‘Vamp’

Thematic Local Child Safeguarding Practice Review

2023/24

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1. Introduction

1.1 This review is about Vamp who died after ingesting drugs sold to her in a park. She was 13 years old.

1.2 Vamp is a pseudonym selected by her family. Vamp has also been referred to as Child M during the review.

1.3 This review is also about the wider system that exists to support children such as Vamp. The review explores how the system needs to change to provide a better fit around children as individuals, rather than having an expectation on the child to fit with the service.

1.4 There have been extensive discussions across the multi-agency partnership, from frontline practitioners to senior leaders. Learning has been taken forward throughout the review.

1.5 Efforts to contact Vamp's family were only successful once the review had been completed. Their views mirrored the findings of the review. They also provided Vamp's voice. Therefore, the family reflections of Vamp provide the starting point of the review.

2. Introduction and Rationale for the Child Safeguarding Practice Review

3.1 In July 2022, Vamp, a 13-year-old White British girl, died following drug use following risk taking behaviour. Vamp's death met the threshold for a Serious Incident Notification[1], as she had been subject to a child protection plan in Merton since March 2022 under the category of neglect.

3.2 The subsequent rapid review was submitted on 24 August 2022, highlighting the rapid review panel's decision that, while this case met the criteria for a potential local child safeguarding practice review, the process had itself identified considerable learning, which was already being actioned by agencies, removing the need for further review locally.

3.3 In their letter dated 6 December 2022, the national panel responded to say they "*thought that there were compelling reasons to undertake a Local Child Safeguarding Practice Review (LCSPR)*". In February 2023, a meeting took place with the national panel's regional lead who provided some more context regarding their response.

3.4 In March 2023, the MSCP Executive agreed to assign an independent lead, internal to the partnership, to undertake a paper-based exercise 're-reviewing' the rapid review submission, meeting minutes and information gathered from agencies, to consider the queries and themes raised by the national panel. This 're-review' concluded that a greater understanding of Vamp's lived experience could be of benefit to the wider learning for Merton, and that the criteria for an LCSPR is met.

3.5 In May 2023, the Executive received the findings of the re-review and accepted the recommendation to undertake an LCSPR focused on the specific areas identified for further learning:

- Lived experience of adolescents e.g. risk-taking behaviour, missing, potential exploitation, young carers
- How can services adapt to be more accessible to adolescents? What can services do differently in response to non-engagement?
- How cross borough working can be strengthened, and bureaucracy reduced for education and CAMHS.

3.6 The purpose of the LCSPR will therefore be to draw upon the existing learning from the rapid review from Vamp to enhance our wider understanding of work with adolescents with a focus on the above areas.

[1] Within Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)

3. Methodology

4.1 CSPR Methodology

As required by Working Together to Safeguard Children (2018 and subsequently 2023)[2], a systems approach was applied to this review.

4.2 The methods used were:

- A workshop held with the rapid review membership focusing on the three LCSPR themes (members asked to consider the themes in advance)
- Review relevant literature, best practice and learning from national reviews.
- Hold an open learning event to share learning so far and invite contributions on the three LCSPR themes (invitees to consider the themes in advance)
- Report with brief overview of learning from the rapid review and workshops focused on the three LCSPR themes.

4. Family involvement

5.1 The Merton Safeguarding Children Partnership (MSCP) wrote to the family to inform them of the review and offer the opportunity to contribute their views to the independent reviewer. The family did not respond during the review. Following approval of the report by the Executive group of the MSCP, there was a further, this time, successful attempt to contact the family. This enabled the reviewer to speak to Vamp's mother and sister. Their views have been added to the report which has been signed off as final by the Executive group.

5. Vamp's Voice (through her family's reflections)

2.1 Vamp was described by her mother as:

> *'Artistic, sporty, so talented at gymnastics. She was a popular girl who is remembered by her friends'*

2.2 Vamp's sister described Vamp as being tall for a 13-year-old. She appeared older than her age physically and in her attitude. The review found that the police should have checked Vamp's age when she reported an alleged sexual assault. Although it is not surprising that she was considered as older than her years, there should have been formal checks made. When her sister checked with the police about Vamp talking about the alleged sexual assault, they reported that Vamp had already been to speak to them.

2.3 Vamp's sister described how alone she felt during the period of the review when Vamp was uncontrollable, not returning home at night, not attending school. Vamp's sister described how she begged for help from services but did not feel heard. She told the

[2] The LCSPR was commissioned prior to the publication of Working Together to Safeguard Children 2023.

reviewer that she believed that Vamp needed 24-hour care to keep her safe, and that she had raised this with professionals just a week before Vamp's death.

2.4 Vamp's sister reported that she feels that Vamp was failed by the multi-agency system. She said that everyone knew that Vamp was not managing at school due to her behaviour, but there were barriers to getting her help due to attending school in a different borough to where she lived.

2.5 Vamp's mother did not feel that her daughter had been a young carer for her mother as the mental illness was short term. However, Vamp's sister described the situation as being so difficult for both Vamp and their mother. When their mother was discharged home from hospital, it was only Vamp and her mother at home. Vamp's sister explained that she, herself, was only a young adult, and with own baby to care for. She supported Vamp and their mother but said she felt that no one checked in on their mother. It was at this point that Vamp became more uncontrollable, but their mother could not manage as she had her own care and support needs. Yet, Vamp's sister said that professionals expected her mother to manage to parent Vamp, which she was not able to do alone, she needed professional help.

2.6 In the review, it was reported that Vamp's mother sometimes did not report her daughter as missing. Vamp's sister explained to the reviewer that Vamp would not go 'missing' as she usually kept in touch with her mother or sister. The issue was that she would refuse to return home late at night.

2.7 Vamp's sister described how Vamp, aged 13, was out with a friend of a similar age, when they were offered drugs by an older person. When Vamp ingested the drug, this led to her sudden death.

2.8 The reflections of Vamp's mother and sister give some context to the review findings, and more of Vamp's voice. However, there is still insufficient understanding of why Vamp behaved in the way she did, and what she really felt.

2.9 Vamp was described by her sister as:

> '*A carefree, confident individual. She didn't care about the opinions of others. She would dress brightly, because it was what she wanted'*

6. The Experience of Vamp (professional perspective)

6.1 Vamp was 13 years old when she died, through risk taking behaviour. The understanding of her lived experience was limited, despite Vamp being well known to services. There was little evidence of what Vamp wanted from her life.

6.2 What is known is that Vamp frequently went missing from home, although she would often keep in touch with her adult sibling. Whilst professionals seemed to not be able to establish a clear reason on why she was going missing.

6.3 Vamp's mother had a period of severe mental illness early in the Covid -19 pandemic. Vamp was potentially a young carer from this point. Then, following the first lockdown in 2020, Vamp transitioned from primary to secondary school, during which she struggled to manage further remote learning.

6.4 During 2021, Vamp came to the attention of agencies more frequently. At one point, she took an overdose of diazepam from an unknown source. This was not followed up by agencies. By the end of 2021, Vamp was frequently going missing, with concerns that these incidents were not always reported by her mother. There were also reports, to the police, that Vamp was sexually active with a 16-year-old boyfriend, but her age was recorded as being 15 years rather than 12, approaching 13 years of age, which therefore meant that sexual activity would have warranted investigation of statutory rape.

6.5 In 2022, Vamp increasingly came to the attention of services. The key incidents were:

- Vamp came to the attention of the police, following an episode during which she was followed by a group of people who had a knife.
- Incident in which she was found travelling alone on a train without a ticket.
- Allegation against Vamp of common assault.
- Escalating unreported missing episodes.
- Child Protection Plan to enable agencies to work with Vamp and her family to address her missing incidents.
- Incident of self-harm in the street. Vamp reported that she had previously self-harmed to release stress but that she would not do anything to kill herself and that she was not self-harming on this occasion.
- Allegation of rape by an ex-boyfriend. Vamp was 13 years old, but she was recorded as being 15 or 16 by the police.
- Further missing episodes, reported by Vamp's mother. Some episodes Vamp was believed to be at the South coast.
- Vamp made an allegation of physical assault by her ex-partner's friends.
- Police called to home address due to reports of Vamp harming herself with a razor blade.

6.6 Then, in July 2022, Vamp died following ingestion of drugs when out with friends.

7. Process of the Review

7.1 A practitioner event was held in September 2023, for those who worked with Vamp in Merton and Sutton. There were representatives from education inclusion, police, school, Catch22 Risk & Resilience Service, child protection, CAMHS, Public Health services and Local Authority Children and Family Support and Safeguarding.

7.2 The event was facilitated by the Independent Reviewer using an appreciative inquiry approach. The group reflected on Vamp's experience in relation to the three themes

identified as key lines of enquiry in the terms of reference. This led to wider discussions regarding what works well and what needs to improve.

7.3 From the practitioner event, the themes were narrowed to more specific key lines of enquiry. These were presented to a wider group of managers and specialists at a learning event in November 2023. This event was again facilitated using an appreciative inquiry approach, with participants working in groups to consider what works well, what needs to change, and how to make the change happen.

7.4 The findings are presented to demonstrate the following:

- How the theme featured in Vamp's lived experience
- Practitioner event reflections
- Learning event conclusions

8. Theme 1: How do we understand the lived experience of adolescents, for example, risk-taking behaviour, missing, potential exploitation, young carers?

8.1 How the theme featured in Vamp's experience.

8.1.1 Child Voice
Vamp's views were difficult to gain, and this led to a tendency for professionals to seek the views of her mother and adult sibling.

8.1.2 Missing episodes
Vamp was frequently going missing. There were professional concerns that her mother was not always reporting Vamp missing. It was recognised that Vamp was at risk when out in the community. Return Home Interviews were not always achieved but when they were, Vamp indicated that she went missing due to being unhappy at home. On occasions she was found travelling to be with extended members of the family. The concerns about Vamp's care were escalated and led to an Initial Child protection Conference being convened, where Vamp was made subject to a child protection plan under the category of neglect. There seemed to be limited investigation of why Vamp was going missing and whether there could be opportunities to keep her safe with extended members of the family. Vamp was taken to another family member on one occasion, but it is not clear how successful this was, as a few weeks later she was back home.

8.1.3 Allegations of Assault
Vamp had made allegations of sexual harm by her ex-boyfriend and historically by her father. However, CSC and police did not consider her to be at risk of sexual exploitation. When Vamp reported the alleged assault by an ex-boyfriend, the police recorded her age as 15-16, although at the time she was 13 years old. The investigation was ongoing at the time that Vamp died. However, there was no information that any agency referred Vamp to the Sexual

Assault Referral Centre (SARC), despite there being strategy discussions about her during this period.

There was evidence that Vamp was subject to adultification at times. This meant that there was insufficient consideration of the exploitation risks.

8.1.4 Recording of age

In a recent rapid review in Merton, it was found that the police did not check the age of a child, despite it being on record. Instead, the child was treated as an adult as they looked much older. For Vamp, she was 12-13 years of age when coming to the attention of police in relation to missing episodes, self-harm, sexual assault allegations. However, police noted her as being 15-16 years as the date of birth was incorrectly recorded.

8.1.5 Self-harm

There were reports of Vamp self-harming. These seemed to escalate following her disclosure of a sexual assault. Vamp reported that she self-harmed to release stress and would not do anything to kill herself. She was referred to CAMHS, but it was reported that Vamp had made it clear that she did not want engagement with any services. Therefore, CAMHS worked to support Vamp's family network instead. The assessment was that the risk factors exhibited were not uncommon and would not have warranted any additional action. Nevertheless, other agencies assumed that Vamp was 'engaging' with CAMHS herself as she was open to them.

8.1.6 Young Carer

At the start of the Covid-19 pandemic, Vamp's mother became seriously mentally unwell. Although she was reported to recover well, she was under the care of mental health services for two years. Information about Vamp's mother was shared with children's services working with Vamp. However, this did not seem to be fully understood in terms of the reliance agencies placed on Vamp's mother to address her daughter's issues. Vamp was noted in multiple records as 'not engaging.' There did not appear to have been an assessment or understanding of Vamp's experience of her mother's health problems, and potential of being a young carer.

Vamp transitioned from primary to secondary education following the first Covid-19 lockdown. There had been concerns raised in primary school and these were handed over on transfer to secondary school. However, there did not appear to be a full understanding of Vamp's life at home, in the context of her mother's health needs.

8.2 Practitioner Event Findings

The practitioner event was interactive with participants asked:

- To reflect on what was known about Vamp's experience.
- Consider the wider learning key lines of enquiry from the rapid review.
- Present ideas for further exploration.

What works well?	**Reflections**
Working together	• Risks in the local area are shared by police with schools. • Contextual Safeguarding in Education meetings have been set up by some schools. These are attended by the police and there is discussion about local themes and hotspots in relation to children at risk of exploitation. • Peer mapping using tools from Contextual Safeguarding Network. • There is strong multi-agency working that is responsive and keeps the young person's voice central to decision making as much as possible, that allows joint thinking, problem solving and shares responsibility to provide seamless care. • Agencies work to support parents with a safety plan and clarity on management of a crisis with a child. • There are working links between CAMHS and Hospital Emergency Departments to address concerns about children who self-harm.
Merton's approach to working with children and young people	• Catch22 has a variety of services nationally, working on County Lines, Child Exploitation and Missing, Substance Use, Health, and Wellbeing. The service reported that this enables them to draw on wide experience in respect of current trends/behaviours and children and young people (CYP) in Merton. • For young people where there is a contextual risk, it is necessary to consider their peer group and to recognise how those relationships influence and impact their circumstances.

What works well?	Reflections
outside of the home.	• There are examples of cultural genograms[3] being used to understand the family network, and to explore gaps in knowledge which has helped in thinking about the patterns and trends for adolescents. Alongside mapping of the areas within which they spend time, this helps to build a picture of push and pull factors for them. • Curiosity as a key concept of systemic practice also supports the focus on understanding the lived experience of young people, and this is further enhanced by the offering of reflective spaces provided by Merton's CAMHS in Social Care Team. • There is an ongoing piece of work to improve group working with young people at risk of harm outside of their families alongside their respective family networks. • The missing panel in Merton has been reviewed and returned to a face-to-face model in Spring 2023, which allows for greater multiagency reflection, analysis, and decision-making. Additionally, the on-going discussion regarding the role of contextual safeguarding in Merton (U-Turn) has outlined the need for practitioners to have greater access to provide support for young people on the ground. • A key area of focus has been championing the voice of young people and empowering them to share their lived experience from their perspective. An example of this is from Autumn 2022 when young people open to support within Child in Need and Child Protection interventions joined a meeting co-arranged by the participation team and the family support and safeguarding service to consider how best to capture feedback from children and young people. • Education Inclusion Services (Including Youth Services and Behaviour Services as examples) in the council work with a varied group of adolescents. The staff group have considerable experience over time of building effective relationships, managing risk taking behaviours and deepening the understanding of the potential drivers for behaviour, the child's special needs and any cultural intersectionality.

[3] Drawing-a-genogram.pdf (rip.org.uk)

What works well?	Reflections
Post Covid-19 Pandemic initiatives.	• The practitioner event heard that young people seemed to be seeking support and the need to form more intense relationships with each other coming out from lockdown. They appear more open to taking higher risks. There has been more self-harm reported, suicidal ideation and intent along with high levels of school related anxiety and avoidance. • For a few they have appeared to withdraw from the social norms, and their main interactions are within their peer groups which become almost everything to them. Or they have become solitary and withdrawn into their own world, which is mainly online, where they have made a new type of friendship/relationship with similar young people. Support from both internal key workers within school and outside key workers has helped to maintain some stability for some of these young people.

What needs to change?
• The discussion at the practitioner event concluded that there needs to be more frequent checks of the pupil voice and to do more with the information from these surveys. It is acknowledged that not all young people want to open up and so anonymous reporting tools are needed. Some schools do have platforms to facilitate anonymous reporting of crime or fears. • It was discussed that schools are not always aware of young carers, but practitioners are not sure what else can be done. • There needs to be more engagement and information gathering from siblings to be able to understand the impact of the wider family and what support can be made available to them. • It was agreed that there is a challenge for practitioners when a child does not consent to a service. There was a discussion about the use of trusted adults to support children and young people to navigate the system. This becomes more complicated when a child is subject to a child protection plan as, ultimately the CP plan is to support the parent to increase their capacity to safeguard. • A crucial element of working in this way is ensuring that adolescents and their parents/carers are supported to understand the approaches taken within children's social care according to their own level of understanding. • The school explained how they had looked at how best to engage those hardest to reach students. Their conclusion was that there needs to be a preventative, and personalised, approach to supporting students with social, emotional and behaviour issues. However, there is a dilemma in whether it is better to provide fewer interventions for students so those who have interventions have them for longer and more intensively, which will result on a large number of students on waiting lists not receiving interventions, or whether it is better to provide interventions for all students who need them, which would result in the interventions having less impact on the more complex students.

Key areas for further enquiry
• Safety of 12–13-year-old children on the street • Identifying young carers • Identifying and meeting the needs of children and young people at risk of child sexual exploitation • Social, emotional, and mental health needs of children and young people • Improving school attendance

8.3 Wider Learning Event

At the learning event the key areas for further enquiry, identified by the practitioners, were discussed. Participants attended from Merton, Sutton, and Croydon.

Area of focus	What works well?	What needs to change?	How will we make change happen?
12-13yr old children on the street	• Police identify/ councillors MP information from residents. • Detached Youth work in some boroughs. • Direct youth engagement on the street (Croydon) • Keeping the child at the centre of practice and matching them to professionals. • Good identification of risks as a Partnership and improved training. • In Merton, the detached Youth Work Team work to engage children on the street and identify them well. Sutton do not have a detached service –	• No agreed level of detached youth workers across London • Transition between primary and secondary. • Adultification- continue to improve. • More contact with young people to understand their views. • Identifying practitioners and adults with whom the child can relate. • Recognising the transient nature of some young people. • Multiple practitioners (SWs) working with the young person which can lead to a lack of consistent relationships with a trusted adult. • Onward monitoring of plans is needed with regular assessment and evidenced to monitor which aspects of plans may need to change.	• Young scrutineer work around cost of living – voice of young people • Look outside of the partnership (community) • Identifying the touch points for the child in individual situations. • Awareness raising campaign. • Report trends by location. • Consider work outside of the borough, such as in Croydon of cases where young people went on to commit crimes/violent behaviour despite support. • Working with the community needs to be improved by bringing together voluntary and

Area of focus	What works well?	What needs to change?	How will we make change happen?
	however, there is a service is run by voluntary centre. • All London boroughs have funding for the Your Choice Mentoring Programme, which links workers with young people at risk of contextual safeguarding issues.	• Meeting focus must not be solely on the chair and all participants should feel able to speak up. Any difficulties in this should be part of supervision. Core group members must understand their role in plans. How do we develop diverse ways of working when young people`s needs do not fit within plans and roles? • A recent peer review with Lambeth and Southwark showed that youth workers in the community are well placed to build trusting relationships with children and young people. Plans must also be concentrated in a single place. • How do we overcome challenges working with parents who are focused on the community harm? • Merton reviews of youth violence found that perpetrators had often been identified as having SEN or trauma at a primary school level, but no support was put in place. How do we set up a trauma-informed process for primary schools? • Use of community and sharing risks. How do we help young people navigate safely? • Raise awareness with parents of children aged between 12-16 years in relation to missing episodes and associated risks of drug misuse.	Council-run youth organisations across London. A forum is in place to do this. • Role of the parent and whole family working needs to be focused on. Nuanced family challenges can be push factors but are often not the biggest safeguarding concern.

Area of focus	What works well?	What needs to change?	How will we make change happen?
Identifying young carers	• Some evidence of signposting for young carer support. • Schools identify but with a limited service available. • Respite /trips are offered.	• Adult services not recognising young people as carers. • The title of young carer may not resonate with the young person. • Better tracking of young carers needed. • Embedding of think family to support young carers and identify their needs. • Cultural expectations of familial carers.	• Consider recommissioning young carers service. • Awareness raising – think family. • Review of the young carer offer and impact (or sharing of findings if it has happened).
Identifying and meeting the needs of adolescents at risk of exploitation	• Your choice programme. • Relationships with youth workers and key workers in school. • Strong relationships in pupil referral units (PRU). • Multi agency missing meetings held weekly. • Interface between Pre-MACE and missing children meetings. • Contextual safeguarding screening tool used. • Intelligence sharing –multi-agency across Merton. Information regarding risks is shared with partners across neighbours (certainly in health) • Daily missing meetings identify young people who go missing and regular patterns of behaviour.	• Family focus and adolescent relationship-based work needs to be strengthened. • Need for IT systems between local authorities to speak to each other to enable sharing of information. • Agree what preventative work with parents looks like. • More prevention work. • Better monitoring of child protection plans for adolescents. • Child focused working together.	• Review of protocol around information sharing across local authorities. • Community empowerment • More focus on plans to prevent exploitation. • Regular reviews with actions on what is not working.

Area of focus	What works well?	What needs to change?	How will we make change happen?
SEMH needs of adolescents	• Good identification of SEMH in primary and secondary schools. • Girl specific group work (Croydon). • 6-month engagement with residential support.	• Trauma based services. • Recognition that professional network can normalise risk for children coming to attention frequently.	• Take learning forward from Croydon CSPRs regarding serious youth violence, in which some related to childhood trauma. Strengthen relationships between schools and CAMHS, including between boroughs. • Early engagement with the young person.
Improving school attendance	• Children Missing from Education panel. • Attendance at secondary school in Merton is above the national and London average. • Attendance support teams • Early identification by the multi-agency network • Unannounced visits to schools • 'Live' attendance oversight	• Need education welfare teams. • School duty of care to focus on attendance of children	• Undertake mapping exercises of friendships across boroughs. • Child centred, not borough focused, resources. • Vamp's school has changed practice and if a child has not attended for 5-7 days and there is a known vulnerability, a home visit is carried out. This is now on a weekly basis for some students.

9. Theme 2: How can services adapt to be more accessible to adolescents?

9.1 How it featured in Vamp's experience.

9.1.1 Vamp was considered to be hard to reach. There were numerous accounts of her being described and '*not engaging.*' Agencies worked well to liaise with Vamp's mother and adult sibling, who was considered to be a 'trusted adult'.

9.1.2 Vamp told a professional that *'talking makes things worse'* and that she felt overwhelmed by the number of professionals involved. *This was evident in the accounts of professionals who attempted to speak to Vamp following self-harm incidents.*

9.1.3 Vamp was reported to have difficulties with friends, self-esteem and to be reluctant to engage and struggled with the lockdown and online learning. Since her death, some of Vamp's peers have been reported to comment that she "*lived her life how she wanted*."

9.1.4 It proved to be a considerable challenge for practitioners to reach Vamp. Some services worked with her family network which was good practice and the family reported it as being very supportive for them. Vamp's social worker persevered, visiting the home, not getting access to Vamp's room, but succeeding through communicating via notes under the door. Just a few days before Vamp's death, she had agreed to do spray painting with her social worker. It was clear that considerable efforts were being made to reach Vamp before she died.

9.2 Practitioner Event Findings

What works?	Practitioner event reflections
CAMHS will work with professionals if the child is not ready to engage.	• Flexible ways of meeting/engaging – virtual/face to face • Try and be accessible in terms of how to share information with young people- website, text alerts for appointments etc. • Self-referral for 17+ • Consider alternatives where possible particularly for young people who cannot attend for appointments. • Close working with parents/carers utilising their relationship to engage YP. • Using virtual medium e.g. video calls, phone calls

What works?	Practitioner event reflections
Robust communication within the care network	• Catch 22 work through the system. • Early identification of need which has included multiagency forums such as the young person's substance misuse group and the iThrive Child and Young Person Working Group. • There continues to be joint working across education and children's social care to explore how themes such as exclusion link to risk of harm in the community. • Preventative support provided to Merton secondary schools by multi agency services. However, these resources are in Merton schools and when a child attends a school out of borough this is a challenge.
Agencies working with adolescents need to develop the capacity to respond to them within the community.	• Take into consideration adolescent development and what this can mean in respect of their decision-making which has been the practice observed for adolescents supported by children's social care. • A whole family approach is also vital to ensuring parents/carers, siblings, and wider family and friends are skilled up to respond to young people and put in place boundaries for them. • Practitioners continue to be adaptable in their interventions with young people and there are examples across the organisation of innovative relationship building and direct work activities. • Catch22 developed a range of young person specific substance misuse information to use to reach out directly to children and young people, not reliant on agency referrals.

What needs to change?
○ Some children are not ready to engage – how do we consider their needs? ○ Do not just give up at the first sign of non-engagement – show them that we are committed. What is stopping them from engaging? ○ Try and use their interests to engage them – also reach out to close family members to better understand the young person. ○ Flexible ways of meeting/engaging – social media platforms, virtual, face to face. ○ Time/location to suit the young person and where they feel comfortable. ○ Review interactions and adapt accordingly – if something is not working, we need to change it. Respond to feedback. ○ A key consideration must be regarding who responds to adolescents between the hours of 5pm and 9am, and how those responding to young people are able to engage them in interventions that lead to safe decision-making. ○ There is a need to respond to the increase in mental health difficulties in adolescents.

What needs to change?
○ Outreach trauma informed service is missing in the CAMHS offer to meet the need of high risk (I thrive model) non engaging young people. ○ There needs to be more strategic thinking and planning to reach a clear understanding of a young person's lived experience and make personalised recommendations for resources.
Key areas for further exploration
• Language of child 'non-engagement ' • Responding to feedback from adolescents • Out of hours MH support for adolescents • Personalised services for adolescents

9.3 Wider Learning Event

Area of focus	What works?	What needs to change?	How will we make change happen?
Language of child 'non-engagement' *'Non-engagement cannot be a reason to stop statutory work to safeguard a child'*[4][5]	• Catch22 has a consistent worker which helps build relationships with young people. Getting the *right* worker can make a significant difference. • There are working links between CAMHS and Social Care in Sutton/Merton, with examples of good practice, meetings, and advice around complex cases.	• How does the language of non-engagement impact how services approach young people? Is there a better, more supportive term we can use? • There is currently a large issue with funding and commissioning. • Reliable resources are needed outside of statutory services - i.e., out of hours, websites.	• Agree how to feed back to professionals and share good practice? • Check how young people are helped to understand and navigate services. • Consider what has worked well in the past. • Need to ensure actions are beneficial for families and broken into manageable tasks.

[4] Dickens, J. et al. (2022) *Annual Review of Local Safeguarding Practice Reviews*. The Child Safeguarding Practice Review Panel
[5] https://www.gov.uk/government/publications/establishing-youth-friendly-health-and-care-services/youre-welcome-establishing-youth-friendly-health-and-care-services

Area of focus	What works?	What needs to change?	How will we make change happen?
	• Operation Wren between Merton and Wandsworth resulted in successful disruption of a group and getting young people into education, especially those in pupil referral units (PRUs). This required consistent and regular information sharing and strong cross-borough relationships. Operations of this scale may also be possible in correlation with Sutton. It was noted that Merton and Wandsworth share a BCU which helped to facilitate information sharing. • Flexibility of professionals in changing models of working – the Sutton School Nursing team and Education Provision went into Vamp`s home and had good engagement.	• Does talking have to be the focus of engagement? Young people can be engaged via other means, such as art, hobbies, and interests. What is their preference? • In Vamp's case, adult mental health services did not link with children`s mental health services.	• The planning process must be more collaborative with young people and families. Accessible language is key.
Responding to feedback from adolescents	• CAMHS formulisation meeting • CAMHS in Social care • Operation Wren • Being active listener to young people • Professional curiosity • Live safety planning in place 'social engagement'	• Trauma informed response. • Parents unable to get through police. • Medium risk needs further review. • Gloves not guns • More use of community engagement services similar to Croydon models	• Constantly review high risk cases. • Relationship building. • Move towards daily missing meetings with agencies present including police. • Consistent key adults 'right person, right time, right location'

Area of focus	What works?	What needs to change?	How will we make change happen?
	• Regular missing meetings once a week • Daily risk meetings • Identification of hotspots and missing patterns • Catch 22 are trusted consistent adults. • Services being flexible home visiting voluntary centre based. • Online messaging • Network trying to work together.	• Mapping exercises • Croydon specific team • Reframe language – have not engaged or have not reached. • Adaptive responses / knowing what works for the child. • "How can we help not what we're going to do." • Recognising smaller steps as stages toward engagement • What is the offer? – square peg in round hole – resource provision.	• Commissioning – move to online offer. • Consider how do to adapt to create more outreach.
Out of hours MH support for adolescents	Online resources	• Mental Health (MH) outreach service youth workers supervised by MH works to engage on the street. • Multi Systemic Therapy (MST) had out of hours for young people. • Professionals being more adaptable – access /promote alternative support/recognition that we may not hold the solution/choice/ownership of their next steps.	• Build service across Southwest London. • Spot purchase MST.
Personalised services for adolescents		• Finding the right worker to engage parent and child at same time. This will enable better understanding of the child's lived experience within the home and outside. • Flexibility of worker	

10. Theme 3: How cross borough working can be strengthened, and bureaucracy reduced for education and CAMHS

10.1 How it featured in Vamp's experience.

One of the challenges for Vamp was that although she was a Merton resident all her services were provided by Sutton and her peer support network was also in Sutton, as well as Croydon. This made accessing services initially complicated and caused some delays at a crucial point as she was demonstrating trauma through her self- harming behaviour.

Regarding the risks outside the home for Vamp, her peer group in Sutton and Croydon were not immediately identified. A mapping of intelligence from her missing episodes might have provided more information about risks at an earlier stage.

10.2 Practitioner Event Findings

What works?	Practitioner event reflections
Cross borough working	• Practitioner experience of working with CYP with co-occurring conditions appears to have improved, and services are not declining CYP. • Cross-borough mapping meetings support the activities to address adolescent risk in the community. Merton's lead for contextual safeguarding works towards maintaining relationships with her counterparts in other Local Authorities, which aids joint working when concerns are highlighted for a group of young people. • Schools improving relationships with neighbouring boroughs, enabling sharing information about individual children. • Representatives from different boroughs at some meetings. • CAMHS workers based in Pupil Referral Units (PRUs), and Youth Justice are linking cross borough for joint learning, professional development. • Consistent pathways into services. • Since Vamp's death, partner agencies have worked on a schools protocol on how to respond to incidents involving substance misuse. This has seen an emphasis on viewing such incidents in the first instance as 'safeguarding' as opposed to criminal response alone.

What needs to change?
• More consistency needed in cross borough representation at meetings. • Regular review meetings and information sharing with ALL agencies involved with the young person. • Whole family approach to support and intervention needs to be considered when deciding on next steps. • Services available in some areas but not others – need to find a way of 'bridging the gap.' • Promote what services are available in each area. • Resources should be child centred and not dependent on which borough the school is in or which borough the child resides in. For example, some resources in Sutton (for residents of Sutton) are free to Sutton schools (PRU interventions) however for some Merton resources the school would need to finance for example - Merton's behaviour service. • Cost and the general lack of knowledge of resources seems key for a young person who attends a Sutton school but needs additional support from the borough that they reside in. In Sutton it is hard to know what other boroughs offer and how to access their services as they all have different panel arrangements. Is there a way that neighbouring boroughs could have strengthened links, so there is more understanding of what is available and what the systems are? • Merton and Sutton are covered by different Police Borough Command Units. This means that there is not a clear link for sharing intelligence.
Key areas for further exploration
• How to strengthen cross borough working in general.

10.3 Wider Learning Event Conclusions

Area of focus	What works well?	What needs to change and how will this be achieved?
How to strengthen cross borough working in general.	• Good meetings with multiagency and cross-borough engagement. Cross-border mapping meetings are beneficial but hard to regularise due to the number of boroughs involved and the fact that issues can move. • Good relationships are being developed, especially in the Schools Exclusions Group which meets regularly. • SW (Sutton Education) works closely with Merton counterpart.	• Better commissioning arrangements and options to spot purchase. Financing can cause issues with cross-borough work. • Individual needs assessment for every child – consider every child as an individual. • Consideration is needed for when children have split living arrangements across multiple boroughs. Could SWL ICB offer more commissioning opportunities across boroughs? • Engaging young people with one professional for holding of risk – giving young people the choice of who to commence working with can empower them. • Involve young people or advocates to give them ownership over their plan. It was noted that Merton IROs meet with young people prior to conferences to ensure their voice is captured. • Assessment of all child attendance under 25% is now carried out.

11. Conclusion and Recommendations

11.1 From the rapid review and the practitioner event, it was evident that the professional network was trying to work together to reach Vamp. Cross borough communication had commenced, and Vamp had made small steps to engagement. However, this was not in time for professionals to understand Vamp's experience and why she seemed to be taking risks with her safety. There was no conclusion as to the extent to which Vamp was at risk of, or being subjected to, exploitation. This was not only due to insufficient time. Indeed, Vamp was known to be in a group of peers who were becoming a challenge for parents and agencies to manage. In such circumstances, there is a risk that these children become the '*problem*' rather than services focusing on the exploitation of children, and the perpetrators.

11.2 The reviewer would like to thank those who participated in the practitioner and learning events. There was a clear commitment to learning for Vamp's experience and to continually improve the services for children and young people who are at risk of exploitation.

11.3 There is some positive work going on in Merton and across the borough boundaries, with Sutton. It is vital that this continues to improve through the good relationships and the shared services across parts of Southwest London. The contextual safeguarding work that is in place needs to support and facilitate child protection arrangements beyond the home and parental responsibility.

11.4 Recommendations

Recommendation	Specific areas for consideration
1. The Merton SCP should gain assurance as to how partners are strengthening the working together approach to safeguard children from extra familial harm.	• In Child Protection plans involving children going missing, there needs to be consideration of actions beyond neglect in the home and how agencies can protect the child within the community, with the child as an active agent[6]. • Consider how those who might be vulnerable to exploitation are identified and supported e.g., through utilising a trauma informed approach. • Consider ways for community development: to empower members of the community to share risks with agencies. • Do we feel confident that workers are able to discuss substance misuse and risk for children and young people. • Facilitate voluntary and council run youth organisations to come together to plan how CYP navigate the locality safely. • Consider national research about the need for professional to engage children in relationships of trust if they are to be most successful in enabling children to explore and address risky behaviours, situations, and relationships[7].

[6] Hallett, S. 2016 'An Uncomfortable Comfortableness': 'Care', Child Protection and Child Sexual Exploitation *British Journal of Social Work* (2016) 46, 2137–2152

[7] Lefevre, M. et al (2017) Building Trust with Children and Young People at Risk of Child Sexual Exploitation: The Professional Challenge *British Journal of Social Work* (2017) 47, 2456–2473

Recommendation	Specific areas for consideration
2. The Merton SCP should consider how children and young people can be supported to navigate services more easily.	• Change the narrative: stop using 'non-engagement' for children and young people. Prioritise reaching the child[8] • Any service working directly with CYP must have a policy for how they will adapt their service to meet the needs of CYP, with a commitment not to view any CYP as 'non-engaging.' • CYP need to be able to trust professionals to balance the need to protect the CYP with that CYP's right to make choices about their own lives.[9]
3. The Merton SCP should work with neighbouring safeguarding Children Partnerships to influence stronger commissioning arrangements across boroughs.	• Consider how to breakdown the barrier that finance agreements make towards effective working together across neighbouring boroughs. • There are some good working relationships as workers stay in SWL and move between boroughs. Harness this knowledge and develop shared commissioning arrangements and protocols.
4. The Metropolitan Police need to ensure all avenues are explored to determine the age for children and young people under the age of 18.	When a young person discloses an alleged sexual assault, all efforts should be made to confirm the age of the victim and perpetrator.
5. The Merton SCP should liaise with other Southwest London Safeguarding Partnerships to push for a consistent approach to Detached Youth Work services, using this review.	The Merton DCS should raise this issue at the DCS South London sub region meeting, outlining Merton approach & offering to share best practice, and referencing this review
6. Merton SCP should seek to understand the experience of young carers and agency responses to them.	• How does the Local Authority meet its statutory duties to identify and support young carers? • How effective are education providers in working with other agencies to adapt systems for young carers? • How accessible are mental health services to young carers? [10]

[8] Stafford, V. et al. 2014 "Why are you here?" Seeking children's accounts of their presentation to CAMHS *Clinical Child Psychology and Psychiatry*, Vol. 19 No. 4: 489-505 2014

[9] Lefevre, M. et al (2017) Building Trust with Children and Young People at Risk of Child Sexual Exploitation: The Professional Challenge *British Journal of Social Work* (2017) 47, 2456–2473

[10] Carers Trust (2022) *Its harder than anyone understands: the experiences and thoughts of young carers and young adult carers: A Carers trust Report*.