Local Safeguarding Practice Review
PRINCESS
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Cambridgeshire and Peterborough Safeguarding Children Partnership Boards

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Contents

1. INTRODUCTION

1.1 Why was this Review undertaken?

The Chief Executive of Peterborough City Council asked the Cambridgeshire and Peterborough Safeguarding Children Partnership Board to review the case of a teenage girl, Princess. This request was made on behalf of the Chief Officers in the Safeguarding Partnership. Princess has very complex needs, including an escalating pattern of behaviour which put both herself and others at significant risk. It had proved impossible to find a suitable placement to meet those needs despite ceaseless attempts to do so.

The resulting degree of harm Princess was experiencing and the unprecedented demands on statutory services led to the establishment of a Gold Group initiated by Cambridgeshire Police. It was subsequently agreed that due to the complexity of Princess's situation and the continuing inability to find a suitable placement further contributing to the harm she was experiencing, a review would most appropriately be undertaken as a Local Safeguarding Practice Review. The National Panel was informed and an Independent Reviewer commissioned.

1.2 Methodology

The ultimate purpose of a Safeguarding Practice Review is to identify improvements which could be made across the multi-agency partnership, to safeguard and promote the welfare of children. The methodology for this Review reflects the principles outlined in Working Together 2018[1], set out as follows:

"*The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.*"

In keeping with this statutory guidance, the purpose of this report is not to focus on the actions of individual professionals. Specific decisions, actions and gaps in services may be analysed but the focus is on the strengths and weaknesses of the multiagency systems currently in place and the learning that inevitably results.

The following key lines of enquiry were agreed within the Terms of Reference:

- What can the Partnership learn about managing and supporting children who have experienced complex trauma?
- What are the barriers to ensuring effective early responses to children exhibiting traumatic behavioural responses and ensuring the focus is not only

[1] Working Together 2018, Chapter 4. The relevant version at the time the review was commissioned.

on managing risk but also the child's therapeutic needs, educational needs, culture and identity, and wider wellbeing.
- What does this child's experience tell us about the effectiveness of partnership working across agencies and with provider agencies.
- What learning is there for the Partnership about the support and care provided to staff working with children and families in these situations.
- What learning is there from this child's experience about access to National resources for children with complex care needs.

The National Panel also requested that the following issues be considered within the report:
- DoLs and missing episodes.
- Risk assessment.
- Placement providers giving notice.
- Risk management in unregistered settings.

The starting point was chosen to cover the period when concerns about Princess were being identified by her school and because missing from home episodes had led to the involvement of Police and Children's Social Care (CSC). The end point was fixed at the time Princess returned to Peterborough from a Secure Children's home in Scotland and the Local Authority Chief Executive had requested a review. This Review will not be analysing the current active arrangements for Princess.

It was accepted from the outset that this Review could not undertake a full analysis of all the contact between agencies, Princess and her family. The quantity of information that would have needed to be gathered was not considered to be proportionate in relation to any potential additional learning that might be identified.

The Review was led by and authored by an Independent Reviewer working with a Panel of Senior Managers from the key Statutory Agencies and supported by the Cambridgeshire and Peterborough Safeguarding Children Partnership Board.

Information sources included the following:

- Reports from 24 organisations involved with Princess and her family.
- A multi-agency chronology.
- Individual records and documents as requested by the Reviewer.
- Meeting with Princess.
- Individual meetings with a range of relevant professionals, including in person meetings with 12 practitioners who had significant involvement with Princess at this time.
- Online meetings with senior members of Peterborough Council Commissioning Team.
- Online meeting with a group of professionals from northern England.
- Gold Group Terms of Reference and sample of meeting notes.
- Police body-worn video recordings.

Methodological limitations

- At the time the Review was taking place, agencies were still actively involved in working with Princess. This at times created difficulties in separating current events and practice from the time period under consideration.
- Difficulty in creating a panel of suitably senior individuals who had not themselves either at the time or since had some involvement with Princess.
- Capacity to review all available information as previously noted.

Recommendations and Practice Points

Recommendations are made in relation to learning of a significant nature relevant to the effectiveness of partnership working.

Professional Practice Points are practice issues which individually would not lead to a recommendation but are recorded to support wider learning, and can be used as a refresher, or a tool for training. They are features of good practice which are recognised as needing continued highlighting and which may be difficult to achieve when working in pressurised contexts.

1.3. Contributions from the family

The involvement of children and their family is a very important feature of Reviews. While this, of course is not a requirement of family members, it can significantly contribute to learning. Princess was able to contribute, however her parents did not wish to do so.

Princess's contribution

Princess, agreed to meet with the Independent Author and the Cambridgeshire and Peterborough Safeguarding Children Partnership Board Head of Service. She was supported by her Independent Reviewing Officer (IRO).

At the outset of the meeting the IRO explained that he and Princess had prepared in advance and had agreed that Princess would like him to answer on her behalf as she would find that easier, but that she would join in when she could. In fact, although sometimes Princess asked for questions to be explained, she contributed significantly during the meeting.

When we arrived, Princess was playing a video game with the IRO, but quickly got up to meet us and asked questions about us. On her behalf the IRO described her as bubbly and energetic, which reflected what we had already experienced. Princess added that she talked a lot and very fast. She talked about liking sports particularly gymnastics and proceeded to demonstrate with a backward crabwalk. She told us she was quite good at gymnastics and had taught herself a lot when she was younger, but she has also had lessons. She said that she loved going out for walks and seeing her family. She likes school and is interested in Child Development which she wants to study. She likes cats and dogs, but hates spiders, especially jumping spiders.

Princess told us that she had just started having the chance to meet some of the other girls and had started making friends. Her IRO described her as very bright and really good at retaining information. He also said that her heritage was very important to her. Princess agreed that her family were very important to her. Princess likes it when her mother comes and told us that her second language is English.

We talked about what had and had not helped Princess over the last couple of years. Princess told us that her time living in a house with care staff had definitely not helped. She said she hated the time there and it made her issues worse. The house she talked about was completely empty, nothing there, just a mattress on the floor and the diet was bad. The windows were frosted over, so she couldn't see out, except for a few inches if she stood on the windowsill. She also did not like being taken places in an ambulance which parked outside. The staff were from different cultures, and she could not relate to them they talked in their own language and played their own music.

Princess talked about her triggers, which she said included: being locked in; not going out; not being able to talk to her mum. She said that the carers from one of the agencies were the best as they were younger, and she could relate to them.

Princess remembered the placement in the north of England. She said the carers were nice, there were lots of activities, she could go out, nice rooms – but it was too far from home. She felt that she was just beginning to settle there, then they just moved her. She described her frustration that there had been lots of placements but there were never any discussions about moving, it just happened. She talked about an upcoming proposed future move. Workers are starting to talk to her about the move, but she needs an image of where she is going, so she can visualise it. She wants to know about where she is going next, she tries to picture her room and where her bed would be. The IRO commented that the uncertainty was not helpful, and Princess agreed.

Princess remembered one social worker in particular that she liked. She was nice and had empathy – "*she understood me and what I needed, she gave me a hug*". Princess said she liked people who were straight with her and treated her normally. Princess agreed that there were other professionals she liked and she understood they were trying to help, but they didn't understand what it was like being a teenager living like she did. Princess said that she does not like the therapeutic sessions, they just keep going over the same things and she is going through the motions. She said the psychologist thinks she understands her, but she doesn't, "*I keep being told I have PTSD, but I know that*". The IRO said to Princess that this was probably because they were having to talk about difficult things, so there was a bit of tension with the psychologist. Princess described some workers as 'robotic', she really disliked the way that professionals from Positive Behavioural Support acted, that they just came and watched her, it didn't feel good. She wants people to be straight with her. She prefers younger people; they can relate better.

Princess said that being restrained wasn't good and that the police restrained her on her front, which they shouldn't do but she knows sometimes they had to do this. She hates having her feet touched, she doesn't like feet and toes and her socks are a comfort, when they took her socks off that triggered her.

Princess told us that she had now been 40 days without an incident, which she is really pleased about. She nearly lost it once, but then thought it wasn't worth it and told herself to walk away. Princess didn't really know what was different that time. The IRO suggested that maybe it was because she knew she was working towards a goal she wanted, being moved from the secure placement to a placement that was being developed especially for her. This placement would give her more freedom. Princess agreed. The IRO reminded her that not long ago she had seen her dad for the first time in 2 years and that had been really positive. Princess agreed and said she felt her dad had not been treated well when the problems first started. She said that before she left home social services should have provided more support, not just believing parents and police about things. Her dad had been ok with the social workers but then she heard them being derogatory about her dad and this affected her. The first time she was arrested the police left her outside at 4am and didn't tell her dad what was happening, just told him he had to get out of his own kitchen.

At the end of our meeting Princess was exactly as she had been described, bubbly and full of energy.

2 Summary of the agencies' involvement with the family

Princess and her siblings first became known to statutory services as a result of reported incidents of domestic abuse, her father's alcohol use and allegations that Princess had experienced physical abuse. A total of 4 referrals were made to CSC. CSC undertook an Initial/Child and Family assessment on 3 occasions and support was offered, but the threshold for statutory intervention was not reached and the family did not want other support.

Princess again came to the attention of the Police and CSC after being missing from home on a number of occasions and stating that she was being physically abused by her parents. This was denied both by her parents and by her siblings. Strategy Meetings followed and a Child and Family Assessment was initiated by CSC. There were increasing concerns about Princess's welfare including vulnerability to exploitation, self-harm and her at times aggressive behaviour. A Mental Health Assessment was undertaken by CAMHS[2] which concluded that Princess was '*emotionally dysregulated but does not have a mental health need*'. Family relationships were deteriorating and Princess's parents said they could no longer cope with her behaviour, and she was placed in temporary foster care with parental agreement under S20 of the Children Act.

Over the following month Princess stayed with a number of different temporary foster carers but continued to be missing from home and made threats of suicide and violence in the last placement. With her parents' agreement the Local Authority applied for an Interim Care Order and an out of county placement in a residential home in the north of England. No suitable placement nearer to Princess's home was available.

[2] CAMHS: Children and Adolescent Mental Health Services

Almost immediately on arriving at the residential home Princess's behaviour escalated dramatically. This included repeatedly running away, contact with older men, self-harm and suicide attempts, physical assaults on staff and very serious damage to the home in which she was staying. As a result, a further CAMHS assessment was undertaken, and this came to the same conclusion as that of the previous assessment in Peterborough.

Before the end of the month, the placement gave notice as they could not manage the risks that Princess posed to herself and others. A Deprivation of Liberty Order (DoL)[3] had been applied for, to attempt to protect her from exploitation and from absconding and this was granted by the Court. The Local Authority was granted permission by the Secretary of State to place Princess in a Secure Children's Home[4]. However, Princess remained at the residential home for a further month before a place was found in at a Secure Children's Home near her family home.

Whilst in there, Princess continued to present extremely disturbing behaviour, with almost daily episodes when she was seriously dysregulated, self-harming and assaulting staff and other professionals including police and ambulance staff. Staff needed to restrain Princess on numerous occasions. Psychological assessments and interventions were begun. However, within one month the Secure Children's Home gave immediate notice to the Local Authority that they were terminating the placement. This followed an incident in which Princess injured several members of staff, two of them seriously.

Despite daily searches for a suitable registered placement willing to accept Princess, none could be found. In the absence of any alternatives Princess was accommodated in a hotel with support staff from an agency. This marked the beginning of a long series of moves between different types of accommodation, supported by agency staff, with the ratio of staff increasing over time eventually reaching 8 staff to1 child. The agencies and their staff also changed frequently. The moves would be triggered due to Princess causing serious damage to the accommodation and therefore being required to move. The changes of support staff were as a result of the agencies withdrawing, the availability of staff and decisions that they were unable to support her safely.

There were periods when Princess lived in houses provided for her alone by the Local Authority, but frequently she lived in hotel rooms or Airbnbs, also spending nights in police stations or hospitals. At times this meant placing her in neighbouring counties, further away from her family and involving agencies from other authorities in her care almost always at very short notice.

The Secure Accommodation Order remained in place whilst in the meantime the Local Authority tried repeatedly to find her more suitable regulated residential accommodation. This meant that she was living in unregistered[5] accommodation for

[3] A Deprivation of Liberty order is a court authorised order made when restrictions are placed on a child's liberty beyond what would normally be expected for a child of the same age.

[4] The Secretary of State's approval has to be granted in order for a child under 13 to be placed in a Secure Children's Home.

[5] Unregistered provision is when a child who's being provided with some form of 'care' is living somewhere that is not registered with Ofsted.

the best part of a year in isolating and unsuitable conditions. Support was provided to Princess by Education, Children's Services and Mental Health professionals, but the capacity to undertake consistent programmes of work or therapeutic interventions was limited. Princess's behaviour continued to present very serious risks to herself and to those trying to care for her. The impacts of this both for Princess and others will be covered further in the following section.

An extraordinarily wide range of agencies and staff supported Princess, particularly, but not only:

- Virtual school providing education.
- Mental Health practitioners from CAMHS and CPFT
- Children's Social Care staff
- Residential workers
- Police
- Medical staff in at least 3 hospitals
- Fire and Rescue
- Ambulance and paramedics
- 4 agencies providing support staff
- Secure transport staff

Alongside planned contacts and meetings there were significant demands for urgent responses that fell particularly to Emergency Services and Children's Social Care. In preparing information for this review Cambridgeshire Constabulary alone identified more than 200 records during this period, from strategy meetings to missing episodes, to emergency responses. Princess was assessed repeatedly, including around 25 Mental Health or Mental Health Act assessments undertaken over a 12-month period. She experienced restraint both by carers and the police on numerous occasions. The frequency and seriousness of Princess's episodes of dysregulation was at a level that the agencies involved said they had never previously experienced. Her capacity to cause extraordinary levels of damage, from ambulances to the places where she lived, as well as violence to staff and serious harm to herself was overwhelming from every perspective, not least the impact it has had on Princess herself.

After what had appeared to be a more settled period, the decision was taken not to renew the Secure Accommodation Order which had expired However, the settled period did not last and Princess was placed at a Secure Children's Home in Scotland. On arrival, Princess informed staff at the home that she did not want to be there and would behave in such a way as to ensure that the placement was terminated. Within a month this proved to be the case with the Home concluding the level of injury and abuse to staff was intolerable and notice was given to terminate the placement.

Establishing exactly the full range of placements and professionals acting as carers during the period under consideration is difficult. However, this review has identified that Princess lived in or spent nights in at least:

- 5 Foster placements
- Police stations – 6 occasions
- Hotels 16 different occasions, in 11 different hotels/Airbnb's

- 4 hospitals, total of 5 occasions
- 13 occasions at 5 different unregistered placements
- One out of county residential home
- Two secure children's homes, one of which was out of county.

She was cared for in these different placements by various professionals including 2 police officers for one night and 2 emergency duty social workers on another night in the early weeks. For most of the placements she was cared for predominantly by 4 Care Agencies with up to 8 carers with her at any one time. The number of agency carers was in line with the DoL order made by the court.

3. Analysis: Understanding Princess, her needs and experience

3.1 Introduction

Princess lived with her parents and siblings prior to the events outlined here. The family moved to the UK when she was very young. The children all attended local schools. Some extended family members also lived locally, but there was little other information about Princess and her family's wider community.

3.2: How organisations understood Princess

The initial response

When Princess came to the attention of Children's Social Care and the Police, there were clearly identified concerns about why she was missing from home and how vulnerable that made her. The police were routinely able to find and return her home quite quickly. On each occasion Independent Return Home interviews[6] were triggered according to the required process. The records were detailed, clearly including a focus on Princess's voice.

Whilst the contacts with the family in previous years were known, no significant recent history of concerns was identified, and the allegations of physical abuse could not be substantiated. However, over the next few weeks, and before the Child and Family Assessment had been completed, the continued missing episodes and problems within the family resulted in neither her parents nor available foster carers being willing or able to care for Princess. At that point, there appeared to be little choice but to move her to a residential placement. Achieving a comprehensive assessment in this context would not have been easy. A CCE/CSE (Child Criminal Exploitation/Child Sexual Exploitation) assessment was completed and identified her as high risk. Although other concerns remained, the urgent risks for Princess at this time were understood primarily as being outside the home, when she was missing.

[6] Independent Return Reviews, also known as Return Home interviews, are undertaken with the child by an independent organisation to identify if the child has experienced harm and what is causing the child to go missing.

If it had been possible to spend more time and/or resources working directly with the family and developing an understanding of the family dynamics this may have created a richer, more nuanced picture of Princess's experience within the family as well as outside of it. A longer time period might also have revealed that there could be the beginnings of a pattern of emotional dysregulation and damaging behaviour. With the advantage of time and hindsight, and without the pressure of having to find a home for a child who was frequently missing and becoming hard to place, it is easy to conclude that a different approach could have been adopted in order to maintain her within her family. However, the unresolved allegations and the fact that her parents were clear they would no longer accept her at home were a very real barrier.

There is evidence that Princess's voice was sought and listened to, as professionals tried to understand what was leading to her worrying behaviour. However, understanding what she wanted, what she was feeling and why she became so dysregulated was not straightforward.

It was widely understood that Princess must have experienced some form of trauma, but difficult to identify exactly what this would have been. It is worth noting that despite numerous assessments this continues to be the case.

> A trauma can be defined as a physical or emotional experience that has had an adverse impact on an adult, child or young person's wellbeing. The effects of trauma may not always be significant or long-lasting. However, for some the impact stays with them throughout the life course.
> Research in Practice
> https://www.researchinpractice.org.uk/all/topics/trauma/

All the professionals described two very different aspects of Princess's presentation. She is often described as appealing and charming, a lively child who can enjoy activities with adults and appear engaged. Reconciling this with the very different experience when Princess became dysregulated could be very difficult. Princess could be contradictory and confusing in what she said to professionals, but equally at other times could be very clear and unambiguous about what she wanted. For example, professionals said that she would tell people she was going to run away at a specific time and, even if she was in the middle of something she appeared to be enjoying, when that time arrived, she would run.

An additional difficulty arose as a result of contradictory information about some of what Princess told the professionals, including some of the allegations of abuse. Princess had described meetings with a 17 year old male, which bore all the hallmarks of sexual exploitation, although she was not explicit about this. Significant attempts were made to identify this individual by the police, but without success and there was some evidence that this individual may not have existed. During their investigation it was identified that a snapchat account said to belong to this individual had in fact been created by Princess. On another occasion it was discovered that she had faked a positive pregnancy test. It could be hard for staff to know what was true and what was not, and therefore how best to respond.

Professionals working in the world of safeguarding are trained to listen to children and take them seriously. There is plenty of evidence that in Princess's case, that was very much the approach taken. It is widely recognised that not taking a child seriously when they tell us about abuse or neglect is in itself dangerous as well as risking damage to maintaining any trust with that child. However, there is also an equally careful path to be trodden which enables practitioners to accept that for many reasons a child may not always be telling us the exact truth. If, this is happening then in itself it is of concern and requires serious consideration as to why this might be the case.

Further, it is crucial that such concerns are shared amongst key professionals in order to contribute to the collective understanding of what may be happening and to enable a considered and consistent response. It has become apparent that this was not always the case with Princess. This contributed to some very different understandings between professionals about what Princess might have experienced, what had been established and what had not. It also contributed to a degree of unhelpful criticism amongst some agencies.

The dramatic change in Princess's behaviour after she arrived at the Residential home in northern England was without doubt a shock to the professionals. Staff at the home were initially, and understandably, critical of what they had felt was a failure to inform them of the nature of her needs and behaviour. However, whilst there were examples of poor or unhelpful communication, there is clear evidence that information was not knowingly held back. The sudden increase in suicidal ideation, self-harm, destructive behaviour and violence to staff, was not something that had been anticipated by any of the professionals involved. The impact on the Residential home and staff was significant and this marked a fundamental shift in the way professionals sought to understand Princess.

With hindsight we can more clearly identify indicators that the family history and Princess's behaviour might be cause for greater concern than was understood in the first few months of agencies' involvement. However, it is not the conclusion of this Review that it would be reasonable to criticise individual professionals in the early weeks and months for not anticipating how Princess would react to the change in her circumstances. Identifying that a particular child may develop behaviours which will become heightened to the level experienced by Princess would be extraordinarily difficult based on the information that was known.

Identifying the underlying cause.

The apparent change in Princess inevitably resulted in an even greater wish to understand what might have happened in her life and why she was behaving in a way that caused her so much harm. A recurring feature throughout has since been the challenge in identifying what has caused Princess's difficulties and therefore what interventions should be put in place. The power of this need to understand has also at times created a distraction and a drain on multi-agency relationships. That it remains such a powerful issue has even been reflected as a live feature during the process of the Review, which at times has itself been caught up in the desire to '*get to the truth'*.

The purpose of this Review, with the advantage of time, information and greater emotional distance, is to consider the complexities which faced professionals and what

this might tell us for the future. It is not to reach a conclusion about what is causing Princess's difficulties or what the ideal response to her needs would be. Princess has a diagnosis of Complex PTSD, although this has also at times been cause of disagreement. At the point of writing Princess continues to be subject to assessment and Family Court proceedings and as yet there is not a fully agreed picture of what has led to her distress and dysregulation. The implications of this will be considered further in Section 4.

In trying to understand what Princess was saying to professionals there was rightly a considerable focus on what not just her words, but also what her behaviour was indicating. Health and Social Care professionals are expected to consider what might be an underlying cause for a child's presentation. It is absolutely right that professionals took this approach in relation to Princess from the outset, yet the often contradictory information, unresolved allegations and disclosures, and the dramatic deterioration in her behaviour made it difficult to achieve a clear picture. It is evident that to some extent the unresolved focus on what was causing her behaviour itself contributed to creating other barriers to helping her. Two particular aspects of this focus on '*getting to the truth'* exemplify the difficulties that professionals faced in making assessments of Princess and the subsequent problems this created.

From very early on, both Princess's actions, and what she told professionals suggested the possibility that she could have been a victim of sexual abuse or exploitation, with the latter remaining a live concern. Princess was very significantly viewed as a child who had experienced trauma, which in itself is an entirely reasonable hypothesis, but it cannot in itself provide a complete answer. What has caused that trauma, and what the implications may be for Princess, have at times resulted in unhelpful professional disagreement and exposed a weakness in the capacity of agencies to resolve professional disputes, including at the highest level. This will be considered further subsequently.

Police from the Protecting Vulnerable People unit were first involved with Princess due to the possibility that she was being sexually exploited but could not identify either the alleged perpetrator or other supporting evidence. Nevertheless, a decision was sensibly taken at a senior level to keep the case open as there was a general belief that "*something must have happened to her"* in the light of her behaviour.

When Princess some time later alleged that a carer had assaulted her, a specialist Police officer was allocated in a further attempt to build a relationship with her and also provide another opportunity for her to disclose any previous sexual abuse. Several interviews took place, but no other disclosures were made and the allegation against the carer resulted in no further action. That the police have been unable to establish any evidence of sexual abuse in itself does not mean it could not have happened. However, it indicated that whilst sexual abuse should remain a significant hypothesis it could not at this point be considered an established conclusion.

It is absolutely essential in these circumstances to maintain an open mind and a willingness to keep listening, and it is also important not to allow a particular hypothesis to cloud the possibilities of other important factors. Unfortunately, what has been apparent during this review is that the lack of certainty has contributed to some disagreements between agencies including to some extent the development of myths

about what different professionals and agencies have or have not done and who has the correct understanding.

It is important to note here that this Review has not seen any confirmed evidence that Princess had been sexually abused before she was accommodated away from home.

Many professionals commented on the speed at which Princess could change from being calm to being completely out of control. A key aspect of trying to understand this was to seek to identify what triggered these extremely destructive episodes, including threats to take her own life. Trauma Informed Practice has significantly raised awareness in recent years of the way in which specific situations can trigger behavioural responses, such as hyper-arousal and emotional dysregulation. What can be harder for professionals to contemplate, particularly with such extreme behaviour, is that behaviour may not have been triggered by a trauma response but could be instead a very conscious action to achieve an outcome. In reality both causes can be present, something which is recognised by those working with Princess now but has not always been the case across agencies and individual practitioners.

There is evidence that Princess had learnt to use increasingly dangerous behaviour to achieve an outcome. At its most extreme this included deliberately holding her face down in such a way as to suffocate herself, leading to loss of consciousness. Princess has herself said – "*there was no trigger – my trigger is when people say no to me*". Concluding that a child would put herself and others in such danger might not be a trauma response, but instead a calculated decision, can feel counterintuitive. Equally it raises the possibility that the behaviour may be of a very different nature and could be indicative of a serious Conduct Disorder which might itself if not treated correctly develop into a personality disorder in adulthood.[7]

> Conduct disorder is an overarching term used in psychiatric classification that refers to a persistent pattern of antisocial behaviour in which the individual repeatedly breaks social rules and carries out aggressive acts that upset other people.
> NICE Guidance, 2023 p12

The extreme nature of Princess's behaviour may understandably be seen as suggestive of some equally extreme form of trauma, such as sexual abuse by a trusted adult. However, trauma can also be the result of other long term chronic experiences such as neglect or exposure to domestic abuse. It is apparent from talking to some of the professionals that there have been some very strongly held views on whether trauma, Conduct Disorder, or both were at the root of Princess's behaviour. The differences of view have at times become quite an emotive feature of professional conflict and will be considered further in Section 4.

Despite the difficulties identified here in the way that professionals tried to make sense of Princess's behaviour, it is important to acknowledge that professionals were also

[7] www.nice.org.uk/guidance/cg158

quick to identify the positives they recognised in Princess. All of the professionals spoke about how engaging and lively she could be - "*a lovely child*" "*an incredibly beguiling child*", lively, full of energy. What has without doubt been evident across a wide range of professionals is the level of concern for her wellbeing and commitment to continue supporting her.

The complexity presented by Princess and the impact this had on the professional capacity to meet her needs is reflected here in a number of key practice points.

PROFESSIONAL PRACTICE POINTS

- Information about family history is a vital ingredient of assessment.
- The significance of gaps in family history needs to be explored and explicitly acknowledge in assessments.
- Maintaining an open mind, challenging professional beliefs and assumptions is always a crucial part of practice, especially where information is contradictory.
- The possibility that a child may not be telling the truth about a serious issue, should be acknowledged; neither used in effect to dismiss what the child is saying, nor ignored as 'child blaming'. It should instead be a cause for concern as to what is happening for that child.
- Persistence in ensuring that all information is shared with relevant partners is key to good practice.

4. Analysis: The system's capacity to provide effective care for Princess

4.1. The overwhelming impact of risk

There is considerable evidence that agencies and professionals have sought to care for and support Princess, however their ability to do so has been significantly impacted by the risks resulting from her behaviour. This is evident in the decisions taken at an early stage first to apply for a Deprivation of Liberty order (DoL), followed shortly afterwards by a Secure Accommodation Order.

Both of these legal routes have had a significant impact in terms of restriction of Princess's liberty and her overall welfare. However, the inability to find and maintain suitable safe accommodation has also obstructed all attempts to put in place and maintain a fully structured plan of therapeutic and behavioural work. All the agencies have been acutely aware that the constant change of accommodation, with all that has come with it, has inevitably affected Princess negatively. That Princess has spent months of her young life in these circumstances is of serious concern. It is apparent to all that her behaviours will have become more entrenched and that she is at very real risk of seriously injuring or even killing herself, irrespective of whether she means to do so.

Awareness of the degree of risk being posed by Princess to herself and others has demanded attention in practically every aspect of the multi-agencies' work with her. Because of the need for safe accommodation, which time and again has been withdrawn because of destructive behaviour, the risk Princess poses has become the deciding factor about where she lives, who she lives with, what she is able to do. The constraints on her life have fundamentally impacted on her capacity to live like a normal child. This without question is not due to a lack of concern from individual professionals but is due to a lack of options and the failure of the wider system to provide appropriate care for children like Princess.

Deprivation of Liberty Orders

A Deprivation of Liberty Order must be obtained from a court when a Local Authority seeks to put in place restrictions around a child that would otherwise be judged as breaching their human rights. In effect this means any constraint on a child which would exceed the level of parental control and supervision that would normally be expected for a child of the same age. Typically, a child subject to a DoL will be placed in a children's home, although they can also be granted in other situations. The restrictions must be clearly set out in the court order and are intended to be understood as the maximum restriction in place. The restrictions are not intended to simply be adhered to at all times if they are not necessary.

A DoL order was first sought for Princess when the decision was made to find her a residential placement to prevent her from absconding. The Cafcass Guardian questioned the usefulness of this approach because it required a home that could manage a DoL (which was not the case with the placement that had been found) or a Secure Home. By the time the DoL was made in court, the placement had given notice on the grounds that they indeed could not keep Princess safe.

The DoL order continued in place while an application for a Secure Accommodation Order was made and was then renewed again on a regular basis throughout the period under consideration. The content of these orders was undoubtedly very restrictive, ranging from the ratio of staff required, through the restraint used, to the precise level of supervision of Princess within the home. There is little doubt that the level of restrictions in place for a child of her age represents a position of last resort. However, that these were put in place has to be understood in the context of the risks to both Princess and staff caring for her. Those involved in drafting the DoL have described the approach taken throughout as always seeking to use the minimum restriction at every point given the lack of other options to keep Princess safe. It is clear from talking to those concerned that they were very aware of the impact on Princess but found themselves in an impossible position given the absence of any other placement options.

Restraint

The use of restraint for a child is inherently dangerous and additionally can damage the relationship between the child and their carers. "*There is substantial medical evidence of the physical and psychological impacts of restraint, particularly when used*

upon children".[8] Restraint is subject to both legal and professional regulation and guidance, varying to some degree depending on the setting in which it might take place. The fundamental principle as defined by the Department of Education is that "*restraint should only be used where absolutely necessary and should be reasonable and proportionate to the circumstance."* What is clear in this review is that restraint became a regular part of Princess's experience.

It is difficult to identify exactly how many times restraint was used with Princess during this period. However, we do know that it was very frequent, whether used by police, in hospital settings or by carers, and that it was often an extremely disturbing and lengthy event. Princess told the Review that being restrained was '*not good*' and that sometimes the police restrained her on her front, although she also said that she knew they sometimes had no choice. This use of the 'prone' position is known to be a particular risk due to the possibility of asphyxiation and should only be used when there is no other option, and for very short periods. The Review has also been told that at times Princess would shout at carers and effectively force them into restraining her in this way. The author of this report has seen Police body-cam footage where Princess is in a police cell, lying on her front, actively pressing her face into a mattress despite evident attempts of the officers to prevent her from doing so. What was apparent was both that Princess was highly distressed at this point, but that the police officers were also desperately trying to calm her and keep her safe.

As Princess spent considerable periods in unregistered placements, this meant that the overview of her experience of being restrained was with the Local Authority. An adequate number of carers supplied by the agencies were required to be trained in restraint and to adhere to their company policy, but it has been acknowledged that some managed this better than others. From a police perspective their staff were often asked to respond when Princess's behaviour had become so heightened that it was impossible to de-escalate the situation. Restraining a child will never be an easy solution, and it was clearly particularly difficult for those concerned when Princess was restrained.

Staff in some agencies such as Police, Children's Homes and Mental Health units are more likely to be required to use restraint and as a result have clear policies and guidance in relation to restraint. This will include: - staff training, de-escalation procedures, legal requirements, information about the risks and use of safe procedures, debriefing, recording, and monitoring. However, Cambridgeshire and Peterborough Safeguarding Children Partnership, including Children's Services, does not currently have similar policies and guidance for the wider staff group. In Princess's case it is not clear that there was a shared overarching framework and system for monitoring the occasions when Princess was restrained.

> **Recommendation 1:** The Cambridgeshire and Peterborough Safeguarding Children Partnership should assure itself that all relevant agencies have policy and guidance in relation to the use of restraint.

Finding and maintaining a suitable placement

[8] https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/99405.htm#footnote-169

When Princess was found a placement in northern England, it appeared to provide a good match with her needs given their therapeutic approach and experience of working with trauma and exploitation. Princess loves activity, gymnastics and getting outdoors and the home seemed ideally placed to meet her interests. However, neither the home itself nor the staffing arrangements were equipped to manage Princess when her behaviour became extremely damaging. Princess has told this Review that she liked the place, and the staff, but it was simply too far from home. That she had been placed so far from home was due to this being the only placement that could be found in the 36-hour period the Local Authority had to find somewhere for her. As a result of the acceleration in her behaviour, the Local Authority made an application for Secure Accommodation and the search for a placement for her was now limited to that of a Secure Children's Home.

Princess was found her first secure placement near Peterborough. The home is owned by Peterborough City Council, but nevertheless the placement was terminated within a month. The second time she was found a Secure placement was inin Scotland and again, this was terminated within weeks.

At the point when a child is identified as needing care in a secure setting, the options available to the Local Authority, and their capacity to provide that care, becomes extremely limited. Secure Children's Homes are a national resource predominantly run by private companies, although some Local Authorities, including Peterborough, also manage Secure Homes. Irrespective of who manages the home, the process for securing a place is through a national system.

Local authorities face three specific problems when trying to obtain a secure placement for a child, particularly a child who has very complex needs:

- Availability
- Suitability
- Stability

Availability: At a national level there is a severe shortage of suitable residential placements for children. Before a child can be placed in a Secure Children's Home on grounds of their welfare, a Court Order must be applied for and must meet the following criteria:

1. That he/she has a history of absconding and is likely to abscond from anything other than secure accommodation; and
2. If he/she absconds he/she is likely to suffer significant harm
3. If he/she is kept in anything other than secure accommodation he/she is likely to injure him/herself or other persons).[9]

Additionally, for a child under 13 the approval of the Secretary of State has to be obtained. Then the Local Authority seeks a placement through a national system, the Secure Welfare Coordination Unit (SWCU).

[9] Section 25 of the 1989 Children's Act

There is a wealth of information available evidencing that there is a severe shortage of suitable residential placements for children[10]. Serious Case Reviews and also Courts have frequently raised concerns at the lack of placements, not least the President of the Family Division who described this as a:

> *"Wholesale failure to provide adequate resources to meet the needs of these most vulnerable and needy people*".

Waiting times for a place can run to several months, with significant numbers of children waiting for a place at any one time.[11] After Princess's placement at the first Secure Children's Home was ended, she joined the 60 plus children already waiting. It took 8 months for another Secure placement to be obtained for her, and that was a placement in Scotland. The waiting list for children is not a waiting list in the sense that children move up the list when there is a vacancy. Secure Children's Homes are under no compulsion to accept an individual child, they are able to choose to whom they offer a placement. Princess's history meant that she became one of the children who is not readily chosen, and as a result she spent those 8 months in unregistered placements.

The agencies' frustration at the inability to procure a place for Princess led to the Local Authority writing to the Secretary of State describing their serious concerns about Princess's welfare and the inability of the system to provide her with a placement. They did not receive a reply. The Family Court Judge at the time also suggested that the Secretary of State be invited to attend Princess's next court hearing due to the concern about her situation.

The ultimate responsibility to ensure adequate provision of care places for vulnerable children sits with the Secretary of State. When no place is found the Local Authority is left in the situation of placing a child in an unregistered placement – breaching their statutory duty.

Suitability: Access to secure placements is not simply a number of available beds, there is an additional barrier to children with complex needs[12], who are more likely to be rejected for a place and to remain longer on the waiting list. This group of children are significantly those identified as having behavioural problems.

> *"Behaviours that are violent, sexualised or related to crime or that could damage property have the most impact on referral decisions." [13]*

The Ofsted report published in January 2024 also identified that most local authorities reported that:

> "*Children with complex needs are 'often' or 'always' placed out of area, experience unplanned placement moves, have referrals rejected by homes and/or are served notice by their setting*."

[10]Children's Commissioner: Nov 2020 & https://www.gov.uk/government/publications/childrens-social-care-market-study-final-report/final-report
[11] WWSC: December 2020
[12] Ofsted Jan 2024 & Children's Commissioner 2020
[13] Ofsted Jan 2024 p13

There is a range of reasons for the unwillingness to accept these children, not least the significant difficulties in recruiting and retaining suitably skilled staff and having inadequate staff to achieve the ratio required for children with complex needs. Staff who look after these children need more specialist training and highly developed skills, as well as resilience and strong commitment to the work. This is not easily resolved as there is a national shortage of staff with this skillset willing to work in this sector.

Princess's first secure placement broke down within weeks reflecting the issues described above. The home was at that time assessed as inadequate by Ofsted whose report specifically referenced Princess's experience:

> *"A lack of management oversight and poor care planning decisions mean that children do not receive the levels of care that they need. This was particularly evident when a child whose needs were assessed as beyond the scope of the home was admitted at the direction of senior managers in the local authority. This had a significant and detrimental impact on children and staff who were already struggling. It led to a poor care experience and another failed placement for the child. "*

That the home was directed to provide a placement for Princess despite the known concerns about the quality of care it was providing at that time is of concern. It is evident that there were inadequate staff without the skills or management support necessary. This is a clear message that good quality care and support for children with complex needs cannot simply be created at the command of senior managers. A message that will be returned to later in this Review.

It is important to note that this Secure Children's Home has achieved significant improvements in the interim and has now been judged as Good by Ofsted.

Stability: The third key concern was one which has created a sense of disbelief amongst the professionals working with Princess, in that Secure Children's homes can terminate a child's placement at any point, irrespective of whether the child has another home to go to. Princess experienced this on two occasions, and as she has told the Review, having to move with no information and no chance to prepare added to her frustration. From the perspective of the Local Authority, short notice terminations from a Secure Home cause great difficulty and almost inevitably result in the child moving into an unregistered placement. We know that a planned move of placement is likely to lead to a better transition and increase a child's sense of control. Again and again, this was not Princess's experience, nor was it the intention of the Local Authority.

There is little doubt that the impact on both of the Secure Homes was substantial, with a level of physical damage to buildings, assault and abuse of staff, and responsibility for a child highly likely to cause herself serious injury or death. Whilst it is shocking that notice can simply be given, yet, at a human level when care staff are at serious risk of harm, it is simplistic just to blame the home. Fundamentally the problem lies at a higher level in the system which has failed to ensure these children can be properly accommodated and cared for in settings which have the capacity to do so.

> *"These homes can and do, throw them out at short notice, and such is the shortage of other homes than many children are left in limbo, in flats surrounded by agency staff, waiting for somewhere, anywhere in the country, willing to take them. No child should be treated like that."*[14]

The outcome: unregistered placements.

When there was no secure place available for Princess, the only option was that of an unregistered placement.[15] Such placements are known to fail more frequently and in Princess's case the reality was that of living in hotel rooms, Airbnbs and other unsuitable accommodation not designed to meet the needs of a child with complex needs. These placements are known to be more liable to breakdown as was routinely the case for Princess.

The accommodation itself was often practically unsuitable, particularly in the case of hotels and Airbnbs. When two houses owned by the Local Authority were used, adaptions were made to try to make the houses safe and minimise the potential for damage and harm, but this was never entirely successful. Crucially, it also resulted in a barren, inhospitable home for Princess, likely to increase, rather than decrease her distress and frustration. Additionally, the capacity of care staff to care for Princess positively was inevitably variable, given their different experience, skills and compassion.

Other than a couple of occasions in the early weeks when Police Officers, Social Workers and professionals from CAHMS stayed with Princess overnight, the Local Authority paid for Agency workers. The Agencies were required to work within the parameters of Risk Assessments & Risk Management Plans agreed with the Local Authority. The first evidence of a joint multi-agency 'trigger plan' i.e. a multi-agency agreed risk management plan, was not until December 2022. As time progressed the Risk Management Plans changed and developed including increasingly detailed instructions as to how to ensure minimum harm to all. By the end of May 2023, the Management Plan ran to 24 pages. However, identifying a clear timeline for the development of risk assessments and planning has proved difficult. Evidence to this review from many of those involved was that there was often a degree of confusion amongst agencies about the production of Risk Assessment/Risk management and trigger plans, as well as which plan should be used or whether there was a plan.

Conclusion

What is apparent is that the options available for Princess were limited, to a damaging degree, and the Local Authority were placed in an almost impossible position in trying to find her suitable therapeutic accommodation. Whilst Princess's presentation and resulting needs were at the extreme end of what one Authority is likely to experience, this must not be seen as something unique. Other children with similar difficulties have been, and still are known to agencies locally. There has been a national increase in the numbers of children with mental health concerns, or otherwise complex needs and a growing number of children with similar needs.

[14] Children's Commissioner 2020 Briefing p1.
[15] Unregistered Placement: a placement that is not registered with Ofsted.

In the absence of fundamental national changes to the Children's Home estate, it is crucial that the learning from Princess's experience now is acted upon with a sense of urgency. The need for suitable provision, in local settings, with the minimum of restrictions, for children at an earlier stage is evidently crucial in order to avoid repeating Princess's experience. In this context there are already positive developments taking place within the Local Authority. The commissioning team are, as a direct result of Princess's experience, working to build and strengthen the options available at the point a child is unable to live at home. These options include a particular focus on working to increase the pool of high standard foster care placements and the possibility of establishing small, well designed and resourced homes locally. They currently include:

- **Regional Care Co-operative Fostering Hub** - DfE Foster East Targets; Joint Ventures Regional Hub; Fostering Recruitment Hub Targets
- **Fostering Mockingbird Model** - Mockingbird Coach Introduction
- **Fostering Transformation** - Fostering Business Case
- **High Acuity Foster Carers** – Plan to develop and commission specialist, emergency, high acuity foster carers from Independent Fostering Agencies to support in meeting Peterborough's sufficiency need for older and more complex young people with challenging behaviours. High acuity homes are intended for short periods of will aim to prevent an escalation into residential care/unregistered provision and enable a fuller assessment.

This focus on providing better resources for children at an earlier stage is to be applauded.

> **Recommendation 2:** That the Local Authority should prioritise ensuring it has access to the full range of placement options, including in house residential care, keeping children closer to their homes and communities and maximising the likelihood of a safe return home.

4.2 Meeting Princess's wider needs

The issue of managing risk has sadly had to play a central role in the way that agencies have worked with Princess. However, the balance of focussing on the risk whilst meeting her other needs has undoubtedly been compromised. Acknowledging this uncomfortable truth is not about seeking to find someone to blame, rather it is crucial that this Review highlights the reality of the problems faced by the agencies in trying to care for Princess.

The absence of the things that mattered to Princess.

Conversations with the professionals during this Review clearly evidenced that there was a strong awareness of the negative impact on Princess as a result of living in the way that she did. Just some of the routine features of life that children need to thrive, were noticeably absent for Princess, including:

- Absence of regular contact with her family.
- Lack of contact with peers and the opportunity to make friends of her own age.

- Impact on her physical health
- Lack of regular time outside of a very limited environment
- Lack of safe physical contact and emotional warmth
- Absence of a consistent carer
- Lack of opportunity to learn and practice social and other skills with children her own age.
- Inability to just be a child, rather than the centre of numerous professionals' concerns, and anxiety.
- Lack of control or information over decisions that a child could have expected to contribute to.

Princess in her contribution to this Review has offered us some powerful insights as to what she has lost during this time. At the day-to-day level, there were undoubtedly caring professionals who attempted to provide her with some of these crucial aspects of care – for example, agency staff who made a point of cooking the food she might have had at home. But this wasn't always possible, or welcomed and not all care staff will have had the skills or commitment to provide this sort of empathetic care.

Princess spoke powerfully to this Review about not having anything in common with so many of the adults who surrounded her. The constant change of location and staff will not have helped and is highly likely to have impacted negatively on her understanding of what healthy relationships with others feels like. Viewing some of the Police videos provides a disturbing picture of Child's 'home' life. What can be seen is the absence of anything close to a normal domestic life – empty rooms, with 8 or 9 professionals dressed in protective clothing. In the words of a Police Officer – "*if she lived with her parents and I came into this house – I'd be removing her for serious neglect*".

At the most basic level the system was unable to meet her needs while at the same time trying to keep her safe. The long-term effects on her development into adulthood could be very significant.

Whenever possible, programmes of activity including structured education and time for her interests were put in place. There were lots of interventions, evidence of hard work to engage her and try to help her engage with the professionals working with her. However, maintaining this over time was extremely difficult. But what is clear from Princess's own comments is that the greatest loss was the contact with her family, whatever the difficulties may have been in family life. Princess describes her behaviour change on going to northern England at its simplest as the fact of being so far from home.

The impact of effectively being removed from the established culture of her home and background, is also likely to have been a significant loss. Often it is the little details that can be most important: the family routines, the access to familiar food and language, habits and customs that may have been taken for granted at the time, can all contribute to a sense of having lost your place in the world. Even if that place was not always a happy one. Princess's relationship and contact with her mother was not always easy for professionals to understand. Although this contact was important to Princess it seemed to trigger her dysregulation and as such they were told to speak in

English. One of the inevitable consequences of this was to limit Princess's ability to speak her first language.

Partly this was due to the lack of availability of other professional services, partly, because almost all of their time was focussed on the absolute basics of keeping her safe and accommodated. All the agencies, in Peterborough, including courts and police, struggle with a lack of available interpreters. This was even more difficult when CSC staff were trying to find interpreters often at short notice and in what was a chaotic home environment with things changing constantly. Children's Social Care and other professionals working with her did make attempts to meet Princess's cultural needs, but with limited success.

The uncomfortable truth is that it was impossible to meet Princess's wider needs while she lived in the circumstances that have been described here. This was powerfully described by one senior manager as a '*cause of professional shame'*. This is not to say that some things could not have been managed better and there is much for the agencies to learn, and have already learnt, about the detail of working with a child in these circumstances. If this inability to meet the needs of a child in these circumstances is not openly recognised, there is a risk that Princess's experience will become seen as a terrible one-off experience. In reality the partnership is still working with children with similar problems and can anticipate that other children will become a similar cause of concern without some fundamental changes.

PROFESSIONAL PRACTICE POINTS

- The importance of attention to the detail of a child's daily experience should not be underestimated.
- When a child is in a residential placement, the features of a child's cultural life, from language to food, music to family tradition, should be identified and promoted as actively as possible.
- A child's desired family contact and normal day to day routines should be maintained as a priority wherever possible.

4.3. Therapeutic and behavioural interventions

> "*a sense of desperation – no placement, no therapeutic placement. It needed a stable environment where they couldn't give notice and a long-term therapy model and network model to wrap care around the child"*[16]

From early on, programmes of intervention were developed and work with Princess was started. However, the capacity to put in place a comprehensive and structured plan for intervention with Princess was significantly affected by the reality of her circumstances. For example, when Princess was first in a Secure Home a multi-

[16] Reflection from one of the professionals.

agency intervention plan was created. When her placement was terminated the Clinical Psychologist continued to meet with Princess hoping to keep working with her. However, at this point there was little she could do other than support both Princess and the carers in the unregistered placement simply to help manage the constant day-to-day difficulties and crises.

Multi agency plans were developed, but there were some aspects of the collective response to Princess's therapeutic needs that at times were unhelpful, adding to the levels of stress and emotion that has been a theme in this case. What was needed was for an overall plan to be agreed and supported by the key agencies, which unfortunately was not always the case. This was represented most starkly in two ways:

1. Does Child have a mental health need or is it a social /behavioural issue?
2. Is Princess's behaviour fundamentally reflective of trauma or does she have a Conduct Disorder?

These are not mutually exclusive questions, the two are in fact closely linked but benefit from considering separately as well as together. The significance of these different perspectives is in how any treatment programme is then created and put in place.

Mental health or social care?

There was without doubt a major difference of opinion, leading to an unhealthy degree of conflict about whether or not Princess had mental health needs, and as a result which part of the system, should be taking primary responsibility for providing her care and treatment.

Princess's first mental health assessment took place before she was moved into the residential placement. As previously noted, this concluded that she did not have mental health needs, nor did she have suicidal ideation. Over the following year there were innumerable further mental health assessments including those ordered in both family court and criminal court proceedings, and those undertaken by CAMHS and within a Children and Young People's Secure Unit. The conclusions from these reports largely supported that of the first CAMHS assessment. However other reports, for example reports provided to the criminal court also assessed her as not fit to plead in court proceedings.

The number of times that Princess has been assessed is a cause for concern. For a child to be repeatedly assessed by so many different professionals is not good practice. It is intrusive and likely to contribute to a child's sense of frustration with professionals. We know from children's feedback that a particular dislike is the need to be constantly telling your story and Princess was no different. This ongoing level of disagreement, particularly between Health and Children's Services, played out most notably in the repeated arguments about further assessments and was counterproductive. This will be considered further in the following section.

Trauma or Conduct Disorder.

Alongside the dispute about whether Princess had mental health needs was another disagreement, which played out more at practitioner level, as to whether she should be primarily seen as a child who had experienced trauma or who was displaying a conduct disorder. All concerned would acknowledge that this is not an either/or issue, but there were perceived differences in the resulting understanding of what the treatment issues would be depending on what was seen as the primary concern. The cause of trauma can be seen as falling into one of two groups:

- Events which are one time or short-lived occurrences
- Complex or developmental: chronic events over a long period of time, e.g. repeated neglect or abuse.[17]

Using a trauma informed approach is increasingly familiar and promoted in both health and social care when working with children and families. It is well established and recognised as an important basis for working with children who have experienced traumatic experiences and what are referred to as Adverse Childhood Experiences (ACES).

> "*The intention of trauma-informed practice is an increased understanding of the ways in which present behaviours and difficulties can be understood in the context of past trauma"*[18]

Where the cause of the trauma is unknown, the approach typically will include, ensuring the child has a safe and stable base and professionals developing trusting relationships with the child to create a suitable environment to work therapeutically with the child.

This has formed the key basis of the interventions with Princess, but the apparent lack of progress has been a cause of concern. On several occasions it appeared that Princess was settling and had more positive relationships with some practitioners, but this would not last. At one point it did appear that Princess was becoming more stable, even though she was at the time living in unsuitable accommodation with 24-hour cover by agency staff. However, again she became dysregulated and again the damaging behaviour escalated. There were a number of factors that might have influenced this change including her family situation and changes of therapeutic practitioners. But as time passed the lack of progress has itself raised questions about the nature of Princess's behaviour and whether the interventions are working. Numerous assessments, many of them in contradiction have not helped this situation.

A number of professionals had also raised concerns about Princess's ability to cause serious harm without any apparent consequences for her in terms of being held to account for her actions. There were concerns about the impact on those who she had hurt, but also the negative effect on Princess in terms of learning socially acceptable, empathetic behaviour. Some of Princess's behaviour has been profoundly shocking particularly in the context of an apparent lack of concern about its impact on other people.

[17] RIP 2018 p3
[18] RIP 2018 p2

There have also been differing perspectives regarding the issue of whether or not Princess should be subject to criminal proceedings. Some practitioners were of the view that it would be wrong to criminalise her until there was a proper understanding of "*what was wrong with her*". Most professionals were very conscious of the possible negative impact for Princess of taking her into the Criminal Justice system given her circumstances. Within the Youth Justice system there is a clear 'Child First' approach, in which a child should be seen as a child first and an offender second.

The police arrested Princess on 30 occasions during this time, but none resulted in a conviction, either because the Crown Prosecution Service did not support a charge, or because charges were dropped in Court. Psychiatric reports concluded that Princess was not Fit to Plead, and all charges were dropped. The police agreed to the Youth Justice's team's recommendation not to pursue further outstanding charges in order not to criminalise Princess and to allow her a fresh start with a new Care Package and Social Work team. After a period when the Police were being called on "*almost a daily basis*" it was decided that she should be charged for some of the more serious offences. Later a further 70 charges were discontinued in Court, but some charges remained active cases and at the time of writing Princess had been convicted of 3 offences, which were typical of many of the offences that had been investigated.

There was a range of reasons as to why this pattern of offences, charging and discontinuation took place, including decisions made by the courts which are not within the remit of this Review. The Crown Prosecution Service Code sets out detailed requirements that have to be taken into account before prosecuting a child[19] with the key principle being to avoid unnecessary prosecutions and criminalisation of children. What is undoubtedly the case is that whilst decisions not to pursue criminal charges were made on the basis either of expert legal and psychological advice or Princess's perceived best interests, the outcome has been to reinforce Princess's view that she can do anything without there being serious consequences. It is almost impossible to see how this could have been approached differently, not least due to the independence of the CPS, Courts and Court experts, who are not part of the Cambridgeshire and Peterborough Safeguarding Partnership.

The possibility of a Conduct Disorder and a professional challenge to the current interventions were raised directly by the Clinical Lead of the Children's Social Care Corporate Parenting Clinical Team and PBS service, whose role at the time also included chairing the parenting group[20] for Princess. The key significance of this was that NICE guideline in relation to Conduct Disorders required a quite specific treatment that it appeared was not being followed at that time. There have subsequently been a number of further psychological assessments which disagree with each other. The resulting debate, which has spilled over into this Review unfortunately became quite polarised. There are strongly held views, not least because the conclusion could lead to different interventions.

[19] https://www.cps.gov.uk/legal-guidance/children-suspects-and-defendants#:~:text=A%20child%20below%20the%20age,with%20the%20criminal%20justice%20system.

[20] The Parenting Group for Princess was set up alongside the Gold Group, to focus on the operational issues.

This Review is not designed to reach a conclusion on the issue itself, the concern here is as to what prevented a legitimate and considered debate between skilled and committed professionals, a debate which could have contributed to the overall understanding of Princess's needs. Whilst this in part may well have been influenced by personalities, it is worth noting that the dispute developed during a period of increasing conflict and frustration between agencies, where individuals felt their voices were not being heard and their professional opinions not respected. Options to resolve the dispute were not considered, for example the use of the Resolving professionals disagreement policy.

What is noticeable is that the Resolving Professional Differences policy,[21] was never considered and it is unclear why this was the case. There does appear to be a mixed picture of how well the policy is known to staff and therefore how effective it is. What is also evident is that the policy needs to cover staff at all levels irrespective of seniority as will become apparent in the following section.

4.4 Multi-agency partnership working

There is no doubt that at all levels of the organisations the work undertaken to respond to and manage Princess's needs was extraordinarily demanding of both individuals and the overall system. The resources required both financially and otherwise to maintain the constant search for and management of placements alone was immense. The capacity and opportunity for practitioners and managers to focus on significantly more than managing crises from day to day was bound to have been affected, leaving limited time for reflection and for work with other children. The levels of anxiety that were being carried by so many staff about what else could happen was also clearly overwhelming at times.

This Review has heard about individuals, teams, whole organisations feeling like almost all their time was focussed on this one child and the risks she posed. Social Workers with hugely reduced caseloads, Team Managers whose first job every morning was to deal with what had happened the night before, commissioners constantly searching for placements. Time to prepare Princess for yet another move, to visit her, sometimes at a significant distance, to update new members of staff, to attend another meeting. This is not the context that supports time for reflection, respectful challenge, rethinking, seeking advice. In this setting the capacity to keep a needle-sharp focus on the child as a whole will be pushed to the limit.

The operational level

Princess's experience brought her into contact not only with the usual range of agencies working in her local authority, but a much wider network including privately run provider agencies and those from at least 4 other Local Authorities as well as national organisations. This itself provided a considerable challenge to those with the prime responsibility for her care.

[21] https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/escalation_policy/

The picture of partnership working at the operational level is mixed with examples of both positive working relationships and of problems across agencies. The Review did hear from a number of practitioners about good relationships across agency boundaries. This was not a perfect picture but there were more positive than negative comments. Issues relating to information sharing have been raised particularly about the early stages. One difficulty was ensuring that every organisation who had contact with Princess had adequate, up to date Risk documents. This was clearly acknowledged as a significant challenge by Children's Services who had the primary role in managing it. The hospital, for example, identified a lack of clarity as to who was responsible for restraints and the absence of details for a hospital setting. However, overall, they considered that information sharing by both the Local Authority and the ICB amounted to good practice. One of the providers, was also very positive about the working relationship with Children's Social Care.

A significant point of tension related to the expectations placed on the Police by partner agencies and the private providers. The Police were frustrated at regular call outs by agency staff to help manage Princess's behaviour, or requests from the Local Authority to keep Princess at the Police station when this was on the very limits of, or outside of their legal role. The implications of withdrawing Police Officers from other duties in the community, frequently at evenings and weekends, were very significant.

From the evidence available, the concerns about information sharing and joint working at an operational level on the whole appear to be a reflection of the pressures on all agencies in trying to manage an extremely demanding situation, for which there were inadequate resources. The perspective of managers contributing to this Review is very clear that there was no lack of dedication and good practice from very many staff.

Alongside the human factor, other systems and arrangements did not appear to be adequate to manage the demands of a child with such complex presentations. These included:

- Not having a Single Point of Contact (SPOC) or identified system to ensure a planned response, when evening and weekend calls were made to Children's Services Out of Hours team.
- System to share information, trigger plans etc quickly to any agency or individual professional that might unexpectedly need them.
- Clarity about how and who decisions should be taken, particularly in emergency situations.

The role of Senior Management.

What is needed in these circumstances is early, strong, and effective management oversight and a strategic approach, both for individual agencies and within the multi-agency partnership. This was too much for individual practitioners and their immediate managers to manage alone. By the time there was a meeting of Senior managers within Children's Services, Princess's frequency of dysregulation and the options available for her care were already a firmly embedded pattern that was proving difficult to break.

An “Acute and Complex Meeting” was established, to focus specifically on the Criminal Justice issues. This was a group that met regularly and appears to have functioned positively, to the extent that it is now a permanently established group meeting to discuss complex cases of both Princess and other young people who may be coming into the Criminal Justice system.

A formal management meeting at Executive level was established when a Gold Group was triggered by the Police. A separate Parenting Group was subsequently also set up which was attended by senior operational staff to focus on the day-to-day arrangements for Princess. Information about the working of the Gold Group during the period considered in this Review is at times confusing and it appears that minutes were not always kept or made available.

Those who were involved in these two groups at the time have identified a range of problems, and different perspectives on how the group did or did not work. These included:

- A degree of overlap between the two groups sometimes creating confusion.
- Too many meetings – sometimes more than daily. More meetings not leading to a different outcome.
- Repeating discussions about Princess which, in the absence of a safe placement, could not lead to an outcome.
- Repeated conflict between Children’s Social Care and Health.
- Senior non-operational officers making operational decisions or instructing others to do things that were not possible in reality.
- Less senior staff attending the Gold Group not feeling respected even being “*barked at*”.
- Concerns that the right people were not always invited or represented properly.
- Lack of family/child involvement in the meetings.

It is impossible for this Review to judge how fair a description of the meetings this presents, but it is clear that there was a lot of concern across the agencies as to its effectiveness.

The disagreement about whether or not Princess had mental health needs and which agency therefore held key responsibility was possibly the most significant issue at these meetings. Information from the two available Gold Group meeting minutes, and the descriptions from several individuals who had experience of the meetings, provides a sense of how the conflict between Health and Social Care got in the way of finding a solution, or at the least a shared approach, to the collective difficulties. What can be seen are very different, at times inaccurate, understandings of the different roles, legislative constraints, and thresholds across agencies. If attempts were made to find a genuinely shared solution, that is not particularly apparent, and was not achieved. Arguments over taking steps which would not have been within statutory parameters were taking place and the Review has also heard about the impact of strong personalities which did not contribute to a problem-solving approach.

What has been raised by a number of contributors to this Review is a belief that the ongoing argument between the Local Authority and the Mental Health Trust was fundamentally an argument about which organisation was meeting the financial cost

of Princess's care. Without direct evidence, this remains a supposition, but given the financial pressures on statutory services it would not be entirely surprising. Children's Services managers have told this Review that money was absolutely not their motivation, and they would have found whatever money was necessary for the right placement. If money was a driving factor, it would be easy simply to criticise those concerned, and when the needs of the child are lost as a result of such disputes, it is right to be critical. However, there also is a genuine issue here about the way in which the Health and Social Care System with its various financial pressures, legal requirements and other restraints fails children who do not fit into the neat categories that exist within that system. Irrespective of labels and diagnoses, Princess required help and support from both health and social care, but it proved impossible to create a genuinely shared approach to managing her needs.

Agencies and professionals view the Gold Group and the discussions within it very differently and some of the frustration and criticism of each other clearly still remains. Health professionals have been very critical of the Local Authority particularly in seeking further assessments. Children's Services have felt that too often they have been left alone to manage a situation they were no more able to manage than their partners. Both perspectives have some merit, but what appears to have been lacking was the capacity to step back from what had become a stuck and unresolvable argument and work together to find a shared approach at that senior level.

This is not to suggest that there would have been some easy, quick solution. Nevertheless, progress at best would be held back without a break in the deadlock. As the Resolving Professional Difficulties policy describes it:

> '*Effective working together depends on an open approach and honest relationships between agencies. Problem solving and resolution is an integral part of professional co-operation and joint working to safeguard children and young people*.'

What could have been considered was some form of independent support to help achieve what the escalation policy was designed for. An 'independent' person was brought in by Children's Services, but the role appeared to be to contribute a different perspective to decision making rather than acting as someone independent of all parties with the skills to focus on restoring a less conflictual tone to the discussions.

The crucial learning taken from this experience must be the need for a multi-agency system at senior level able to respond quickly to complex cases and with agreed parameters and good practice as a blueprint for action. When it is proving impossible to meet a child's basic needs within the current system, this must be a trigger for escalation to the highest levels.

Recommendation 3: Cambridgeshire and Peterborough Safeguarding Children Partnership to relaunch the Resolving Professional Differences Policy. This should be made fully inclusive, irrespective of role or status, including the option to commission an independent person as facilitator in complex cases.

Recommendation 4: Cambridgeshire and Peterborough Safeguarding Children Partnership to review the effectiveness of its working relationships in achieving its statutory goals, within the next 6 months.

Recommendation 5: Cambridgeshire and Peterborough Safeguarding Children Partnership to agree a process for ensuring a prompt Multi-Agency Managerial response to complex cases resulting in a child's fundamental needs not being met. This should include an agreement when, how and by whom this should be triggered and a model for achieving best practice in such cases.

4.5 The impact on staff

The impact of working with and providing care to Princess has been significant across the agencies and roles, irrespective of seniority. At a structural level the pressure on services should not be underestimated. From the pressure on resources, which inevitably impacts on agencies' capacity to meet other commitments, to the financial cost, to staff absences for related health reasons, managing the consequences of trying to provide a proper service to Princess have been as many have said, exhausting.

At an individual level there have been very immediate consequences for those practitioners who have been subject to violence and other abusive behaviour from Princess. Some staff have been subject to quite serious allegations although none of these were ultimately evidenced. Others have told the Review about Princess threatening them, including threatening that she could make them lose their jobs. The impact of this sort of threat and violence in the workplace can be very serious.

> *"Serious or persistent verbal abuse or threats can also have a serious effect on a worker's mental health….*
>
> *For employers, violence can lead to increased staff sickness, poor morale, and a damaged reputation, making it difficult to recruit and keep staff"*[22]

Almost everyone we spoke to talked about various levels of stress, exhaustion, and anxiety. At times this has been visibly apparent. Long working hours and responding to crises outside the normal working day were a feature for many.

> *"The impact on my time was huge and led to 9 months of me doing the 'day job' at night - so working at least 14-hour days for months on end".*

It is evident that for many staff there has been a significant emotional impact. However, it is interesting that none of the professionals we spoke to told us that they were frightened. (We did not speak to anyone who had been seriously harmed.) From what has been described, fear would be a very normal reaction. This must raise the question as to whether it is still difficult for those working in child protection to admit fear in the workplace, perhaps particularly when it relates to a child.

[22] HSE. Health and Safety Executive. https://www.hse.gov.uk/violence/employer/index.htm

The impact of being required to use restraint has also been of concern, not only the impact for Princess, but also on staff who were required to restrain her. Restraining a child to the extent that was required for Princess by professionals only used to doing this with adults in very different circumstances, itself had an impact and led both to emotional distress about the impact on Princess, and also huge anxiety about the implications if the restraint was to go wrong. The serious risks involved in restraining anyone, never mind a child, in a prone position, was well understood, particularly by police and was avoided wherever possible. However, it was not always possible.

It should not be assumed that the impact is only on frontline practitioners. For example, we heard powerful evidence of anxiety and distress from team managers trying to support the staff doing the direct work. Filling in where there were gaps created by sickness or other absence, holding responsibility for staff, themselves and of course Princess. A lot of this distress was not directly about their experience of Princess's behaviour when dysregulated. What we heard frequently was a level of distress about individual and collective inability to help resolve Princess's situation. Professionals talked about feeling powerless or helpless, lack of sleep, high levels of anxiety. Practitioners were also generally unwilling to simply point a finger at Princess:

"*It wasn't caused by Princess. It was the system. I knew she needed love and stability, but I couldn't get it for her. As a system we failed her."*

It is evident that there were many attempts to support operational staff, including reduction in workloads and arrangements for clinical supervision across teams and agencies.

Within the designated Social Worker teams there was a strong recognition of the importance of caring and supporting workers:

> *As Head of Service, I checked in several times a day with staff, worked alongside and tried to create a 'we're in this together' culture, however I don't think this was enough at all to manage the emotional impact for particularly the social worker and team manager who had a relationship with Princess and were significantly more impacted as a result".*

By the end of the period under review the Social Worker's caseload was reduced to Princess and at most 1 or 2 others. A routine plan of structured support was also made available.

The Police were able to draw on a well-established strategic welfare policy and a dedicated wellbeing hub on the force intranet accessible to all staff. The support to relevant officers including:

- Daily welfare checks
- Staff who had been assaulted by and those dealing with Princess being regularly spoken to and visited by the Senior Leadership Team, including the Chief Constable.

It is not clear however, whether there were always conscious decisions taken by senior managers to provide help and support for staff when needed. Not all organisations had such a clearly identified system as the Police and often support was provided on

a more ad hoc basis, or when asked for. Staff in Peterborough hospitals, particularly those working in the Emergency department told of having no debriefing or support after their shift. This then immediately led to the setting up of "Group restorative supervision" for any of the staff who asked for it. The need for support should include staff irrespective of role, from the Security Guard at one Acute Hospital Trust whose empathetic response to Princess and the emotional impact on him was noted by medical colleagues, to the Senior Managers trying to resolve what seemed unresolvable.

Recommendation 6: Cambridgeshire and Peterborough Safeguarding Partnership should require assurance from all partners that they have in place robust policies and procedures for supporting staff welfare which meet the needs of all employees. Additionally, the Partnership should explore options for sharing learning, and opportunities for collaboration, across the partnership regarding the support of staff welfare.

5. CONCLUSION

There can be no doubt that Princess did not receive the comprehensive care she needed during this period and that it continues to be a challenge to ensure that she does so now. This conclusion is shared by all of those involved in contributing to this report. Looking back, we can see that if different routes had been taken this could have led to a better outcome for Princess. However, what is equally clear is that those routes were not always available at the times they were desperately needed. The speed at which it appeared Princess's problems accelerated and the absence of suitable safe, supportive environments in which her needs could have been met, effectively destabilised the Cambridgeshire and Peterborough Safeguarding Partnership's capacity to provide the care that they were evidently seeking to provide.

This is not to say there is nothing to learn from Princess's experience or that practice and decision making could not have been improved from the front line to the most senior levels of management. However, it is hard to envisage that this would have fundamentally changed the outcome in the absence of a suitable placement.
Two very significant lessons in particular stand out:

1. The need for the Cambridgeshire and Peterborough Safeguarding Partnership as far as is practically possible to develop systems, practice and resources locally and regionally that will help reduce the need for children to be placed away from their homes and communities.

2. That in the absence of accessible residential care with high quality staff for those children who need more secure care, Princess's story will continue to be repeated across the country.

RECOMMENDATIONS

Recommendation 1: Cambridgeshire and Peterborough Safeguarding Partnership should assure itself that all relevant agencies have policy and guidance in relation to the use of restraint.

Recommendation 2: That the Local Authority should prioritise ensuring it has access to the full range of placement options, including in house residential care, keeping children closer to their homes and communities and maximising the likelihood of a safe return home.

Recommendation 3: Cambridgeshire and Peterborough Safeguarding Partnership to relaunch the Resolving Professional Differences Policy. This should be made fully inclusive, irrespective of role or status, including the option to commission an independent person as facilitator in complex cases.

Recommendation 4: Cambridgeshire and Peterborough Safeguarding Partnership to review the effectiveness of its working relationships in achieving its statutory goals, within the next 12 months.

Recommendation 5: Cambridgeshire and Peterborough Safeguarding Partnership to agree a process for ensuring a prompt Multi-Agency Managerial response to complex cases resulting in a child's fundamental needs not being met. This should include an agreement when, how and by whom this should be triggered and a model for achieving best practice in such cases.

Recommendation 6: Cambridgeshire and Peterborough Safeguarding Partnership should require assurance from all partners that they have in place robust policies and procedures for supporting staff welfare which meet the needs of all employees. Additionally, the Partnership should explore options for sharing learning, and opportunities for collaboration, across the partnership regarding the support of staff welfare.

Recommendation7: That this Review is shared with the Secretary of State and the Children's Commissioner.

Appendix A: Professional Practice Points

PROFESSIONAL PRACTICE POINTS

- The value of Information about family history is a vital ingredient of assessment and should not be underestimated.
- The significance of gaps in family history need to be part of assessments.
- Maintaining an open mind, challenging professional beliefs and assumptions is always a crucial part of practice and especially where information is contradictory.
- The possibility that a child may not be telling the truth about a serious issue, should be acknowledged, neither be used as a form of 'child blaming' nor dismissed as 'child blaming'. It should in itself be a cause for concern as to what is happening for that child.
- Ensure that all information is shared with relevant partners.
- The importance of attention to the detail of a child's daily experience should not be underestimated.
- When a child is in a residential placement, the features of a child's cultural life, from language to food, music to family tradition, should be identified and promoted as actively as possible.
- A child's desired family contact and normal day to day routines should be maintained as a priority wherever possible.

Appendix B: References

Children's Commissioner Nov 2020: The children who no-one knows what to do with.

https://www.gov.uk/government/publications/good-decisions-children-with-complex-needs-in-childrens-homes/how-local-authorities-and-childrens-homes-can-achieve-stability-and-permanence-for-children-with-complex-needs#executive-summary

https://www.gov.uk/government/publications/good-decisions-children-with-complex-needs-in-childrens-homes/how-local-authorities-and-childrens-homes-can-achieve-stability-and-permanence-for-children-with-complex-needs#executive-summary

NICE GUIDANCE: https://www.nice.org.uk/guidance/cg158/resources/antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-and-management-pdf-35109638019781

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RIP: Developing and Leading Trauma Informed Practice 2018

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