Young people | September 2021

Why are older children in care proceedings? A themed audit in four local authorities.

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Report

This is a themed audit involving 73 children (aged 10–17) from 49 families who were the subject of care proceedings issued by four local authorities in England and Wales in 2019/20. It is part of a series of work that aims to help build a better understanding of the reasons why older children and young people are being brought into care proceedings.

research in practice

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Contents

Summary and Welsh translations are available from:
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Abbreviations

ADHD	attention deficit hyperactivity disorder
CAMHS	child and adolescent mental health services
EHCP	education, health and care plan
FDAC	family drug and alcohol court
FGC	family group conference
ICO	interim care order
MACE	Multi-Agency Child Exploitation [group, panel or partnership]
PTSS	post-traumatic stress syndrome
SGO	special guardianship order

Foreword

Nuffield Family Justice Observatory is publishing a series of studies to explore why more young people are becoming subject to care proceedings in England and Wales and what might be done to better support them.

It is hard to read about the experiences of young people whose cases are reviewed in this report without a sense of regret that more could not have been done to prevent such circumstances.

At the same time, the examples point to the sort of practice that can make a difference, as well as to what needs to change: more effective and earlier support for parents and children, better coordination across the family and youth justice systems and a re-examination of what 'care' consists of when young people require the intervention of the state.

The examples outlined in this study provide an important reference point for future discussions about how we transition towards better provision for young people. I am very grateful to the authors and to the local authorities involved.

Lisa Harker

Director

Executive summary

This summary highlights the key findings of a themed audit of 73 older children (aged 10–17) from 49 families who were the subject of care proceedings issued by four local authorities with high levels of deprivation in England (north, south and London) and Wales in 2019/2020.

The audit questions explored intrafamilial and extrafamilial safeguarding concerns that triggered proceedings, the plans made for the children, the children's circumstances up to two years after proceedings had ended, and the achievements and challenges for local authorities and their local safeguarding partners (see Appendix A).

The local authorities completed their audit forms in March and April 2021. Findings were reviewed and analysed with each local authority in May and June (see Appendix B).

The work also provided an opportunity to learn about local policy and practice imperatives, and to capture the views of experienced practitioners and managers about what was working well and what more might be done, or what might be done differently, to help similar children and families in future.

Key findings

What do we know about the children and families concerned?

- Most of the 73 children in our study (68%) were aged 11–13. There was only one 17-year-old.
- Overall, there were slightly more boys in our study (38, 52%) than girls (35, 48%).
- Overall, nearly 80% of the children (58) were in proceedings with brothers or sisters. Just under half had older siblings in the proceedings and just under a quarter had younger siblings in proceedings. Nine children (12%) had siblings who were not in proceedings at all, and just six (8%) were single children.

- In London and Wales, the children involved in the audit were mainly Black or of dual heritage, or from a broader range of different ethnicities. In the other areas (north and south England), the children in the cohorts were predominantly White.

- The vast majority of families (40 of the 49, 82%) were known to the local authorities at the time proceedings were issued. Most (32 of the 49, 66%) had been through the various stages of local authority support and safeguarding, and in almost half the families (31, 42%), children were already in care as proceedings started. For nearly a third of families (15, 30%), it was the second time the child or children had been in care proceedings. The gap between the first and repeat proceedings varied considerably—from one to twelve years.

This points to the importance of looking at some data through the family lens, as well as that of the individual child.

What brought the children into the family justice system?

- All the children had experienced some degree of emotional harm, generally through the adverse effects of other grounds for proceedings: neglect (78% of families), domestic abuse (49% of families), physical harm (43% of families) and sexual abuse (10% of families).

- In terms of the ability of parents to provide safe care, there tended to be more than one factor at play: substance misuse and cumulative trauma featured most frequently, each present for almost half the families (45% and 43% respectively). Poor parental mental health was a factor for over a third of families (35%). In addition, all the children had fractured relationships with one or both parents. These related to difficult and unresolved past and current experiences and to changes in family circumstances, often compounded by the separation and uncertainty prompted by the proceedings themselves.

- Extrafamilial concerns were present for a quarter of the children in the audit (18 children from 12 families, 25%).

*The family stories showed that the children were not in proceedings because of **either** intrafamilial or extrafamilial harm. Rather, they were on a continuum of extrafamilial safeguarding concerns that varied from low to very high, and these external concerns were in addition to the intrafamilial reasons for issuing proceedings.*

What plans were made for the children's futures?

- In just over half the cases the judge had granted one or more extensions to the 26-week requirement for case completion. The reasons varied but included long delays in trying to find suitable placements for children with serious and complex difficulties, time needed to assess different needs of children in sibling groups, and the use of a few extra weeks to test out plans (such as a return home or a move within the family network).

- At the end of proceedings care orders were made for just over half the children (38, 52%). In addition, all but one of the seven unfinished proceedings were anticipated to end with care orders too, given that the children were in (foster) care on interim care orders (ICOs). Those with a care order were mostly living in fostering arrangements, including some who were placed with an approved kinship or connected person carer. The other children were in residential placements.

- Just under half of all the children (34) returned to a parent/parents or remained within their wider family network. The decisions made by the court for these children included supervision orders, special guardianship orders (SGOs), child arrangement orders, and kinship foster care arrangements under a care order.

- Placement moves were also recorded on the audit forms. Almost half the children remaining in care after the end of proceedings stayed where they were living, and so experienced no move. These children were overwhelmingly those whose placement became a long-term foster/kinship care arrangement with the granting of a care order. Almost two-thirds of these children have had no more than two placements during their time in care. The children in kinship fostering arrangements have experienced the least change in placement.

- Children who experienced more than four foster placements since being in care were likely to then move to a residential setting. We found a general lack of suitable placements for older children—especially worrying where public safety or welfare considerations were driving the thinking about deprivation of liberty. Acting in an emergency was an added burden in terms of finding a suitable placement.

- For some children who spent time in a secure setting during or after proceedings (e.g. in the youth secure estate, secure children's homes, or alternative

placements depriving of them of their liberty under the inherent jurisdiction of the High Court), it had the potential to provide opportunities for them to engage with interventions and education services, and bring about positive change. We found that positive change seemed more likely when the deprivation of liberty was made in a planned way, as part of a clear strategy for a child, rather than as emergency action because no bed was available in a secure children's home.

What was the involvement of youth justice, health, education and other partner agencies?

- We found examples of highly imaginative, multi-agency care packages to support and safeguard some children.

- There was evidence of youth justice involvement for 12 of the 73 children (16%). This ranged from minor offences, with early intervention responses directed at specific risks, to serious offences that resulted in older children spending time in the youth secure estate. It may be that the audit forms underrepresented the early intervention responses by the police and/or youth justice services. We add this caveat because it became clear that there was no easy way for auditors to find more than very basic information in the children's services records about the involvement of youth justice services.

- We found many examples of school as a positive factor. It was described as a safe haven and a source of continuity in times of disruption and stress, with teachers who boosted confidence and progress in children and parents. We were surprised to find no mention of education welfare services, bar one reference to a mother having been prosecuted for her children missing school.

- It was notable that some children's health needs (across the age range) were identified only after proceedings had started and the children were in care. This occurred in separate cases involving attention deficit hyperactivity disorder (ADHD), autism, sleep disorder and complex trauma. Auditors noted that some children were reluctant or unwilling to accept child and adult mental health service (CAMHS) and other offers of help. In the main, however, those who were enabled to access support began to make some progress. Some children were being helped to explore their feelings in creative ways, for example through songwriting and sport.

Reflections

Treading water is not enough

We must make and take opportunities to help children differently, through earlier attention to the difficulties that face those closest to them. This would include a renewed focus on tackling parental needs—as soon as they arise—through a family lens and with greater understanding across all services of complex trauma and its impact on how people respond when they feel under threat and in distress.

Action is needed:

- To attend to parental needs relating to substance misuse, domestic abuse and poor mental health and tackle the related underpinning poverty and disadvantage faced by families in everyday life.
- To offer better support when children return home on a supervision order, given the high rate of those cases becoming repeat proceedings.
- To act sooner rather than later. Being prepared to take a case to the family court when there are clear indications that things are highly likely to continue getting worse is one example. Another is providing an intensive support programme at home, to avoid unnecessary prolonged family separation.
- To strengthen support to vulnerable children in Years 5 and 6, before transition to secondary school.
- To build earlier connections between children's services and the youth justice system.
- To provide an up-to-date literature review of the specific issues relevant for children and families in the overlapping but separate (and sometimes siloed) systems and services of family justice and youth justice.

Provide safe havens

We must resolve to bridge the yawning gap in suitable provision for older children with complex difficulties who need to be in care. The adverse impact on their safety and development, and the parallel frustration of practitioners, managers, and often their families, in finding suitable placements and provision, have confronted us for too long.

Action is needed:

- To ensure that local authorities have access to small, safe, specialist local homes where young people can be helped to deal with their past experiences and feel inspired to look forward to the future.
- To build on the safety that school provides for some children and parents.
- Given that absence from school is a trigger for heightened vulnerability, we must actively challenge policy and practice around school exclusion.
- To acknowledge and harness what secure accommodation can provide for some children—including, as the audit shows, helping to compensate for lost education, enabling children to engage in activities and self-development programmes, allowing children to get warm support from staff, and enabling access to therapeutic help after release. Further research is needed to understand outcomes for children in secure accommodation, and what type of care is most beneficial.

Maintain the lifeline

A crucial vulnerability to extrafamilial harm relates to losses that stem from weak or poor relationships, separation, bereavement and other traumatic events or circumstances. It follows that a top priority in supporting children is a concerted effort to mend and sustain existing relationships so that children retain as many links as possible with people who love them, and so that they get the best possible support to restore fraught and fractured relationships with their parents, brothers and sisters, and other relatives. Added to this is the value of professionals being curious about children's lost connections and being diligent about exploring what they might have to offer.

Action is needed:

- To learn from the experiences and views of children and those close to them who have waited a long time—in the view of auditors sometimes far too long—for the welcome relief from burdens they have been struggling with. And to learn, too, about the need for, and experience of, being drawn back to the place that is home and the people who are family, and of understanding and dealing with the tensions, emotions, risks and benefits involved.

- To learn from what the audit has highlighted about successful practice using family group conferences (FGCs) and other family decision-making meetings, and the added value of that work being led, driven and supported by agency policies and strong leadership committed to a family inclusive approach. We recommend the continued promotion of—and support for—this model of work and for professional practice in and out of court that values the importance of seeing parents and older children as partners with professionals in identifying and tackling the problems they face.

Natasha's story: a life of trauma and the hope of the right support at 13

When Natasha's parents separated she stayed with her mother. In primary school, Natasha said she had been sexually abused by a male family member. He was found not guilty after a criminal trial. Natasha's mother always said she did not believe her daughter's allegations and professionals wondered if she had experienced abuse herself as a child. Children's services worked with the family under a child protection plan, but things deteriorated, and the local authority moved to pre-proceedings. A family group conference (FGC) led to Natasha moving in with her father. She seemed to settle down and made a smooth transition to secondary school.

In Year 8 (age 12), Natasha started staying out late. She was found with cannabis, and she became secretive with her phone. She often had money beyond what could be expected for a young person. She started to skip school frequently, and her poor behaviour resulted in a short-term and then permanent exclusion. She moved back in with her mother, but then missed two school terms and did not get on with her sisters. She set fire to the home and became beyond the control of both parents. At a further FGC other family members felt that Natasha was too difficult for them to look after, and the local authority agreed with their conclusion.

Natasha came into care under section 20 [Children Act 1989] with agreement from both parents, but she moved rapidly through seven foster, residential and other placements because of her behaviour, which included assaults on carers and other children and fire setting. She went missing frequently and during these episodes she was assaulted both physically and sexually.

The local authority applied successfully for a care order and, during the proceedings, for a secure accommodation order, but there was no secure placement available. She was held in an unregistered setting, with the High Court having sanctioned deprivation of her liberty for eight days because of the risk to herself and others.

The youth justice service was involved, on account of convictions for assault, as was CAMHS, because of her self-harm and suicidal feelings that resulted in several visits to hospital. In her current therapeutic residential placement, she is being treated for post-traumatic stress syndrome (PTSS).

There are signs that Natasha is finding the current support helpful: for the past six months she has had better attendance in her current educational provision and is completing her GCSEs, with some good grades expected. In particular, she enjoys singing, songwriting and the performing arts, and these have given her a new focus. Her relationship with both parents remains fragile but there is some intermittent phone contact. Natasha has a care advocate and is becoming involved with the local children in care group.

Introduction

The report sets out the findings of a themed audit of 73 older children (aged 10–17) from 49 families who were the subject of care proceedings issued by four local authorities with high levels of deprivation in England (north, south and London) and Wales in 2019/2020.[1] It forms part of a series of work that aims to help build a better understanding of the reasons why older children and young people are being brought into care proceedings. This includes analysis of national Cafcass and Cafcass Cymru data to quantify the increase in the number of older children and young people subject to care proceedings in the last decade (Roe, Alrouh, and Cusworth 2021), and an accompanying case file review of proceedings heard at the East London Family Court (Roe, Ryan, and Rehill 2021).

This series aims to explore what is working well, what needs to change, and what will enable that change to be visible in the systems and services for older children and their families.

The research explored the following questions through a series of audit questions (see Appendix A):

- What brought these children into the family justice system, and what were the safeguarding concerns, both intrafamilial and extrafamilial?
- What plans were made for the children's future, and what was the involvement of youth justice, health, education and other partner agencies?
- How are the needs of children and families being met, up to two years after the start of proceedings?
- What can be learnt from the achievements and challenges for local authorities and partners, and from the experiences of the children and their families?

The four local authorities completed their audit forms in March and April 2021. Findings were reviewed and analysed with each local authority in May and June (see Appendix B for methodology).

1 The local authorities agreed to their findings being amalgamated into an anonymised aggregate final report. We refer to them throughout as Local authority A, B, C and D.

Data gaps and limitations

Although we succeeded in recruiting a range of local authorities and a satisfactory cohort size (73 children in 49 families), and the topics and findings resonate with other evidence, as indicated later in the report, there are caveats to bear in mind when interpreting the results.

First, the information held by the local authorities varied in quality and detail, resulting in variation in the ease with which the local auditors could locate either relevant information about the children or administrative data about the cohort in the context of their proceedings overall. There was variation too in the number of children in each local authority cohort and in the proportion of sibling groups as opposed to single children in the audit age range.

Second, this was predominantly a file exercise (of electronic social care records completed and held by children's services, and supplementary information from local authority legal planning meetings and reviews on children in care). Some extra information was included because an auditor knew the children and families concerned or checked with a colleague who did. It follows that there has been no exploration of the extent to which the children, parents or other carers (and other agencies) took a similar view to that transferred to the audit forms about what had happened and why, or about what might have been done differently. This was not our remit, but it does leave a gap in perspectives—a limitation that has been challenged by others.[2]

Third, as the audit focused only on the children aged 10–17 brought into care proceedings during the audit year, it excludes three other groups of local children of the same age: those already in the care of the local authority, those known to children's services as children in need (under section 17 of the Children Act 1989), and all the other children in the local authority's general population. This considerably limits the overall picture of work that safeguarding agencies are likely to be undertaking to disrupt and prevent harm to children from within or outside their family.

Fourth, the audit included only three local authorities in England and one in Wales. Findings may therefore not be generalisable to other areas.

2 Note the recommendation of the Care Crisis Review (Family Rights Group 2018): 'That there is a presumption that the methodology of research studies exploring practice with, and outcomes for, children and families incorporates the experiences of family members.'

What do we know about the families and children concerned?

The audit form (see Appendix A) was completed for the 73 children from 49 families who met the criteria for inclusion (age 10–17 at the issue of proceedings in 2019/20).[3]

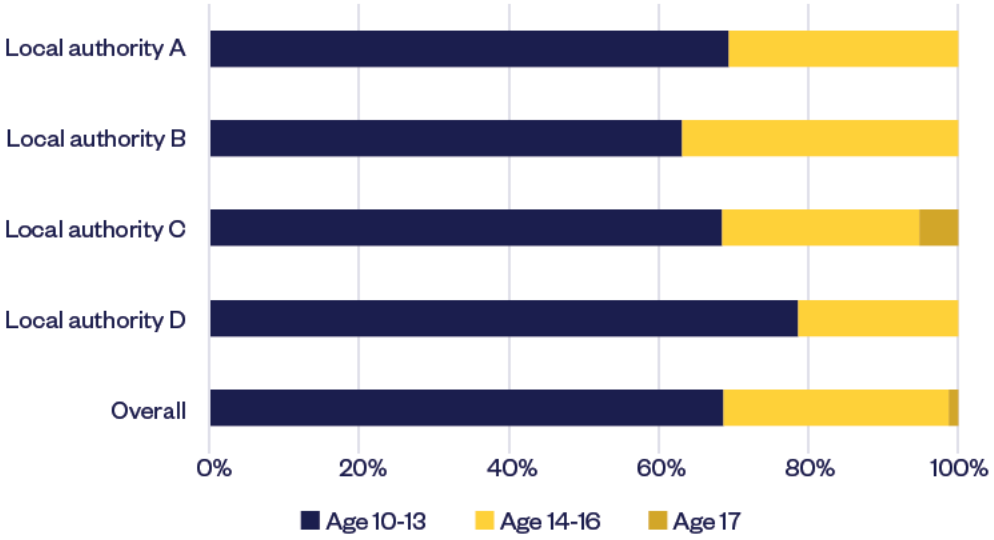
Table 1: Number of children and families per local authority

Local authority	Children		Families	
	Number	%	Number	%
A	13	18%	9	18%
B	27	37%	19	39%
C	19	26%	12	24%
D	14	19%	9	18%
Total	73	100%	49	100%

The majority of children in our study (68%) were aged 11–13 (see Figure 1). Local authority B had a higher number of children in the 14–17 age bracket, including six 14-year-olds, four of whom were from two sibling pairs. The only young person aged 17 was one of two sisters in Local authority C; both sisters went to live with a person closely connected with their family (see Tables C.1 and C.2, Appendix C). This reflects the national picture where the majority of adolescents in care proceedings are aged 10–13 (66.1%) (Roe, Alrouh, and Cusworth 2021).

3 The data excludes any application made solely to discharge an order made in previous years.

Figure 1: Proportion of children by age bracket by local authority

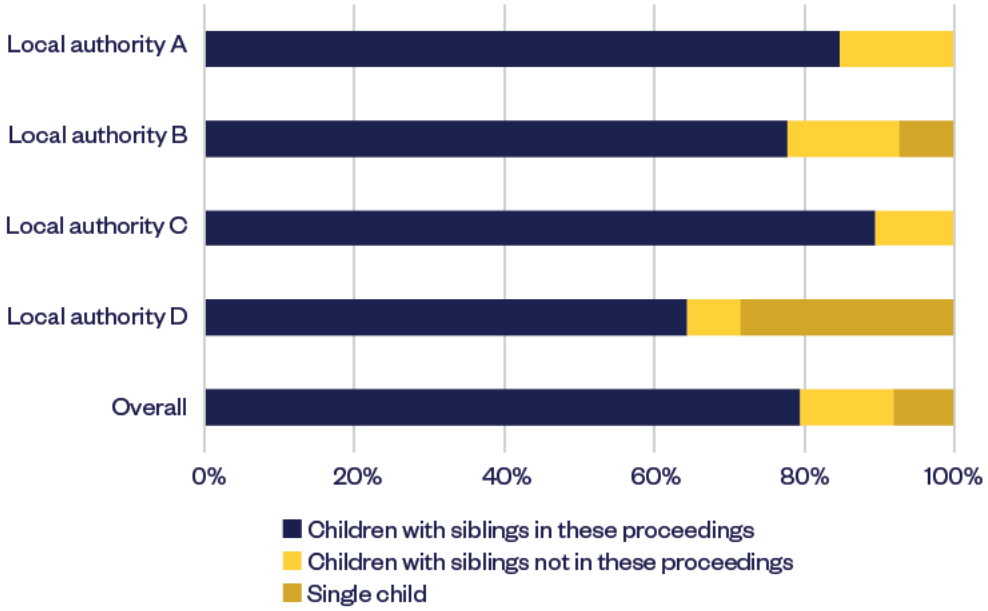


We found that the proportion of children age 10+ coming into proceedings in 2019/20 varied widely between the local authorities—from 10.6% of all children in care proceedings in Local authority D to 52% in Local authority A. This compares to a national average of 27% (Roe, Alrouh & Cusworth 2021). The secondary analysis of data available for Local authority B showed the extent to which the proportion of older children (10+) has grown—from 14% to 26% over the past six years.

Nearly 80% of the children (58) were in proceedings with brothers or sisters (see Figure 2). Just under half of these children had older siblings in proceedings and just under a quarter had younger siblings in proceedings.

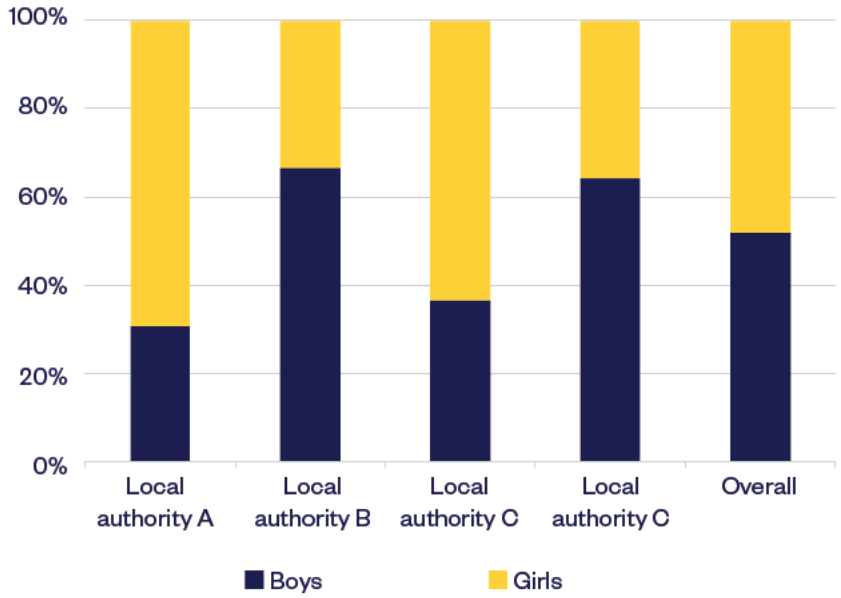
Nine children (12%) had siblings who were not in proceedings at all, and just six (8%) were single children. This information points to the importance of looking at some data through the family lens as well as through the lens of the individual child.

Figure 2: Proportion of children with siblings in these proceedings by local authority



While there were slightly more boys in our study (38) than girls (35), the ratio varied by local authority (see Figure 3).

Figure 3: Percentage of girls and boys in these proceedings by local authority



Child and family ethnicity varied across the local authorities.[4] In London and Wales, the children in the cohorts were mainly Black or of dual heritage, or from a broader range of different ethnicities. In the other group (north and south England), the children in the cohorts were predominantly White (see Table C.3, Appendix C, for overall ethnicity breakdown per child and family; ethnicity data is not broken down by local authority to avoid identification).

4 Ethnic group classifications were based on the ONS Census categorisations, used by the local authorities. Slight adjustments were made in the reporting of data, to preserve family and local authority confidentiality.

Before, during and after proceedings

Prior involvement with children's services

Most of the families (40 of the 49, 82%) were known to the local authorities at the time proceedings were issued. Only 9 families (18%) were unknown at the time proceedings were issued. One of the nine families was later found to have had substantial contact with a different local authority, and two other families (with children thought to have been trafficked) were not known to any local service before the children came to local authority attention via police protection.

Of the families known to the local authorities, 32 (80%) had gone through the various stages of local authority support and safeguarding: information sharing with other agencies, 'child in need' support to the family, 'child protection' registration and repeat registration.

Almost half of the children (31 of the 73, 42%) were already in care at the point of proceedings starting (under either section 20 or police protection).

A fifth of the families (11 of the 49, 22%) went through pre-proceedings before the local authority issued proceedings, and for almost a third of the families (15 of the 49, 30%) these proceedings were the second time that the children had been in care proceedings.

For further details and a breakdown by local authority, see Table C.4, Appendix C.

International involvement

Seven cases (10 children, 14% of the total), from two of the local authorities, had an international element of work and involved enquiries about the whereabouts and circumstances of parents and/or other relatives—either to trace people or to identify potential carers for a child. The countries involved were Gambia, Egypt, Sierra Leone, Spain, Nigeria, Poland and the United States. None of the work has resulted in missing people being found or a family placement being made, although there remains hope of this possibility for two of the children.

There were strong suspicions that two of the children, from different families, had probably been trafficked from Africa for exploitation—one possibly for domestic slavery or a forced marriage (see Hannah's story).

Hannah and Omar's stories: suspected human trafficking

Hannah was 14 when she came into care via police protection. She had run away from circumstances of domestic slavery and was in fear of female genital mutilation. She reported having been brought to the UK after the death of both her parents. Enquiries were made in her home country, but no relatives could be traced. She was placed in foster care where she is now flourishing and excelling in school. Hannah aspires to be a doctor.

Omar was 13 when he came into care via police protection. He had been brought via Europe to the UK by a man who

was possibly related to him, but apparently without the permission or knowledge of his mother who remained in their country. Omar was moved around the UK, locked in properties and left on his own. He was not enrolled in school or registered with a GP. Despite efforts, his mother has not yet been located. Omar was experiencing severe difficulties and trauma, and struggling in school, and in foster care and residential placements. As a result of these difficulties, he was sectioned under the Mental Health Act. After his discharge from the psychiatric unit, the High Court authorised the deprivation of his liberty.

He has been gradually improving and moved into a bespoke placement, with a care team giving priority attention to his linguistic, cultural and spiritual needs. This approach, together with a restorative approach to his offending behaviour, means that his liberty is no longer restricted. He is attending school, enjoying sport, and engaged with his faith group in the community.

Prior involvement with court: children in repeat proceedings

All four local authority audits included children in proceedings for the second time.

19 children (26% of the total) from 15 families (31% of the total) were in proceedings for the second time. The gap between first and second proceedings varied considerably between the local authorities—from a one-year gap for each of the two cases in Local authority D to a gap of 11 and 12 years for each of the two cases in Local authority A. The range between first and repeat proceedings in Local authority C was two to four years, and two to nine years in Local authority B.

The majority of repeat proceedings (11 of the 19, 58%) followed a supervision order to the child's mother in the first set of proceedings. This chimes with findings from national research about high incidences of repeat proceedings following a standalone supervision order (Harwin et al. 2019). In three of these cases the court decision was the same as in the first proceedings—that is, a supervision order to the mother.

In the other eight sets of first proceedings, the final orders granted were two residence orders to fathers, five SGOs to grandparents, and one placement order for adoption.

- In five of these eight cases, involving younger children, the case returned to court as earlier plans for permanence had been disrupted. The local authorities

worked hard with different types of intervention to try and prevent these disruptions.

- The other three cases involved older children in more recent repeat proceedings.

Between the end of proceedings for the children in the current cohort and the completion of the audit work, one child had come back into proceedings. This was a child with a supervision order to their mother.

Further details can be found in Table

Craig's story: a case of repeat proceedings

Craig lived with his mother and had been a child in need, with things escalating to child protection, and then care proceedings that ended with a supervision order when he was 10. Concerns had included physical and emotional abuse and neglect, with his mother's ability to provide safe care affected by her past trauma, poor mental health and substance misuse.

After the supervision order expired, the situation deteriorated at home, with a lack of routines and boundaries. This led to increasing concerns about Craig's safety, including vulnerability to criminal exploitation. His behaviour at school was difficult to manage, resulting in short-term exclusions. The youth justice service did some one-to-one work with him to try and address the risks. Further care proceedings were issued when Craig was 12, which ended with a care order.

Craig was making good progress in foster care but the COVID-19 pandemic had a negative impact in that Craig's mentoring work and local support group were suspended. Craig refused mediation work with his mother. Sadly, his placement has been disrupted and he is waiting for a new long-term placement.

Grounds for bringing proceedings, and concerns about children and parents

Table 2 sets out the grounds for issuing proceedings in each case, the main difficulties affecting parenting capacity, the needs of the individual children, and the nature of any extrafamilial harm identified.

Table 2: The grounds and issues affecting parenting capacity, and the nature of concerns relating to the children

	Local authority				
	A	**B**	**C**	**D**	**Total**
Nature of grounds per family					
Physical	4	10	6	1	21
Sexual	1	2	2	-	5
Emotional	9	19	12	9	49
Neglect	6	14	11	7	38
Domestic abuse	3	7	9	5	24
Issues affecting parenting capacity					
Mental health	1	6	4	6	17
Trauma	2	9	6	4	21
Learning difficulties	-	1	1	-	2
Drug/alcohol	3	7	6	6	22
Absent	4	1	5	2	12
Deceased	2	2	1	-	5
International element	2	5	-	-	7
Issues for children					
Child with disabilities	1	2	3	-	6
Emotional and behavioural difficulties	2	6	8	2	18
Beyond parental control	2	5	3	1	11
Criminal exploitation		5	5	-	10
Sexual exploitation	2	2	2	-	6
Human trafficking	1	1	-	-	2

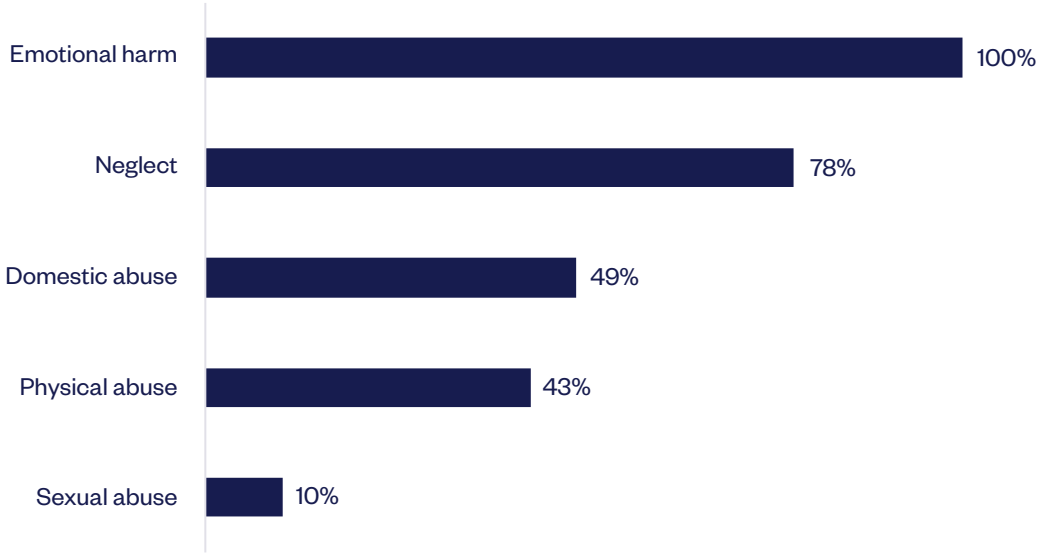
Grounds for proceedings

The local authority auditors recorded the grounds for proceedings, which usually included more than one category of harm per child.

In our analysis, while not every form had a tick against the emotional harm variable, the free-text comments gave compelling evidence of emotional harm in every case. This harm was generally about the adverse impact of the other grounds for proceedings: physical harm, sexual harm, neglect, or domestic abuse.

In no case, however, was emotional harm the sole grounds for proceedings (see Figure 4). Cases featured a mix of grounds for proceedings, with neglect being the second most common reason (78% of all families). Domestic abuse was recorded in 49% of families, and physical abuse in 43% of families. Sexual abuse featured in five families (10%), affecting seven girls. Two of these girls, from two families, were at high risk of child sexual exploitation and may well have experienced it already.

Figure 2: Grounds noted for proceedings (proportion of families affected)

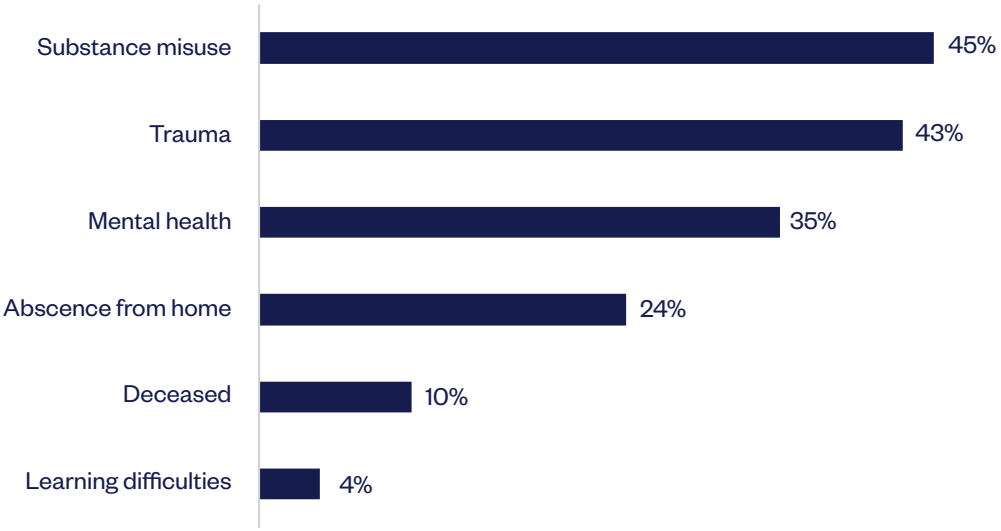


Note: In some cases, emotional harm was inferred from free text responses to the audit rather than the box being checked by the auditor.

Concerns about parenting capacity

The auditors recorded the issues affecting parenting capacity and here too there was usually more than one factor involved. Substance misuse (45% of families) and the experience of trauma (43%) featured most, each in almost half the families, with poor mental health a close third in frequency (35%).

Figure 5: Concerns about parenting capacity (proportion of families affected)



The audit did not seek details about the specific nature of the mental health problems or traumatic experiences that affected parents' ability to provide safe care, but many parents were recorded as having a psychiatric or psychological assessment during the proceedings.

As Figure 5 shows, relatively few parents had learning difficulties recorded on the audit form (two families). One parent had impairment that was severe enough to need the involvement of the Official Solicitor; other parents had mild or moderate difficulties. The prevalence of learning difficulties in our sample may have been underrecorded given research suggesting that a significant minority of parents in care proceedings may have hidden or undisclosed learning difficulties (Booth 2000).

See Table C.6 and C.7 (Appendix C) for further information.

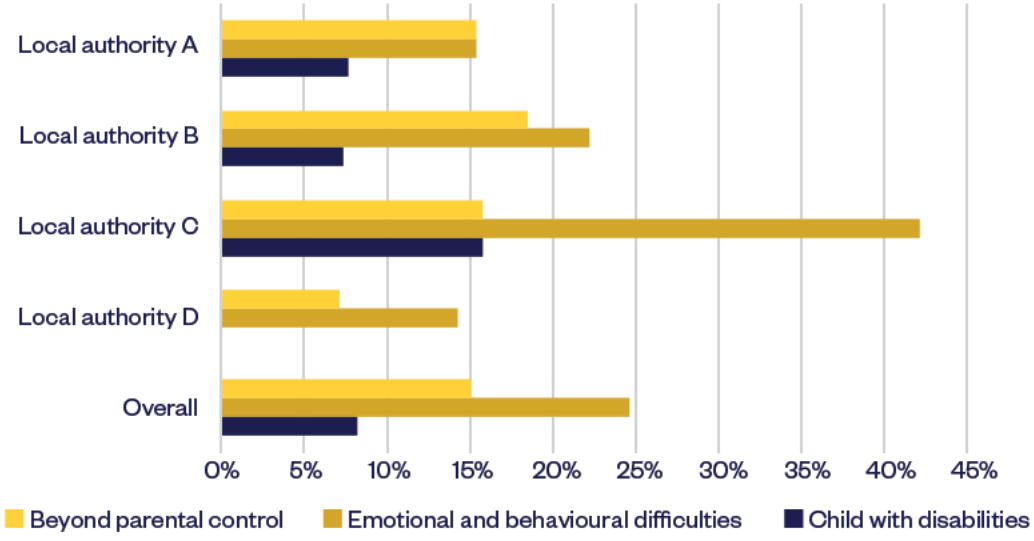
Concerns about the children

As noted earlier, all 73 children had experienced some degree of emotional harm. In addition, all the children had a fractured relationship with one or both parents.[5] This was as a result of difficult past experiences, change in family circumstances, separation, and fluctuations in the living arrangements while children were in care.

Around a quarter of the children (18 of 73, 25%) were noted as having emotional and behavioural difficulties (see Figure 6). A smaller proportion of children (11, 15%) were described as 'beyond parental control'—a view shared in some cases by both parents/family and the local authority. A few children (6, 8%) had significant disabilities, including autism with sleep disorder, ADHD, foetal alcohol syndrome, and learning difficulties. The term 'beyond parental control' does not always imply parental failure; it is also a way of acknowledging the difficult task facing parents (and local authorities in their role of corporate parent) in supporting older children to steer clear of adverse influences and risks.

See table C.6 (Appendix C) for further information.

Figure 6: Concerns about the children



5 We use the term 'fractured' to mean a relationship that has been wounded by the impact of, for example, parental loss, separation, maltreatment and/or rejection, resulting in distress to those affected and affecting the availability of support for children and adults, and of direction, boundaries and containment for the children. We use the term to indicate that painful experiences do not necessarily result in permanent damage and that wounds can be healed, especially if the right response is put in place. We have been guided in this definition by the Croydon Safeguarding Children Board report (Spencer, Griffin, and Floyd 2019): young people described the distress they experienced and what they felt they needed from other adults if parents were not able to give them that support.

Just under a third of the children (22, 30%) had an education, health and care plan (EHCP), and half of those with an EHCP were in special education provision (12, 16% of the total). A number of other children were missing or disengaged from education but not necessarily on an EHCP, possibly because getting an EHCP for a child beyond Year 9 can be difficult. A further two children had experienced frequent change of school in Year 7, either before or after coming into care, and this was noted on the audit forms as having been very unsettling in each case.

Vulnerability to extrafamilial harm: a safeguarding continuum

We found that the majority of the care proceedings (55 children from 37 families, 75%) did not involve evidence of extrafamilial harm.

The other quarter of cases (18 children from 12 families, 25%) did show evidence of extrafamilial concerns.

This 75%/25% split between intrafamilial and extrafamilial circumstances should not be viewed in isolation because, if we also take account of the free-text comments of the auditors, we get a more nuanced picture of what is happening in the children's and parents' lives.

We found that children were not in proceedings on account of **either** intrafamilial **or** extrafamilial harm. Rather, they were on a continuum where extrafamilial safeguarding concerns ranged from low to very high, and where these concerns were additional to concerns about intrafamilial harm. (This continuum of safeguarding concerns is illustrated in Kay, Lynn, Stephen and Adam's stories).

There were variations in the nature, as well as the degree, of concern. The children in the middle of the continuum were vulnerable because of either their family circumstances (see Lynne and Stephen's stories) or their behaviour in response to the harm they have suffered (see Adam's story).

We were alerted to the vulnerability factors within families that can increase a child's susceptibility to external influences—especially the emotional harm and fractured relationships that feature so strongly in the lives of the children in the audit. A total of 34 children showed vulnerability indicators to harm from outside the family (see Table 3). Children's exposure to a high number of risk factors, experienced simultaneously or over time, was evidence of cumulative vulnerability and high risk. Three local authorities (A, B, C) had children at high risk. Fewer indicators were logged for the five children in the Local authority D sample.

But this aspect of harm is not just a matter of numbers: the way individual vulnerabilities cluster together is also relevant. We found it particularly worrying if children experienced the combination of missing from home, missing or expulsion from school, and contact with other children involved in risky behaviour. The combination of fractured relationships, loss and other traumatic experiences can also dent the resilience of families to cope with difficulties. And so, too, for some children in the audit, did the insecurity and instability resulting from the inability of professionals to find a placement to meet their needs.

A safeguarding continuum

Kay's story: abducted and sexually assaulted

Following two generations of social care involvement with her family, Kay (aged 14) was initially accommodated under section 20, at her mother's request. Kay's early life was marked by her mother's poor mental health and rejection from her community due to Kay's paternity. Kay had also been the subject of a child protection plan on account of her mother's experience of domestic abuse and contact with high-risk offenders. Previous care proceedings had ended with a supervision order to her mother but, in between the two sets of proceedings, Kay had four foster placements.

The repeat proceedings noted Kay's high level of need, including complex post-traumatic stress disorder, with Kay considered a risk to herself and others, and with additional educational needs following her permanent exclusion from school, her misuse of substances, and episodes when she was missing. She was also the victim of abduction and physical and sexual assault, and she was associating with risky peers in areas known for exploitation. After the proceedings, Kay was placed in secure accommodation following incidents of fire setting, threats to kill herself and others, repeated episodes of going missing, and being subjected to serious sexual assault.

Table 3: Indicators of child vulnerability to extrafamilial exploitation[6]

Indicators	Local authority				
	A (4)	B (14)	C (11)	D (5)	Overall (34)
Family/home					
Missing from home	4	11	4	-	19
Fractured relationships	4	14	11	5	34
Violence to parents	-	1	4	1	6
School/college					
Absence or missing from school/college	4	11	7	3	25
Decline in performance	-	9	6	3	18
Exclusion short term	1	5	1	2	9
Exclusion permanent	2	4	1	-	7
Education health and care plan	2	14	4	2	22
Behaviour					
Isolation from peers, including being target and/or perpetrator of bulling	2	2	4	3	11
Acquisition of money or goods	-	3	2	-	5
Mobile phone use – secrecy, multiple phones, change of number, increase in use	2	4	-	-	6
Frequenting areas associated with exploitation	3	5	4	1	13
Risky use of social media	1	-	-	-	1
Alcohol misuse	1	-	3	-	4
Drug use Class B	1	3	3	-	7
Drug use Class A	-	-	1	-	1
Association with risky peers	3	7	4	-	14
Arrest	1	5	2	1	9
Conviction	1	3	2	-	6
Knife possession	-	2	1	-	3
Fire setting	-	1	-	-	1
Physical and mental health					
Sexually transmitted infection/pregnant	1	-	-	-	1
Poor self-care/changes to personal hygiene	1	4	1	1	7
Weight loss	-	1	1	-	2
Other – hoarding	-	1	-	-	1
Disability (foetal alcohol syndrome)	-	-	1	-	1
Loss and trauma					
Bereavement	1	2	-	-	3
Parental absence	3	2	1	2	8
Emotional well-being decline	2	5	5	2	14
Trauma – clinical diagnosis	-	3	5	2	10
Trauma – other					
Has experienced physical assault	2	1	1	-	4
Has experienced sexual assault	2	2	1		5
Protracted instability	-	4	-	-	4
Threat of forced marriage	1	-	-	-	1

6 These potential indicators of vulnerability to extra-familial harm draw in particular on Firmin, Wroe, and Lloyd J (2019).

Lynn and Stephen's story: vulnerable through circumstance

Lynn (13) and Stephen (12)'s mother was misusing drugs but not on the radar of children's services. The situation escalated suddenly when a police raid on their home as part of a county lines investigation found that it had been 'cuckooed' for drug dealing. The children came into care via police protection.

Contact with the children's father had tailed off but was reinstated and this developed positively as professional support helped him bring about big changes in his own life. The children moved into his home during the proceedings, which ended with a child arrangement order to him and no further service involvement.

Lynn had been described as 'sad and serious', having assumed the parenting role for Stephen. Both children have settled well, with much improvement in school attendance and educational development.

Adam's story: vulnerable through the impact of trauma

Adam (11) was in proceedings after long-term emotional harm and neglect. His parents' capacity to provide safe and nurturing care was limited by their poor mental health, accumulated trauma, substance misuse and domestic abuse. There had been three periods of child protection registration and focused service involvement in relation to the domestic abuse experienced by his mother. The first proceedings had ended with a supervision order and the matter now went back to court for an extension. Adam was frequenting areas known for exploitation, was not attending school, and was isolated from his peers. He is now in residential care and is doing well in therapy and education.

Court process: case duration and the use of extensions

Overall, just over half of the cases (29 of the 49 families) had an extension from the judge to the legal requirement for care proceedings to be completed within 26 weeks. The reasons for an extension varied and included the following.

- Placement issues – A striking feature of the audit, although not unexpected, was the persistence and time spent searching for a suitable placement for some of the most vulnerable children. This was particularly pronounced where public safety or child welfare considerations were driving thinking about court-sanctioned deprivation of liberty provisions. Having to act in an emergency created an added burden in terms of finding a suitable placement in a timely fashion.

- Sibling groups – Extra time was needed when there were several sisters and brothers, especially if some needed 'together or apart' assessments or where long-term care planning was more complex because of the different ages or developmental and other special needs involved.

- Other complex circumstances – Examples included: multiple assessments of potential carers or the late step-up by one or more relatives for SGO assessment; disruptions in family care arrangements; requests for a fact-finding hearing where there was an allegation of sexual abuse but no criminal prosecution; and cases that needed international enquiries or assessments or the search for a child's parents.

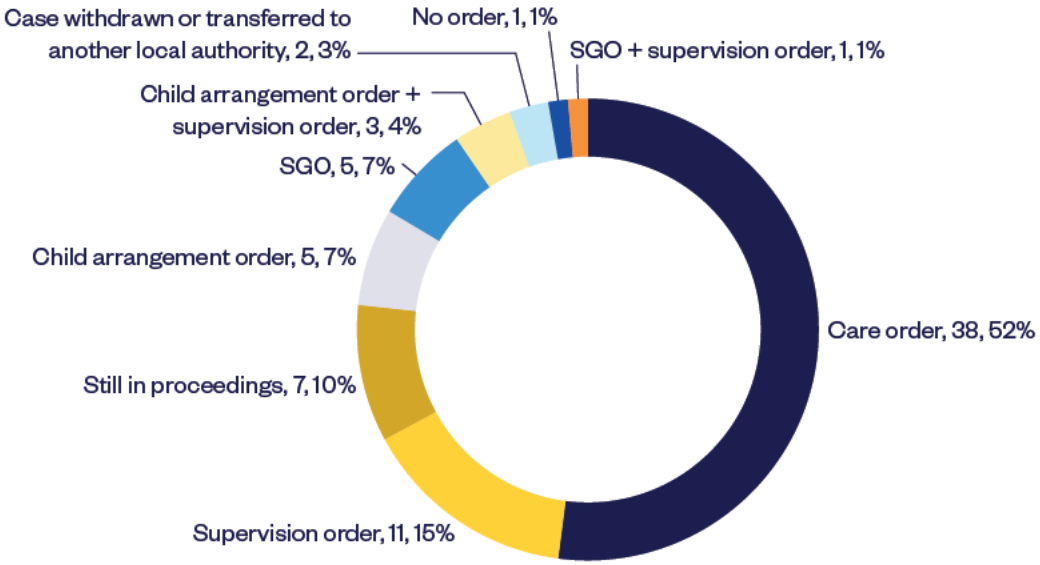
- Testing the preferred plan – Particularly in a case that is progressing well, the judge may agree to an extension as a precautionary way of testing the likely success of a child's safe return to a parent or a move within the family for a few additional weeks.

- COVID-19 created delay in a few cases – This included proceedings issued towards the end of 2019/20, as lockdown was getting underway, or those with a final hearing scheduled for around that time.

Court decisions: orders made at the end of care proceedings

The headline picture here is that just over half the children (38/52%) remained in care under a care order, and just over a third (26/36%) returned to parent/s or remained within their family network under a different order (e.g. supervision orders, SGOs, child arrangement orders). The other few children were either awaiting the completion of proceedings or had come out of proceedings.

Figure 7: Overall summary of court decisions



The different care proceedings orders were used as follows.

Care orders (38): A care order was made for just over half of the children (38/52%). For all but one of the seven children in proceedings that were not yet completed, it was likely that the case would end with care orders, given that the children were in (foster) care on ICOs.

Supervision orders (14, including four with child arrangement orders): These mainly reflected children remaining with their mother (in eight cases), and were made with a view to the local authority providing 'assistance, advice and befriending'. Supervision orders were made most frequently in the London and south England cohorts, possibly reflecting regional difference in their use (see also Harwin et al. 2019). There was one instance of a supervision order being made alongside an SGO; this was done because one of two siblings involved in the case was not related to the special guardian, the arrangement was new, and it followed a bereavement. It was not clear, in any case, whether making the supervision order indicated continuing concerns, or the wish to strengthen the likelihood of the family receiving any 'assistance and support' that they might need from the local authority, or for some other reason.

Child arrangement orders (eight, including three with supervision orders): These mainly reflected children moving from one parent to the other, following safeguarding concerns about one parent and positive assessment of the other. One child moved from father to mother, six from mother to father and one to paternal grandmother.

SGOs (six, including one with supervision order, noted above): These were made in each local authority cohort, indicating that living with a connected person remains on the agenda as a placement option for this group of children.

Case withdrawn or transferred (two): One withdrawn application related to a young person who was approaching 17 and whose younger sister remained in proceedings. In the other case, the matter transferred to another local authority because the family moved home immediately after proceedings were issued.

See Table C.8 (Appendix C) for full data.

Local authority care placement plans

Just over two-thirds of the children who were in care (30 out of 44, 68%) were living in fostering arrangements, some with approved kinship or connected person's carers (five with grandparents, the other with the parent of a school friend).

A quarter of the children (12/26%) were in residential care, including one child who was in secure accommodation at the time of the audit. The other two children were in semi-independent living arrangements.

Figure 8: Current living arrangements for the children in care (38 care orders and 6 ICOs)

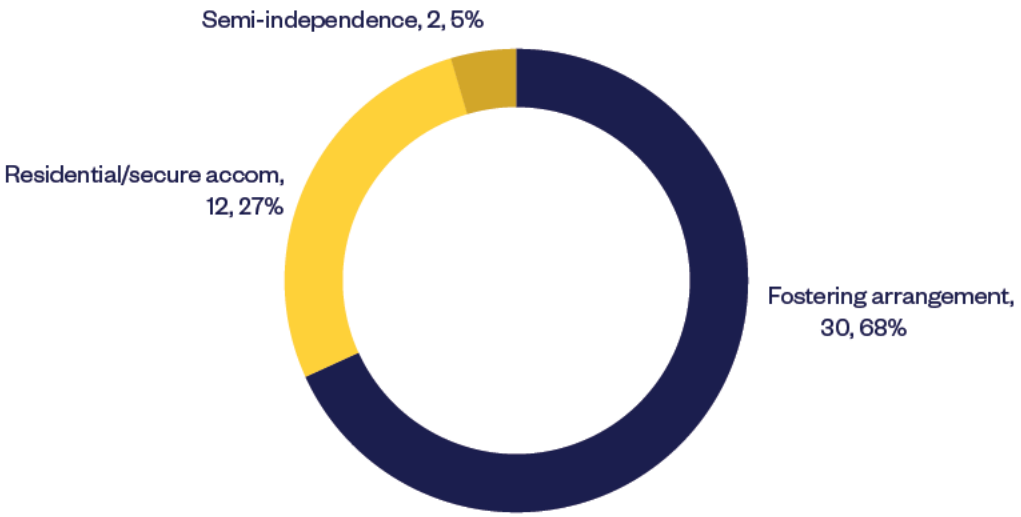


Table C.9 (Appendix C) gives a breakdown per local authority of the placements made for the children subject to a care order at the end of proceedings.

The use of secure accommodation or deprivation of liberty

Seven children from six families across three of the local authorities had been—or were imminently likely to be—deprived of their liberty under a secure accommodation order or the inherent jurisdiction of the High Court. In addition, further children were deprived of their liberty after proceedings. Their circumstances fall into one of three groups.

- At risk of child criminal exploitation: This group included four boys known to both family justice and youth justice, with high profiles for criminal exploitation. They were two sets of brothers from one local authority, one from a Black African family and the other from a White British family. Two of the boys had been held in the youth secure estate (in a youth offending institution or secure training centre), on account of their offending behaviour, and the other two needed secure welfare placements. A lack of suitable accommodation to provide for their high needs, and the high risks involved, had prompted the local authorities to apply (at different stages) to the High Court for a deprivation of liberty order on three of the boys.

- At risk of child sexual exploitation: This group included four girls, from four different families, with a high profile for sexual exploitation, and each with a background of cumulative trauma including sexual assault (see Natasha's story at the beginning of the report). One was in secure accommodation during proceedings, and another was voluntarily admitted to psychiatric hospital. One went into a secure children's home after proceedings, and the fourth girl was the subject of court-sanctioned deprivation of liberty under the inherent jurisdiction after proceedings.

- At risk of further mental health trauma: One child, who had possibly been trafficked, ended up being sectioned under the Mental Health Act at the age of 13, whilst in care (see Omar's story).

The seven children who had been subject to a secure accommodation order, an order depriving them of their liberty via the High Court, or admitted to hospital under mental health legislation, transferred subsequently to a suitable residential setting or a bespoke semi-independent arrangement.

The value of different approaches to high need/high risk in secure settings and at home

As shown in the stories of Natasha, Zach and Mali, time spent in a secure setting has the potential to set children on the path to positive change by providing an opportunity to safely access and engage with interventions. We found that this seemed more likely when deprivation of liberty arrangements were made in a planned way as part of a clear strategy for a child rather than in an emergency because no bed was available in a secure children's home.

We also found impressive creativity in some arrangements to protect a child against the strong likelihood of their ending up in secure accommodation (see Alex's story).

Zach and Mali's story: boys at risk of criminal exploitation

Zach (15) and Mali (14) are brothers. They were first in care proceedings when they were under five, which resulted in special guardianship orders (SGOs) to a family member. This followed neglect and emotional harm by their parents.

As the boys grew older they started having unsupervised contact with their parents and this led to a collapse of routines and boundaries. As teenagers they became linked to local gangs and at risk of criminal exploitation. They had been involved in physical assaults, including stabbings. They were frequently missing from home and school, spent time in areas associated with exploitation, and were arrested for multiple offences. The local youth offending team became involved.

The judge in the family court wanted to place the boys in secure accommodation but, in the absence of the availability of a welfare place, they remained at home. Shortly afterwards, both were arrested for a serious offence and were remanded to the youth secure estate via the youth court. While there, the younger brother was charged with murder and remained on remand in the secure estate. He protested his innocence throughout and was acquitted of that charge, but found guilty of a lesser charge.

Both boys responded well to their time in the secure estate, engaging with interventions and showing insight into their behaviour. They made up for some lost education and sought therapeutic help after release. The exit plan from the secure estate involved separate residential provision for them, and for Zach this involved

a period of adjustment via a court-sanctioned deprivation of liberty order. Mali was released immediately after his acquittal and, as he was then 16, bespoke semi-independence arrangements were made for him. Both boys continue to make progress: they are maintaining contact with family members and have not been involved in further offending.

Alex's story: protected by a support plan while remaining at home

Alex (15) is a middle child in a large sibling group. There had been long-standing involvement of children's services via child in need support, child protection, and pre-proceedings work, all in relation to chronic neglect. His parents' ability to provide safe care is affected by poor mental health, learning difficulties and accumulated trauma.

Alex was diagnosed with ADHD and oppositional defiant disorder. He was highly vulnerable to criminal exploitation. He was frequently missing from home, was excluded from school for possession of a knife, and misusing alcohol and cannabis. He was the subject of regular discussion by the Multi-Agency Child Exploitation (MACE) panel, and he had weekly meetings with the youth justice service as part of a three-month community resolution intervention. During proceedings, he had three foster placements and a short period with a family friend, but he continued to associate with older males involved in criminal activity and exploitation.

When it was clear that being in care was making no positive difference, the local authority moved him back home, and provided bespoke support and intervention for Alex and his parents.

The care plan was intensive and multi-agency, with daily involvement of professionals from children's services, the youth offending team, and the 16+ Team. It was creative and consistent, with social work for each family member, home tuition for Alex, and practical family support. As the younger children remained in their care placement, Alex was able to enjoy a breathing space as the only child at home. His episodes of going missing have reduced (none in 2021 at the time of writing) and it is now safe enough for him to have schooling in a setting away from home. There are hopes that he will achieve GCSEs in English and Maths. The care proceedings ended with Alex at home, with a supervision order to his parents.

Children's placements and the number of moves

The audit form also recorded the number of placement moves children had experienced since proceedings concluded.

- Almost half the children who remained in care after the end of proceedings remained where they were then living, thus experiencing no move.
- The children in kinship care arrangements experienced the fewest placement moves.
- Almost two-thirds of children had no more than two placements since the end of proceedings 12 to 20 months ago.
- For the children with more than four foster placements since coming into care, any subsequent move was likely to be to residential care provision.
- The most vulnerable and most traumatised children in the audit had he highest number of placement moves since being in care. One child had been moved 11 times, and another 9 times. It is also the case that those who were most vulnerable, and who had moved most frequently, were at highest risk of experiencing extrafamilial harm and most at risk of deprivation of liberty via secure accommodation or otherwise.

Caution should be applied when reflecting on the number of placement moves and the time spent in each placement owing to the different variables involved, including: the reasons for each move, the length of time between moves, and the degree of planning that precedes change of placement. Emergency and unplanned moves are more vulnerable to poor matching and likely disruption. Children entering care via police protection are likely to move on quickly from the initial emergency placement but may then need to move again before a suitable longer-term placement can be organised. Those who are aged 16 and above are likely to be making a planned move to semi-independent provision and, here too, thoughtful and careful pre-placement planning and matching is important to support young people to settle into this transitional phase. Finally, more weight will be given to the wishes and feelings of children as they get older, and this applies to decisions about placement as much as to other things.

While in care, children continued to be at risk of extrafamilial harm. Jade's story illustrates the concerns that can arise for a child already in care. Natasha's story, at the start of the report, is similar, although hers is about a child's experiences of harm before coming into care for protection. The juxtaposition of the stories helps to illustrate the continuing difficulty of finding the right response to the enduring vulnerability of some children's lives, irrespective of whether they are at home or in care.

Jade's story: in care long term, and in increasing need of protection

Jade (16) has spent almost all her life in care. As a baby, she was neglected due to her mother's poor mental health and substance misuse. Her father's identity is not known. A plan for adoption at age four did not materialise and her mother died some time later.

Jade is at high risk of child sexual exploitation, with evidence that she was being used to recruit other children. This prompted the local authority to apply for a secure accommodation order. With no placement in a secure children's home available, Jade was placed in an unregistered placement under a court-sanctioned deprivation of liberty order, pending a secure accommodation place becoming free. In addition to a history of trauma and bereavement, Jade has experienced long periods of school absence and alternative educational provision. She has received convictions because of her behaviour in care arising from damage to property and setting fire to the residential care building where she was living.

Jade started to make good progress after discharge from secure accommodation, thus avoiding any further secure placement. A multi-professional 'team around the child' has been put in place. She describes herself as 'the happiest I have ever felt' and is now transitioning to independence.

The involvement of different partner agencies

Throughout this work we have been conscious that the 'system' that children and their families become involved in is, in fact, a complex intersection of systems, built upon different legal frameworks and policy imperatives providing a range of welfare, health and safeguarding services.

The audit work has exposed some of the practice considerations that arise out of this complexity. This is about safeguarding and protecting children from harm, preventing and interrupting their offending behaviour, and reducing the likelihood of further offences. It is also about the delivery of national and local government responsibilities (with differing emphasis) to tackle disadvantage and hardship, to support families in ways that give children the best chance of being brought up within their family network, and to provide the highest quality of care for children for whom that is not possible.

We found evidence from the audit of the interventions and approaches that local safeguarding partner agencies were using in their work with children and families. Below is a flavour of what we found, first about children's services and then about youth justice, education and health services.

Children's services

Before proceedings

The resources provided or coordinated by children's services varied in scope. Some were direct interventions for specific needs: to improve parenting skills; provide practical help or respite from the strain of caring continuously for a child with disabilities; or to reduce the impact of death within the family, broken relationships or entrenched poverty and other disadvantage.

Other responses were about connecting children and/or parents to others in similar circumstances or with similar interests. This was done through faith and cultural organisations, voluntary agencies offering mental health support, and support for children ('young carers') managing care responsibilities at home that were disproportionate for their age.

A third type of resource involved a specialist team offering intensive intervention to divert children and families from court and care, often referred to as an 'edge of care' service.

After proceedings

Resources noted at this stage were about bolstering a child's new situation and helping families cope with the consequences of proceedings. They included: projects with and for birth parents, to support rehabilitation of children at home, reduce the risk of repeat proceedings, and provide advocacy and peer support; help for care leavers, especially those moving to independence; and support groups for those providing care as special guardians.

Other resources were dedicated CAMHS for children in care and their carers; provision of peer support to a small network of foster carers coordinated by an experienced carer; and a scheme of independent interviews with children in care after episodes of going missing.

At all stages: before, during and after proceedings

Countering exploitation

Some resources were directed at identifying, preventing and minimising the risk of criminal and/or sexual exploitation. These included the Contextual Safeguarding approach.[7] One local authority was using scoping meetings. These are complex meetings, chaired by a senior manager and attended by a wide range of professionals. The purpose is to share information about safeguarding concerns for each child and to act on them, and to create wider safety plans and efforts to disrupt 'gangs' and exploitation networks. Multi-Agency Child Exploitation (MACE) panels were doing similar work in other audit areas, and one local authority mentioned specialist worker input and screening to help tackle child sexual exploitation.

One of the local authorities provided helpful insights into the extent to which their local children were receiving close multi-agency attention because of concern about exploitation. At the time of the audit, 10 children (all girls) were at risk of sexual exploitation—6 were at home, as children in need, and 4 were in care under a care order. Another 14 children (all boys) were subject of attention because of risk of criminal exploitation—9 were at home, as children in need, and 5 were in care under a care order.

Family group conferences

FGCs were used by all four local authorities. Across the audit, 21 of the 49 families (42%) had had at least one FGC, albeit with different degrees of extent and intensity. Local authority B facilitated FGCs with just under half of its families. Local authorities A and D did so with one family each; although some attempt had been made to use FGCs more frequently, some were set up too late to be heard in proceedings, some parents declined the offer, and in a few cases no relatives could be found.

Practice in Local authority C was noticeably different. Each audit family was offered an FGC, only one declined, and some families had more than one conference—generally one before and one during proceedings.

The benefits afforded by FGCs in this local authority seemed substantial and wide-ranging.

- Three children (one single child and two siblings) gained a special guardian to live with—they were relatives, godparents and family friends.

7 https://contextualsafeguarding.org.uk

- Five children made a positive move within their family—from father to mother; mother to father; to a grandmother who became the children's kinship foster carer; to a father/stepfather after the death of the children's mother; and one child remains with her mother, with both living with the child's maternal grandmother.

- In two families, FGCs paved the way for smooth transfers—in one case creating the support plan for bereaved sisters to move on together, and in another case ensuring that arrangements for a child to stay with a neighbour remained in place pending their planned move to foster care.

- FGCs boosted confidence in care plans—for example, in one case, children were able to stay with their mother, under supervision orders, because the FGC had prompted fuller assessment of the support available from the mother's family.

- FGCs kept family network options on the table and support families to re-establish connections. One child, affected by criminal exploitation, was enabled to spend time with relatives. A child moving to formal foster care was helped via the FGC to re-establish links with the large maternal side of their family, who had faded from their life after their mother's death. This led to respite periods with one relative and plans being developed with other family members. This approach is consistent with similar work elsewhere in the UK, to help children in care find their 'lost' relatives.

Across all local authorities there was evidence that even when FGCs did not lead to a placement with a family member, they did help to strengthen family relationships. For example, one child was supported to have overnight stays with their father. For another family, the FGC led to respite arrangements within a child's paternal family as a way of supporting their placement with maternal grandparents. In another case, the FGC identified family members to be assessed as carers for a child; although this did not result in the child being placed with them, contact with relatives continued beyond the end of proceedings and so helped promote and support the eventual care plan.

We explored FGC practice and policy in more depth with Local authority C. We found it had a long-established in-house team, that families almost always accepted offers from the service, and that workers persist if families refused initially. Staff are trained in FGC good practice and the service has skilled workers who are confident in managing meetings with family members.

The local authority used the FGC as a required way of exploring all family options at an early stage. The policy is underpinned by generous financial support for relatives caring for children whose parents cannot safely care for them. The child's needs are kept central in the family plan that emerges out of an FGC.

There is a social care leadership that supports family care as a long-term positive option for children, even where there are identified risks. This extends to a child's paternal family even if there is little contact with the father. There is regular challenge to the stigmatising assumption that all severe parenting difficulties arise from the poor childhood care that parents themselves experienced, and therefore that grandparents or other relatives must be compromised as potential carers. Support to carers under SGOs and child arrangement orders is improving, in acknowledgement by senior management that the needs of both carers and children remain high throughout childhood.

Family drug and alcohol courts

Two of the audit local authorities have a local family drug and alcohol court (FDAC) service for cases where parental substance misuse is the main trigger for bringing proceedings. This alternative problem-solving approach to care proceedings was used for four children (in three families) and FDAC was considered but not pursued in two other cases in one of the local authorities.

Two of the four children in the FDAC proceedings returned to their mother under a supervision order, a third (the sibling of one of these) went to live with their paternal grandmother because of their special health needs, and the fourth child went into long-term foster care, with continuing contact with their mother and their mother's support for the placement. Positive comments were recorded about the children's progress, with improved mental health noted for two of them, and a health diagnosis and improved well-being for a third. All three mothers engaged well with their FDAC specialist team and judge. One was noted as continuing to receive help from FDAC after proceedings ended, and none contested the decision of the court.

The cases, while few in number, lend support to the value of FDAC for older as well as younger children.[9]

9 Almost a quarter (23%) of the children going through FDAC proceedings are aged 10–17. This is the same proportion as children under 12 months (22%) at the start of proceedings (Centre for Justice Innovation 2021).

The youth justice service

As mentioned earlier, a key aim of the audit was to understand interactions between different systems or system parts. We asked a general question about any involvement of the children and families with the youth justice system before care proceedings. We also asked for specific information (from before, during or after proceedings) about arrest and/or convictions, the use of secure accommodation on non-welfare grounds, and youth court proceedings.

Information about youth justice involvement was found for 12 of the 73 children (16%). The information on file was minimal in respect of three of these children.

- A girl of 13, in proceedings prompted by parental neglect, appeared in the youth court charged with common assault and was referred to the youth justice service for out-of-court management. The audit form notes: 'No other details on file'. After proceedings, and with the child now on a care order, the file noted a nine-month referral order and mediation work, suggesting re-offending of a more serious nature.

- A boy of 12 was exploited by his father (who had substance misuse issues), to steal goods that he could sell. The boy was arrested for theft but there was no conviction. The youth offending team did preventative support work and the child expressed remorse. He was placed with a relative and the proceedings ended with an SGO with the family. No further issues were noted on file.

- Another boy of 12 was engaged in one-to-one work with the youth justice service to address concerns of criminal exploitation. No other detail was found on file.

These children did not have a high youth justice profile, and preventative work was being undertaken to address the risks identified. It may be that the audit forms were underrepresenting this type of early intervention by the police and/or youth justice services. We say this because it became clear that there was no easy way for auditors to locate anything other than very basic information about youth offending team involvement from their children's services records. The youth offending teams record their work in a separate data system.

The other eight children engaged with the youth justice system were involved in more serious offences. They included, for example, the two sets of brothers noted earlier (see Zach and Mali's story, and Keith and Tom's story). For Zach and Mali, serious offences had led to their placement in the youth secure estate (in a young offender institution or a secure training centre). The most serious charge was overturned, but conviction for lesser offences resulted in a youth referral order.

No other information about youth justice system work was found on the children's services electronic records.

Keith and Tom: interactions between youth justice and children's services

During pre-proceedings work, brothers Keith (15) and Tom (13) were arrested together for theft. Reference is made on the audit form to a case file note about bail and youth offending team involvement. Keith was remanded into foster care and then given a referral order, which required regular meetings with the youth offending team. Children's services did some liaison with the youth offending team and with the police in another local authority and were involved in several strategy meetings. The looked-after children review notes report him as failing to attend court as required, leading to an arrest warrant, with 22 other matters to be taken into consideration. The youth offending team was preparing a pre-sentence report and the care proceedings are ongoing.

Sabrina: addressing safeguarding issues

Sabrina (14) came into contact with the police after assaulting her mother. She later caused minor injuries to a younger girl and received a three-month community resolution order, during which time she received some minimal support from the youth offending team. She later got further support for her anger and aggression after assaulting a child at school. No formal charge was brought. Because of her vulnerabilities, she was referred to a police community programme to help her make positive choices and to divert her from offending behaviour. The police reported difficulties in engaging with her and she did not join the programme.

Free-text comment by the auditor described these events as occurring 'against a background of abuse, loss and repeated rejection', and with insufficient focus on either extrafamilial safeguarding or Sabrina's fractured relationship with her mother.

A note about parents in the criminal justice system

For nine children in the audit, information was recorded about the involvement of a parent or parents with the criminal justice system.

These details were about:

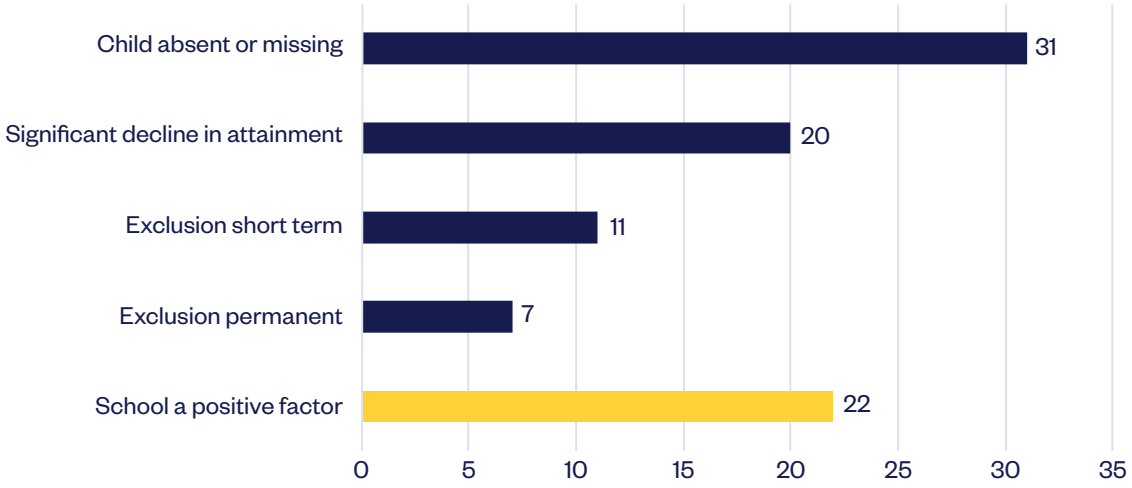
- a father previously in prison and who returned to prison during proceedings
- a parent couple being investigated for criminal activity/ supplying drugs
- three fathers under investigation, or being tried, for sexual offences against their child or partner
- a mother who, on release from prison, resumed care of her child who was being looked after by a family member during her five-year sentence. New proceedings were then issued. The file notes the lack of a prison discharge plan led by children's services and a lack of attention to the mother's needs after release, including managing the loss of her child for the second time.

There was also an example of probation and children's services working together to support a father to resume care of his children.

Education services

The audit form did not include specific questions about the role or work of education services in relation to children and families. It did include variables about educational matters (see Figure 9), and it also asked about progress after the end of proceedings, with specific reference to school as well as other aspects of life.

Figure 9: Strengths and vulnerabilities at school



Various reasons were given for children having difficulties around schooling:

- **the child's unhappiness** at being placed in a different school from a sibling; dislike of a special school compounded by being physically attacked by other pupils; and emotional needs impeding the child's learning and attainment
- **the child's anxiety** about being in school and about changes to routines, leading to noisy outbursts in the classroom
- **moving schools** as a result of moves at home; or the start of a new care episode requiring a change of placement and school; and multiple changes of school whilst a child in care was negotiating transition to secondary school
- **exclusion** following an emotional outburst relating to being in care; for possession of a knife; for being in possession of cannabis
- **missed opportunities** such as lack of engagement between school and parents; lack of attention to the absence of routines and boundaries at home; children falling behind through missing school, some for long periods.[10]

10 Local authority returns show that, in 2017/18, 11% of children in care went missing, with 65% going missing more than once. Analysis of interviews after return suggests that missing episodes were due to suspected sexual exploitation for 4% of the children, and to offending for 2% (Coram 2019).

In contrast, instances of **school as a positive factor** included:

- **school seen as a safe haven** where the child was able to talk about issues at home with staff; the child felt safe while at school
- **high level of support to the child** – supporting emotional and/or behaviour difficulties; help from school counsellor; intensive help and interest shown by staff in secure accommodation
- **high level of support to mothers** – diagnosis of the child's needs and a move to the right school enabled the mother to gain confidence in her ability to cope; compassionate help from a new social worker enabled the mother to engage with school
- **boost to progress** – the child's self-motivation meant education was valued as a passport to other opportunities; educational achievements helped the child overcome past trauma; the child's love of sport was boosted by extra-curriculum sport opportunities
- **acting in partnership** – school's early referral of concerns to children's services helped increase understanding of the child's past experiences; education was part of a daily intensive intervention plan to enable the child to remain safely at home, including home tutoring that progressed to engagement in out-of-home provision
- **continuity** of school and friendship network during period of family disruption and upset.

We noted that there was no mention of education welfare services in the audit forms, bar one reference to a mother being prosecuted because her children were missing school.

Health and well-being services

The audit question about perceived progress after proceedings invited comment about children's health and well-being. In addition, several variables in the form related to the health and mental health of children and parents before and during proceedings.

Some health needs (for children right across the age range) were identified only after proceedings had started and after the children were in care. This occurred in separate cases involving a range of difficulties such as ADHD, autism, sleep disorder, post-traumatic stress syndrome (PTSS) and complex trauma.

Trauma was mentioned in records for just over half of the children from one local authority. The issues included witnessing violent sexual assault, bereavement, not being believed when reporting abuse by a relative, parental substance misuse, emotional abuse, and exposure to parental conflict.

Children in each local authority had witnessed parental domestic abuse, the poor mental health of one or both parents, parental substance misuse, and/or other situations of past or ongoing trauma. Free-text comments indicated the impact of this on children's mental health and emotional well-being. This included anxiety, low mood, lack of self-esteem, insecure attachments, threats of self-harm and harm to others, suicidal thoughts, and strong feelings of loss and trauma.

Responses to health and well-being needs

Audit responses indicated that some children were reluctant or unwilling to accept offers of help from CAMHS and other services. The reasons were not specified. In the main, however, those who did access support started to make some progress in dealing with their current or past experiences.

The type of provision varied. Some children were helped to explore their feelings in creative ways, such as through songwriting, sport and the care of animals. Some received a specialist service, such as for enuresis or bereavement. Other help was provided for foster or kinship carers or residential staff, including clinical psychology, transition planning before a change of placement, family/other specific therapies, mediation training, and parenting training.

Overall, there was a noticeable focus on trauma-informed practice, which chimes well with the growing interest and use of this model, and international backing for a child's right to help to overcome trauma.[11]

We found examples of agencies working together across traditional boundaries to address trauma, and examples of what the participating local authorities considered to be successful approaches to working in partnership with older children and their families. These were about making time for direct work with children and other family members, encouraging children's interests and talents, and building on the strengths and achievements of parents and others close to a child. The style and content of work was also important: being non-confrontational, consistent and persistent, was regarded as being valued by children and parents, as was work that was based on restorative and trauma-informed practice, delivered with humanity and respect.

11 See for example United Nations Convention on the Rights of the Child, Article 39 (recovery from trauma and reintegration).

Reflections

Our study identified 73 older children facing court-ordered separation from 49 families in four local authorities. They had all experienced past and ongoing traumas, and without the right support put in place, face an uncertain future. Sadly, their stories will be all too familiar to those working with children and families in similar circumstances around the country.

The audit exercise that we coordinated was collaborative work with the participating local authorities. It was designed to increase our understanding of:

- the concerns, both intrafamilial and extrafamilial, that brought the children into care proceedings
- the court decisions and the local authority plans for the children
- the interface between the family justice and youth justice systems and services, including the use of powers to deprive children of their liberty
- the challenges and achievements in responding well to child and family strengths and needs.

The joint work also gave us the opportunity to learn about local policy and practice imperatives, and to capture the views of experienced practitioners and managers about what more might be done, or what might be done differently, to help children and families in similar circumstances in the future.

Key findings

First, about the concerns that gave rise to proceedings

The audit gives a more nuanced picture than that of children being in proceedings because of **either** intrafamilial **or** extrafamilial harm. Although a quarter of the cohort were at risk of criminal and/or sexual exploitation outside their family—along a continuum of low to high safeguarding concerns—in the main these risks were present **in addition** to other vulnerabilities and family difficulties.

Intrafamilial concerns were about parents struggling with the longstanding impact of substance misuse, mental health needs and domestic abuse, alongside other experiences of past or ongoing rejection and loss. All this was underpinned by the debilitating impact of entrenched poverty, hardship and disadvantage.

For some children and parents (19 children from 15 families), these were repeat proceedings, with similar or different concerns triggering the return to court between two and twelve years after the first proceedings. In most of these cases the first proceedings had ended with a supervision order to one or both parents.

Second, about court decisions and local authority care plans

Our summary findings were that the majority of the children remained in care at the end of proceedings. Most were in fostering arrangements or kinship care, and a few were in residential placements.

About a third of the children did not remain in care at the end of the proceedings. They went to live with parents or other relatives, under a court order that was intended to support and strengthen their safety and security, and possibly in some cases to monitor the situation.

Although it is early days, for most of the children who remained in care, a placement that matched their needs fostered engagement in education, offered therapeutic help if needed, and boosted positive relationships with family and professionals seemed to offer the best support for progress.

A smaller number of children, from three of the four local authorities, had been deprived of their liberty. This was through a court order for secure accommodation on welfare or youth justice grounds, through an order under the inherent jurisdiction of the High Court to deprive them of their liberty if a placement was not available in a secure home, or through placement in a psychiatric setting via an order or voluntary admission for treatment for severe mental health needs. This group of children was clearly in the greatest difficulty, needing intensive and immediate support for their own safety and/or the protection of others.

Third, about the interface between family justice and youth justice

The local authority auditors found information about involvement with the youth justice system recorded on file for 12 of the 73 children (16%). The reason for involvement ranged from minor theft to assault. We concluded that the audit forms might be underrepresenting early intervention by the police and/or youth justice services because the systems are disjointed, with different recording systems. This reflects other emerging findings about the impact of local systems operating in silos (see for example Fitzpatrick et al. 2019; Munby 2017).

Conversely, it is worth noting how this disjunction may be addressed, as explained in the recent 'outstanding' judgment for Brighton and Hove Youth Offending Service. The inspection report underlines the importance of reliable, high-quality exchange of information to ensure alignment between youth justice and child protection and care planning (HM Inspectorate of Probation 2021). In order to provide a comprehensive response, key teams in Brighton and Hove were brought together in 2018 into a co-located adolescent service.

And fourth, about the challenges and achievements of responding well to children and their families

The combination of the rich information on audit forms—both quantitative and qualitative—and discussion with the local authority senior practitioners and managers, gave us plenty of insights into what professionals find helpful and want to continue to be able to provide. This included proactive support to parents as early as possible in a child's life or as soon as signs emerge that all is not well. Valued, too, was leadership support from committed and creative people who give a strong message to staff that children are generally best helped by those close to them, that parents generally want the best for their children, and that providing the right support to parents to deal with their own difficulties can be the key to unlocking their ability to help children cope and thrive, whether at home, in care, or in a secure setting.

On the downside, we saw evidence of a failure to respond with care and humanity to the circumstances and needs of some children and families. It cannot be right that it takes a change of social worker for a mother with learning difficulties to finally get the empathetic support and practical help that is needed to boost confidence in herself and professionals about her parenting ability. Or that a boy traumatised by life experiences before care is further traumatised by what happens to him in care.

Or that we detected little evidence in files that family members were supported to acknowledge and rebuild fractured relationships that children will benefit from later in life. Or that schools, partners in the local safeguarding system for children, are able to exclude the children most in need of protection and support, in effect delivering an added rejection on top of those experienced already.

And, in the most extreme circumstances, it cannot be right that the fruitless search for a bed for a child in need of security from harming themselves or others ends with a High Court order that takes away their freedom but still leaves them without safe shelter. This experience is sadly not unique and continues: note the mid-June 2021 judgment in which the judge refused to authorise the deprivation of liberty of a child aged 12, to keep him locked in a paediatric hospital ward, on grounds of that being inappropriate, harmful and in breach of the child's human rights.[12] The judge ended their judgment with these words:

> *All those involved have done their level best in a situation that has bordered on the unmanageable. In so far as fault falls to be apportioned, it must settle on those who have not made the provision required to address the needs of highly vulnerable children such as Y [Wigan Borough Council v Y (2021) EWHC 1982 (Fam)].*

12 See for example Munby (2018), which considers the overlap between family justice and youth justice, the concept of a problem-solving court approach to young people in trouble, and what is described as the 'utterly shameful … scandal' of the lack of residential provision for troubled children. See also the recent report from Ofsted about the shortage and inadequate distribution of secure accommodation facilities (Preston 2021).

The audit in context

Safeguarding children from harm from within or beyond their family, while also promoting their safe care and right to family life, is the perennial concern of local and national safeguarding systems. Efforts to make improvements are writ large in numerous reports and long lists of recommendations over many years. In the months working on this project, hardly a day passed without our attention being drawn to another new study, another new finding, another new angle of interest.

It was beyond our brief to review this vast and growing literature, but three recent studies have been of particular interest to us. The first is the thematic review of 60 vulnerable adolescents by the Croydon Safeguarding Children Board, in the wake of the violent deaths of three teenage boys each with life-long family involvement with children's services (Spencer, Griffin, and Floyd 2019). The second is an inquiry into the triggers for offending and exploitation for 13 children by the Office of the Police and Crime Commissioner for Gwent (2019). The third is research into the impact of adversity, abuse, loss and trauma on 80 children involved with the youth justice system, conducted for the West Midlands Combined Authority and the West Midlands Police and Crime Commissioner (West Midlands Combined Authority 2021).

The themes and findings in these three studies, conducted in areas of England and Wales that were different from where we were working, are very similar to the messages emerging from our audit and analysis. Our findings also echo the findings of the Child Safeguarding Practice Review Panel's national review on safeguarding children at risk of criminal exploitation (Crown Copyright 2020) and the results of Nuffield Family Justice Observatory's case file analysis of a similar cohort of children aged 10–17, involved in care proceedings heard in the East London Family Court (Roe, Ryan, and Rehill 2021).

The audit has focused on the often complex and longstanding problems of families with older children subject to care proceedings in four local authorities in one year. As such, it provides a snapshot of the lives of some children and families as they pass through proceedings, but does not cover children of the same age who are in need, on child protection plans or already in care—or their parents, siblings and relatives.

Reflecting on our study, and against the background of similar findings about children and families in other parts of Wales and England, we conclude with a strong plea for attention to three specific concerns.

Treading water is not enough

- We must make and take opportunities to help children differently, through earlier attention to the difficulties that face those closest to them. This requires a renewed focus on tackling parental needs as soon as they arise, and doing so with a family lens, and with greater understanding across all services of complex trauma and its impact on how people respond when they feel under threat and in distress. Key parental needs identified in our study relate to substance misuse, domestic abuse, poor mental health, and underpinning poverty and disadvantage. Continued support for parents after care proceedings, whether or not the children in proceedings return home or remain in care, is essential. For the former, given the high rate of cases returning to court, local authority support for supervision orders will be of particular value. Here we commend the practice in some areas of using independent reviewing officers to review progress in these cases.

- We must take action sooner rather than later. Being prepared to take cases to court when there are clear indications that things are likely to continue getting worse is one example. Another is illustrated by the bold action of professionals in the audit case of a boy who was clearly not benefitting from placements in care; they returned him home and provided intensive support to him and his parents from there instead.

- In a similar vein, strengthening support to vulnerable children in Years 5 and 6, before transition to secondary school, is likely to have more chance of supporting children to manage complex behaviours and resolving difficulties earlier on .

- In addition, earlier connections between children's services and the youth justice system would help build stronger, supportive teams around vulnerable children and their families. Useful connections would be about people, about agency case recording and tracking systems, and about opportunities for cross-agency reflection on joint work with individual children, young people and family members.

- While there is a welcome and growing body of work on these matters, there is not, as far as we know, a literature review that focuses on the specific issues relevant for children and families in the overlapping but separate (and sometimes siloed) systems and services of family justice and youth justice. We recommend a review of research evidence on this area that would be accepted as a consensus view of our current knowledge.

Provide safe havens

- We must resolve to provide suitable provision for the older children with complex difficulties who need to be in care. It was clear from the audit that staff and managers frequently struggled to find sufficient and appropriate placements for the most vulnerable children, with serious implications on their safety and development. This issue—and the frustrations of practitioners, children and families—has confronted us for too long. In their corporate parenting role, local authorities need access to small, safe, specialist and local homes where young people have access to therapeutic, trauma-informed support.

- We have seen from the audit that school can be a safe haven for some children, as well as being a valuable resource for some parents. So we should avoid missing the possibility that someone or something about school will provide the light bulb moment for a child in distress. Given what we know about absence from school being a trigger for heightened vulnerability to exploitation, especially when it coincides with going missing from home and connecting with peers involved in risky behaviour, we must actively challenge policy and practice around school exclusion.

- We welcome the planned government review later this year of guidance on school policies around behaviour and permanent exclusion. Pending the review, we propose that schools are required to convene a multi-agency conference if they are proposing to exclude a child. The conference should be required to consider the impact that any such exclusion will have on a child's risk of extrafamilial harm. It should also consider the possible impact on the child of the school's explicit rejection of them, most likely on top of earlier rejection by others.

- Secure accommodation provided a brief haven for some children. There were positive comments on audit forms about young people held in the youth secure estate making up for lost education, engaging in activities and self-development programmes, getting warm support from staff, and accessing therapeutic help after their release.

- We note and welcome the commitment by the youth secure estate, and the youth justice service in the community, to a child-first approach to their work (Cordis Bright 2017).

Maintain the lifeline

- Other clusters of vulnerability to extrafamilial harm are to be avoided too. A crucial one is about the losses stemming from weak or poor relationships, separation, bereavement and other traumatic events or circumstances. It follows that a top priority in supporting children is a concerted effort to mend and sustain existing relationships so that children retain as many links as possible with people who love them, and so that they get the best possible support to restore fraught and fractured relationships with their parents, brothers and sisters, and other relatives. Added to this is the value of professionals being curious about lost connections and being diligent in exploring what they might have to offer.

- Some children in the audit were clearly relieved to be in care, to feel less burdened by what they, too, had been struggling with, often over a long and unhappy period. But we also saw how some of these (and other children coming into care) were, nevertheless, drawn back to the place that was home and the people who were family. They wanted to be in touch, and they and their parents needed support to understand and deal with the tensions, emotions, risks and benefits involved.

- The audit highlighted successful practice around FGCs and other family decision-making meetings, and the added value of that work being led, driven and supported by agency policies and strong leadership that reflect commitment to a family-inclusive approach. We recommend the continued promotion of, and support for, this model of work.

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Appendix A: Audit form

The audit tool (a questionnaire) was designed to enable straightforward transfer of information from the children's electronic social care records by experienced local authority staff who were familiar with their own data systems and the circumstances of the children and families.[13]

Figure A.1: The audit tool

Please complete the following questionnaire** using tracked data & electronic social care records for **each child aged 10 and over** subject of care proceedings issued between 1 April 2019 and 31 March 2020.

** The instructions, or places to type, are in bold blue font.

The audit is designed to:

(1) increase understanding of the circumstances of older children in proceedings,

(2) identify the reasons for those entering the care system, including issues relating to extra-familial harm and exploitation, and

(3) learn more about the overlap between family justice, youth justice, and deprivation of liberty.

13 The form was the basis of an earlier audit, described in Parker and Tunnard 2020.

Child identifier: xx (e.g. 01, 02, 03 etc)

Gender: Male or Female

Ethnicity: xxxxx

Age at issue (years 10– 17): xx years

Sibling status: (e.g. singleton in proceedings, or note no. of any sibs in proceedings + age + identifier/s if age 10 or over) xxxxx

Date (Month) and Order made at final hearing: xxxx Order in xxx 2019/20

Number of weeks in proceedings: xx

Family Drug & Alcohol Court: Yes or No

A. BEFORE PROCEEDINGS

1. What were the reasons for the LA bringing care proceedings on this child?
Add X in left-hand column for all that apply

Intra-familial actual or risk of future significant harm to child:	
	- Physical
	- sexual
	- emotional incl. v poor parenting skills e.g. relationships, consistency, routine
	- neglect incl. v poor parenting skills – lack of boundaries
	- parenting capacity limited by either or both parent's mental ill health
	- parenting capacity limited by either or both parent's past trauma
	- parenting capacity limited by either or both parent's learning difficulties
	- parenting capacity limited by either or both parent's substance misuse
	- parenting capacity affected by serious issue with other sibling/s
	- parent or parents in prison
	- parent or parents absent
	- parent or parents deceased
	- domestic abuse
	- child's disability
	- child's emotional and/or behavioural problems
	- severity of child's behaviour puts child beyond parental control
Extra-familial actual or risk of future significant harm:	
	- criminal exploitation including gangs/county lines
	- child sexual exploitation
	- child beyond parental control
	- human trafficking
	- modern slavery
	- parent not in UK
	- other, e.g. radicalisation (please state)
Free-text summary of reasons for any Xs above ("story behind the stats"): xxxxx	
Free-text summary of child and/or family strengths/resilience factors identified xxxxx	

2. At what level was child previously known to Children's Services? X all that apply

	Not known prior to matter before the court
	Past referrals at information/information sharing level
	Referral and assessment followed by NFA
	Referral, assessment and referral to other agency
	Open case in past, or just prior to proceedings - as CIN
	Open case in past, or just prior to proceedings - as CPR
	Looked after child in past, or just prior to proceedings
	Youth Justice involved prior to proceedings
	Other level of involvement (please explain)
	Has a Family Group Conference been used? If yes, please explain purpose and result
	Was formal pre-proceedings work undertaken (as per the PLO guidance)? If yes, describe
	Was there any international element to the case and if so state nationality? Xxxxx

B. DURING PROCEEDINGS

3. Which potential indicators of vulnerability to extra-familial exploitation had been noted before, or became clearer during, proceedings? X all that apply

	- child missing from home
	- child frequenting areas associated with exploitation
	- child using alcohol
	- child using Class B drugs - cannabis, amphetamines, ketamine, other
	- child using Class A drugs – heroin, cocaine, crack cocaine, ecstasy, LSD, other
	- child arrested for alleged offences
	- child convicted for offences
	- child acquiring items or money
	- increased and/or secretive mobile phone use by child
	- child has multiple mobile phones
	- child frequently changes mobile number
	- not attending school Mainstream ☐ PRU ☐ Alternative Provision ☐
	- going missing from school
	- significant decline in school performance EHCP ☐

	- short-term exclusion from Primary school ☐ Secondary school ☐
	- permanent exclusion from Primary school ☐ Secondary school ☐
	- isolation from peers incl. target of bullying ☐ perpetrator of bullying ☐
	- association with peers who present risk of harm
	- sexually-transmitted infections
	- pregnancy
	- victim of physical assault
	- victim of sexual assault
	- weight loss
	- changes to personal hygiene
	- signs of exhaustion
	- significant change to emotional well-being
	- violence against parents
	- loss of parental control incl. poor/ fractured relationships with parents/family
	- unresolved trauma incl. bereavement
	- other (please explain)
	Free-text summary of reasons for any Xs above ("story behind the stats"): xxxxx *Free-text summary of any child and/or family strengths/resilience factors identified:* xxxxx
4.	Has there been any special intervention or approach e.g. close involvement of family, kinship, community used to address extra-familial harm where identified. This might involve mapping, outreach, multi-agency initiatives, specialist service, and projects to address disadvantage or discrimination? If yes please describe
5.	Has there been any involvement from Youth Offending Service, e.g. pre-sentence report writing, Youth Court sentences like Reparation Order, Youth Rehabilitation Order (standard, enhanced, intensive), Restorative Order, Detention & Training Order, and long-term detention? If yes please describe
6.	Has there been any application for Secure Accommodation Order? If yes, please describe
7.	In the event that a place in secure accommodation was not available or appropriate, was an application made for a court's approval to place in an alternative placement? If yes, please describe & note if unregistered.
8.	Have there been any admissions to psychiatric in-patient facilities under the Mental Health Act – informally or under Section? If yes, please describe
9.	If child over 16, has there been any application to the Court of Protection for deprivation of liberty under Mental Capacity (Amendment) Act 2019? If yes, please describe

C.	AFTER PROCEEDINGS
10.	If in 2019/20 the child remained with/returned to parent/s under No Order, CAO and/or SO, does the child remain with parent/s, as per Care Plan? If not, why not? Has the child been subject of further Family Court or Youth Court proceedings? If so, what was the outcome and when?
11.	If in 2019/20 the child was subject of SGO with or without a SO, does the child remain with SG? If not, why not? Has the child been subject of further Family Court or Youth Court proceedings? If so, what was the outcome and when?
12.	Where child became subject of CO in 2019/20, has the child remained in the placement proposed in the Care Plan agreed at final hearing e.g. long-term foster care, kinship foster care, placement with parent, registered residential, unregistered placement, care leaver arrangements? State type or explain other
13.	How many placement changes since the CO? Please note if planned (in line with care plan e.g. move to long-term fostering?) Or unplanned (disruptions etc?)
14.	Have the contact arrangements agreed in the Care Plan been maintained? If not, why not? Did the matter return to court and if so, when, why (initiated by LA or family) and what was the outcome?
15.	Was this child separated from siblings by the Care Plan or have they become separated subsequently? Please indicate how. If so, what sibling contact arrangements were made/have been maintained?
16.	Other comments? Whatever Order the court made at the end of proceedings, what can you ascertain from the records/any review (including e. g. for Looked After Children) about how things are progressing for the child and family? Think about family and peer relationships, placements, school, health, well-being, behaviour, and family contact. Give any view from child or family evident from reviews xxxxx
17.	Other comments? With hindsight, what might have been done differently to prevent level of intervention in family life? Comment on anything helpful/needs left unaddressed xxxxx

Appendix B: Methodology

The participating local authorities responded positively to a request from Research in Practice to join the project. They were invited on the basis of our wanting a geographical spread of areas, and local authority partners with a keen interest in exploring the research questions. We devised the audit form, tested it with managers and auditors for content and language, and advised auditors as necessary throughout their work. By way of analysis, we read each audit form, collated the data, and clustered the qualitative findings in line with the audit questions. We held individual follow-up meetings with auditors and managers to gain feedback about the process and our draft analysis of their findings to iron out any remaining queries or anomalies, and to find out more about existing services and new developments.

Each local authority received a report about their audit; it was an internal document to be used as they wished. It contained our detailed analysis of their data and a pen picture that we had drawn of each child. The local authorities agreed to their findings being amalgamated into an anonymised aggregate final report.

In providing each local authority with a separate report of their work, we were able to:

- offer them an **independent analysis** of the audit responses, giving a local picture of older children in recent proceedings—the grounds, concerns and risks as well as court decisions and care plans
- consider with them the advantages of **tracking and analysing cases over time** to identify changes, emerging trends and ongoing issues
- report the evidence about their **use and effectiveness of FGCs**, to help make/confirm the local case for resourcing this model
- identify any contextual safeguarding work with **children in need and children in care** to better understand how vulnerability to extrafamilial harm was responded to before and after proceedings

- **reflect with auditors and practice leaders** (head of service, principal social worker, case manager, practice manager) on the audit findings, both heartening and disappointing

- discuss their findings in the context of matters that have been reported at **national and local level**, such as repeat proceedings, supervision orders, and the use of new approaches aimed at prevention and diversion from court.[14]

Discussion of the local authority report in draft provided joint reflection and improved accuracy for producing the composite analysis. Where there was consistency of auditor, they reported the discussion as helpful and interesting to take a 'step back' and look at broad themes as well as thinking about what had happened to individual children.

In one authority (Local authority B), previous work undertaken to track proceedings over time enabled us to do an additional report for this project. This was a secondary analysis of older children brought into proceedings six years earlier and through which we gained some insight into trends over a longer period than the maximum of two years possible for the cohort of children in the current audit exercise.

14 For comprehensive research and practice information from the online Community of Practice for services in relation to learning from, and aiming to avoid, repeat care proceedings, see: https://supportingparents.researchinpractice.org.uk/services/

Appendix C: Data tables

Table C.1: Number of children by age at issue

Local authority	Age								
	10	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**Total**
A	2	1	4	2	1	2	1	-	**13**
B	2	9	1	5	6	2	2	-	**27**
C	3	1	5	4	2	2	1	1	**19**
D	1	5	2	3	-	2	1	-	**14**
Overall	**8**	**16**	**12**	**14**	**9**	**8**	**5**	**1**	**73**
Overall (%)	**11%**	**22%**	**16%**	**19%**	**12%**	**11%**	**7%**	**1%**	

Table C.2: Number/proportion of children by age bracket

	Age 10-13		**Age 14-16**		**Age 17**	
	n	%	n	%	N	%
A	9	69%	4	31%	0	0%
B	17	63%	10	37%	0	0%
C	13	68%	5	26%	1	5%
D	11	79%	3	21%	0	0%
Overall	50	68%	22	30%	1	1%

Table C.3: Overall ethnicity by child and family

Ethnicity	Children	Families
Black British	5	4
Black British Caribbean	5	3
Black British African	5	4
White British	34	23
White Welsh	3	2
White European Spanish	1	1
White European Turkish	2	1
White British and Roma	1	1
White Irish and Greek	3	1
Dual heritage: White British and Black Caribbean	3	2
Dual heritage: White European and Black Caribbean	1	1
Dual heritage: White British and Black African	1	1
Dual heritage: White British and Asian	1	1
Other: North African	5	2
Other: Not specified	3	2
Total	**73**	**49**

Note: classifications are based on those used by the local authorities (adapted from Census ethnic group categories).

Table C.4: Involvement of children's services before current proceedings

LA	N/K	Info	CIN	CP	CLA	PLO1	Court1	FGC	PLO2	Total number of families
A	3	1	1	3	3	2	2	1	-	9
B	1	1	4	17	10	6	8	8	5	19
C	2	2	7	10	5	2	3	11	6	12
D	3	1	1	3	3	2	2	1	-	9
Total	9	5	13	33	21	12	15	21	11	49

Notes: N/K = Not known; Info = Information sharing at assessment; CIN = Child in need; CP = Child protection plan; CLA = Child looked after; PLO1 = Public law outline – first period of pre-proceedings; Court 1 = First care proceedings before current proceedings; PLO2 = Public law outline – second period of pre-proceedings.

Table C.5: The children in repeat proceedings

First proceedings					Second proceedings 2019/20	
LA/ child	**Year**	**Age**	**Previous orders**	**Nature of inputs between proceedings**	**Age**	**Orders/plans**
A1	2007/8	1	Care order, placement order	Social work as a child in care, placed for adoption, then placement disruption	13	Care order, then placement in secure accommodation
A5	2008	1	SGO (grandparent)	Numerous, to try and prevent disruption	12	Care order and long-term fostering
B1	2018	9	Residence order (father)	Private fostering/regulation 24, FGC	11	Care order and long-term fostering, with regular respite provided by relative
B3	2016	12	Supervision order (mother)	Child in need, FGC, domestic abuse	16	Supervision order (mother)
B4		10			14	
B5	2010	1	Residence order (father)	Mental health, child in need, child protection plan, private law proceedings	10	Family moved local authority and case transferred at first hearing
B11	2012	7	SGO (grandparent)	Child protection plan, parenting assessments, family meetings	15	Placement in secure accommodation, then semi-independent
B12		6			14	
B13	2010	3	Supervision order (mother)	Child protection plan, public law outline and specialist assessment, EHCP, FDAC	12	Supervision order (mother)
B14		2		s.20/regulation 24 to grandmother, specialist assessment, EHCP, FDAC	11	Care order and kinship fostering (grandmother)
B20	2017	8	Supervision order (mother)	Child in need, child protection plan, maternal aunt earlier carer	11	SGO (relative)
B21	2012	8	Supervision order (mother)	Child in need, child protection plan, EHCP in other local authority	15	Still in proceedings and heading to separate residential provision
B22		6			13	
C2	2017	8	SGO (grandparent)	Public law outline, various interventions, FGC	10	Care order and long-term fostering
C4	2017	8	Supervision order (mother)	FGC, various interventions and groups	10	Care order and long-term fostering
C12	2016	10	Supervision order (mother)	Family declined FGC and intervention	14	Care order and placement in residential home. Currently in secure accommodation.
D9	Not given		SGO (grandparennt)	Child in need, child protection plan	13	Care order and long-term fostering
D10	2019	11	Supervision order (mother)	Child in need, child protection plan, youth justice 1:1 work around criminal exploitation concerns	12	Care order and long-term fostering (awaiting new placement in Mockingbird Hub)
D11	2019	10	Supervision order (mother)	Extension of supervision order	11	Care order and residential provision
Summary: 19 children age 10+ (from 15 families) were in repeat proceedings						

Table C.6: The grounds and issues affecting parenting capacity, and the nature of concerns affecting the children

	Local authority				Total
	A	B	C	D	
Nature of grounds per family					
Physical	4	10	6	1	21
Sexual	1	2	2	-	5
Emotional	9	19	12	9	49
Neglect	6	14	11	7	38
Domestic abuse	3	7	9	5	24
Issues affecting parenting capacity					
Mental health	1	6	4	6	17
Trauma	2	9	6	4	21
Learning difficulties	-	1	1	-	2
Drug/alcohol	3	7	6	6	22
Absent	4	1	5	2	12
Deceased	2	2	1	-	5
International element	2	5	-	-	7
Issues for children					
Child with disabilities	1	2	3	-	6
Emotional and behavioural difficulties	2	6	8	2	18
Beyond parental control	2	5	3	1	11
Criminal exploitation	-	5	5	-	10
Sexual exploitation	2	2	2	-	6
Human trafficking	1	1	-	-	2

Table C.7: Concerns about parenting capacity

Concern about parents	Number of families	% of all families
Substance misuse	22	45
Experience of trauma	21	43
Poor mental health	17	35
Absence from home	12	24
Deceased	5	10
Learning difficulties	2	4

Table C.8: Court orders during proceedings and at final hearing

Any order/s made	Local authority				Total
	A	B	C	D	
Withdrawn/transfer	-	2	-	-	2
No order	-	-	1	-	1
Child arrangement order	-	-	2	3	5
Child arrangement + supervision order	1	-	2	-	3
Supervision order	1	5	4	1	11
Special guardianship order	1*	1	3	1	6
Care order	10	16	7	5	38
Still in proceedings	-	3	-	4	7
Total	**13**	**27**	**19**	**14**	**73**
Including, in terms of restriction of liberty:					
Secure accommodation order	1	2	-	-	3
Deprivation of liberty via inherent jurisdiction of high court	-	2	-	-	2
Sectioned under Mental Health Act	1	-	-	-	1
Voluntary admission to psychiatric hospital	-	1	-	-	1
Total	**2**	**5**	**-**	**-**	**7**

Note: *Plus a supervision order

Table C.9: Living arrangements for the children in care

Placement type	Local authority				Total number of children
	A	B	C	D	
Fostering with kinship or connected person carer	-	5	1	-	6
Fostering	7	6	3	8	24
Residential	3	4	2	1	11
Semi-independence	-	2	-	-	2
Secure (current)	-	-	1	-	1
Deprivation of liberty sanctioned (current)	-	1	-	-	-
Total (care orders and ICOs)	**10**	**18**	**7**	**9**	**44**
Of which, in the past:					
Secure or deprivation of liberty	1	5	-	-	6
Psychiatric admission	1	1	-	-	2
Total	2	6	-	-	8

Nuffield Family Justice Observatory

Nuffield Family Justice Observatory (Nuffield FJO) aims to support the best possible decisions for children by improving the use of data and research evidence in the family justice system in England and Wales. Covering both public and private law, Nuffield FJO provides accessible analysis and research for professionals working in the family courts.

Nuffield FJO was established by the Nuffield Foundation, an independent charitable trust with a mission to advance social well-being. The Foundation funds research that informs social policy, primarily in education, welfare, and justice. It also funds student programmes for young people to develop skills and confidence in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Ada Lovelace Institute and the Nuffield Council on Bioethics.

Research in Practice

Established in 1996, Research in Practice works with organisations to enable them to access, understand and apply evidence in their work with children and families, young people and adults. The Research in Practice membership network includes more than 200 local authorities and third sector organisations and universities across England.

Nuffield Family Justice Observatory

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