop a seven-minute guide on the Pan-Dorset Multi-agency Escalation Policy and ensure training and supervision includes the use of the guide to confirm that all partners understand, are well versed and empowered to use this Policy.

Recommendation 6:

All partners should ensure that their staff and teams are aware of the diversity of organisations in relevant agencies and partner organisations, moving away from generic terms such as Local Authority or Health. This recommendation was also made in the Local Child Safeguarding Practice Review "River" 2022. The BCP - PDSCP should coordinate the development a briefing document to explain the role and responsibilities of agencies and organisations. Existing PDSCP training should provide the opportunity to discuss individual roles and responsibilities to break down stereotypes and myths.

Recommendation 7:

The PDSCP should signpost in the PDSCP procedural Manual, the Centre of Expertise on Child Sexual Abuse's [Signs and Indicators: A template for identifying and recording concerns of child sexual abuse](#). This template may assist in the identification of non-verbal signs and indicators for children and young people who have suffered child sexual abuse.

Recommendation 8:

The BCP - PDSCP should review the current training in Child Sexual Abuse. Ensuring that when professionals are working with a disabled children who are the victims of or witness of sexual abuse the course highlights the increased risk these children are living with due to a broad range of disability.

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Recommendation 11:

The BCP - PDSCP will provide a multi-agency chronology template and protocol to review children where they have been subject to a child protection plan on a number of occasions and have complex needs. This will be in line with the multi-agency chronology template and protocol under development by PDSCP following the Learning Review "Ashley" 2020.

Recommendation 12:

The PDSCP should write to the Department of Education and Ofsted about the challenge in finding placements for children with ASD, and the need for flexible bespoke packages of accommodation, care and support for these children that are based on the child's needs and are not provision-led. They should be specifically asked to review the registration requirement for bespoke placements to ensure they can provide support in a timely way.

Recommendation 13

The issues raised in this CSPR relating to Covid-19 should be presented to the National Covid Inquiry by the PDSCP.

Appendix 2 Single Agency Recommendations:

Children's Social Care:

1. CSC will provide assurance to the BCP PDSCP that disguised compliance and being able to recognise this early and as well as being aware of what actions to take when sporadic and reluctant or disguised compliance is suspected is embedded in training.
2. CSC will monitor attendance at CP Conferences to ensure conferences are quorate with sufficient agencies present to enable safe decisions to be made, escalation should be made immediately to the senior management and assurance should be made to the BCP - PDSCP when sharing the annual report of the IRO, Safeguarding and LADO annual report.
3. CSC will be aware of the need to meet with parents separately when there are disputes, or when one partner is a risk to the other, assurance should be made to the BCP - PDSCP when sharing the annual report of the IRO, Safeguarding and LADO annual report.
4. CSC will share their IRO/LADO annual report with the BCP – PDSCP setting out the progress of CCP, the functioning of the IRO Service and any quality issues.
5. CSC should ensure that the guidance Standards for Enabling Participation of Children and Young People in Child Protection Conferences, is followed in CPCs.
6. The Director of Children's Services in BCP should ensure that the PLO processes are being conducted within 16 weeks and that delays and risks are addressed immediately.
7. The Director of Children's Services in BCP should continue to share the BCP Improvement Plan with the PDSCP for information.
8. CSC should ensure where there is a medical diagnosis offered as an explanation for the presenting features of neglect, all aspects of the child's health and well-being should continue to be considered to avoid the potential for diagnostic overshadowing.

BCP Legal Team

1. The BCP Legal Team should develop guidance on PLO pre-proceedings and the use of PLO and the application to the Court of Protection for 16- and 17-year-old vulnerable young people. This should be presented to the PDSCP and Children's services so this guidance is available for partners and Social

Workers through the PDSCP website and the children's service manual, so that there is a better understanding of a process which becomes integral to many safeguarding cases in which partners are involved.

- 2 The BCP Legal team should monitor the timescales for PLO Pre-proceedings work, ensuring this remains within the 16-week timescale.

NHS Dorset Integrated Care Board (DICB)

1. DICB should lead a review of safeguarding paediatric services in their area working in partnership with all Health Trusts that provide safeguarding paediatric services. To ensure all Health Trusts in the Dorset and BCP areas that provide safeguarding paediatric services are deployed effectively to meet service requirements and local health needs across the area they serve.
2. The DICB should lead a review of the agreed safeguarding paediatric pathway to ensure that children with disabilities / complex presentations who live in the BCP area who require a health assessment due to concerns about their welfare due to alleged or potential abuse are able to access medical health assessments. This pathway should be presented to the PDSCP for ratification and entered into the PDSCP Multi-Agency Procedures.
3. The DICB review will also consider the policy of no home visits, or ambulance support for safeguarding paediatric investigations. The review needs to consider if this policy needs to change to include flexible support for cases where it involves children with disabilities to ensure they can access these services.

University Dorset NHS Foundation Trust

1. UHD should review the availability and if necessary, undertake the adaption of a number of treatment rooms so they are suitably adapted to admit children with special needs for emergency treatment or health assessments.

All Acute Health Services

1. All acute services will review the role of Safeguarding Professional's and their role in attending and providing their expertise and knowledge to child protection conferences.
2. Once this review is undertaken oversight and assurance should be provided to the PDSCP.

Dorset Police

1. Dorset Police should provide assurance to the PDSCP that children with disabilities in Dorset that need to have an intermediary to assist their communication and involvement with the criminal justice system are offered this service to ensure that their access needs were met or adjustments made.