MSCP LLR Briefing sheet

Learning Lesson Review Eve - March 2022

Local Safeguarding Children Partnerships undertake Learning Lessons Reviews (LLRs) when the criteria for a local Child Safeguarding Practice Review (previously known as a Serious Case Review) has not been met but partners feel there is multi-agency learning that can be identified in the case. The purpose of such reviews is to learn lessons and improve practice. This publication aims to share the learning from the Eve LLR to allow professionals to reflect on their own practice.

Trigger event

This Learning Review was undertaken following a referral by Kent Police. The referral related to their concern about 16 year old Eve, who had been at Medway Secure Training Centre (STC) over an 8 week period during 2019 and had been subject to a significant number of restraints and the perpetrator and victim of a high level of assaults. During the 8 week period Kent Police recorded 44 crimes or incidents involving Eve, the majority with Eve being a suspect of assaults on members of staff within Medway STC and 2 as a victim. The majority outline that Eve was subject to a planned intervention due to self harming or other use of restraint by staff.

None of the incidents with Eve as a suspect progressed to a prosecution, some due to concerns that the actions of the officers appeared potentially unnecessary, issues of lack of evidence or the victims did not want to pursue the matter. Neither of the incidents with Eve as a victim were considered for prosecution as they fell outside the statutory time limits.

Summary of known background

Eve was 16 on admission to Medway STC and was subject of a care order to a Local Authority since the age of 8. Eve was a vulnerable child, who was completely traumatised by the abuse she experienced in childhood. Her father was imprisoned due to sexual harm/ neglect of Eve and her mother was also convicted and then hospitalised due to mental health. Eve was the oldest of a large number of siblings for whom she felt responsible.

Eve had previously had episodes in secure accommodation in 2018 and 2019. The reason for her imprisonment at Medway STC was a breach of a Detention and Training Order. Her previous offending related mainly to assaults on staff/ other children in various establishments. A previous psychological assessment concluded that Eve did not have a diagnosable learning disability, however, she is psychologically impacted by trauma.

Placement decision making process

The plan had initially been for Eve to be placed at Rainsbrook STC as the Youth Custody Service (YCS) felt she was too high a risk for a Secure Children's Home (SCH). However, because there were still children at Rainsbrook STC from Eve's previous time there, where there had been assaults and ongoing criminal investigations, Medway STC was preferred. This change was not communicated to Eve whilst at court and when she did find out she became increasingly distressed as the change and its location was significant. A complaint was raised by her YOS worker to the YCS but a response was not received until 8 weeks later.

There are clearly issues raised by Eve's experience of the Placement finding process. Whilst recognising this is a process undertaken under time pressure by the YCS there should have been a more detailed discussion and consideration of Eve's needs, history of offending and what was likely to be the most appropriate placement to reduce risk to herself and others.

Eve's experience at Medway STC

Valuable information from Eve's previous placement at a SCH detailing her presenting behaviours, life experiences, beliefs and feelings, coping mechanisms, potential triggers and recommendations for staff working with Eve was not transferred on arrival. The information did not arrive for six weeks. It would have greatly benefitted Eve and Medway STC staff if they had received it sooner.

In addition, health records contained suggestions for how best to support Eve, including potential triggers and how these can be avoided. There is no record of how these suggestions were shared with custodial staff at Medway STC.

At the time of Eve's placement, plans to implement "Secure Stairs" an integrated behaviour management approach at the STC had been scaled back due to the

planned closure of the centre. This meant that the centre had not been able to implement the approach of embedding healthcare staff on units to support staff in improving the health and well-being of children and would have supported the sharing of information.

Many of the Post Restraint Healthcare assessments completed for Eve did not correctly list Eve having Asthma and none listed her developmental age. In addition, any setting that takes care of children with Eve's needs must have access to multi-disciplinary wrap around support and the ability to be supported to access further help on occasion through the existing nationally commissioned services.

Despite concerns increasing and complaints, it took some time for a multi-agency meeting to be arranged to share strategies the other establishments had used when caring for Eve. Following this, over the next few days incidences did decrease and less use of force was needed when dealing with the incidents.

Safe Organisational Cultures

To establish safe working cultures within organisations arrangements are needed covering areas such as safe recruitment; policies; training and supervision of staff; the creation of transparent and effective arrangements for staff and children to raise their concerns/ complains with clear management oversight and whistleblowing procedures. Medway STC was preparing for closure in March 2020 and had experienced an increasing level of vacancies and recruitment and retention of frontline staff continued to pose a challenge.

Recruitment and Induction of staff - The review reinforced findings from the Medway STC Serious Case Review (SCR) published in January 19 that found custodial staff felt disempowered and had accepted the cultural norm that children need to be contained. There also appeared to be a difference in attitude and skill set between STC staff groups acting as case workers and those officers providing custodial day to day care of children.

Safe and effective recruitment of the right staff is fundamental and the review found the safer recruitment of prison officers appears very different to the wider children's workforce and needs to be addressed.

Training of Staff – Training for all staff so they understand trauma, and the effect it can have on the presentation and behaviour of children and young people is essential.

Supervision of staff- this needs to be a consistent regular support for staff and utilise a reflective learning approach to enhance leaning and performance.

Managing Self Harm – This was the specific issue for Eve. The Ofsted Inspection in 2019 also raised concern about the lack of appropriate responses to children who are repeatedly engaging in self-harm.

Management Oversight – A key learning point is how ineffective safeguarding cultures can develop within services where there is no effective quality assurance of the arrangements. Eve was the subject of restraint on 2 occasions, which were subsequently judged to be assaults, however safeguarding concerns were not identified as there was no separate oversight.

Whistleblowing – There was evidence from the Medway STC SCR of occasions when low level concerns/ complaints about individuals were not recorded or acted upon. The review recommends that the MSCP considers evidence of whistleblowing by all agencies involved with the secure estate.

Responses to female children

Most of the incidents involved male custody staff and this may have had an adverse impact on Eve due to history of sexual abuse and trauma. A Girls Care Strategy has been developed to address how girls in the secure estate are supported and cared for.

Voice of the child

The culture of listening to, consulting with and giving children a voice is crucial to developing safe cultures within organisations. Organisations must be proactive in enabling opportunities for children to raise issues and when they do, adults must actively listen and take preventative action. Eve did use the advocacy service in addition to her YOT worker and social worker who advocated on her behalf. These arrangements for complaints and use of advocacy need to be routinely monitored to ensure effectiveness.

Recommendations

This learning review has been undertaken in the spirit of recognising learning is an ongoing process. The review also included a review of progress against the Medway STC SCR. The report makes 19 recommendations both local and national in total which are available here. View Recommendations Document

Notification and referral to the MSCP

To ensure that children are safeguarded properly by agencies working effectively together the MSCP supports a "Partnership Practice Alert" and "Case review referral" (available on the MSCP website).

Worried about a child in Medway?

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