Kingston and Richmond
Safeguarding Children Partnership

Child Safeguarding Practice Review
Jamilia

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Jamilia is described by her family and those who took part in this review as lively and energetic, well-liked, kind and understanding, incredibly strong and resilient and sometimes fiery. A standout quote was, “She loved from every part of her”. She was affectionate and independent, vivacious, a big personality, funny, engaging, a good listener, sometimes shy and wanted to be loved and to love. Jamilia – “could light up a room”, her sister described her as “sweet as honey” and she clearly touched people's hearts and left an imprint that will stay with those who cared for her forever.

For those who cared for her or visited her in her homes she would always offer them tea or a soft drink, in the summer an ice lolly. She was thoughtful and hospitable. She talked about meeting a partner and having children in the future. She had aspirations, was intelligent and was said to have ‘massive potential’.

She struggled with getting a good night's sleep and could be impulsive and thrill-seeking. She was sometimes fearful and could be guarded and present as defiant. She was observed to struggle to sit still at times and would change the subject or walk away if she didn’t want to answer. She sometimes spoke negatively about herself and needed reassurance from others. These are common traits noted in children who have experienced trauma including through witnessing domestic abuse.

Jamilia’s death came as a shock to all who knew and worked with her and is a huge loss to everyone which provides some insight that suggests her death was not predictable.

Jamilia was born to Middle Eastern parents and was their fourth born child together. Jamilia was from a Muslim background and spoke Arabic. Her family were living in another country at this time, but they returned to their home country for her birth before returning to their temporary home. Life was not easy for the family, and we know that Jamilia and her sister ran away once due to the abuse they were exposed to at home. This resulted in them being placed in an orphanage for a few weeks until their parents located them. Jamilia would have been very young, and this was a frightening and formative experience. Jamilia did not return to her country of birth once war broke out but would have been aware of it and it is possible that she was vicariously traumatised through hearing other people reliving and talking about their experiences. Jamilia and her family arrived in the United Kingdom as refugees.

Jamilia was open about her feelings including her wishes to be closer to her friends and family with whom contact was important and she experienced isolation and racism during a placement in another county away from London.

Jamilia had experienced profound trauma, witnessed domestic abuse, aware of her brother’s death, endured child abuse, instability and had spent some limited time in a war-torn country. She experienced loss at numerous points in her life from the death of a sibling to leaving her country to her parents separating and rejection when she came into care. Moving from one placement to another potentially perpetuated those feelings of loss when on each move she left behind some meaningful relationships whether it be a professional supporting her or another child she had made friends with. She learnt not to trust people. These traumatic experiences had a lasting impact.

1. Introduction

1.1 A Local Child Safeguarding Practice Review (LCSPR) was commissioned by Kingston and Richmond Safeguarding Children Partnership (referred to hereafter as the partnership) following the tragic death of Jamilia. It was agreed by KRSCP to arrange for the conduct of an LCSPR using a process first used for safeguarding adult reviews - Safeguarding Adult Reviews in Rapid Time (SARiRT). This allows for the process and enables learning to be turned around more quickly than is usual for some child safeguarding practice review methodologies.

2. Methodology

2.1 The review focused on a 12-month period prior to the serious incident where Jamilia passed away. Some earlier episodes in Jamilia's life were also considered as they provide further context and a wider systemic lens to aid learning.

2.2 The terms of reference with key lines of enquiry were prepared, amended, and agreed by the multi-agency panel. The review included reading the partner agencies chronologies, some documents and file records, and conducting interviews with the family and multiple professionals. We also held a practitioner event to develop the learning together.

3. Limitations

3.1 Limitations pertain to being unable to meet the final care provider due to the criminal investigation and the most recent social worker being unavailable. The challenges described during interviews which highlighted difficulties in seeking out the right police officer when required was reflected in the review experience.

4. Key lines of enquiry

How do practitioners understand and address issues relating to safeguarding and need for a child/family, which is culturally competent and considers the impact of intersectionality, when working with children, supporting children and creating (but not limited to) care plans for children and young people?

How does the status of being refugees inform and impact the responses from agencies?

From this we hope to explore how the partnership may strengthen understanding and use in practice across the multi-agency of:

- Intersectionality
- Cultural competence
- Language in respect of child exploitation - how it contributes to reducing/increasing worries
- Trauma informed practice
- Working with complex high-risk children and how practitioners can be supported to do this
- Working with children affected by self-harm and suicidal ideation
- Responding to the impact of domestic abuse
- How to mitigate narrowing of focus to a specific concern (tunnel vision), at the exclusion of a holistic understanding of a range of complex concerns.

Placements: including commissioning, matching, management of moves (information sharing, risk assessment and care planning), what therapeutic placements can offer and how this can be optimised, and quality assurance.

From this we will consider:

- What work may be taken at a national level to influence availability and suitability of therapeutic placement of children with complex needs
- Potential to strengthen local processes

How well do we listen to, and act upon, the wishes and feelings of young people particularly considering disclosure of child sexual abuse and how agencies respond; specifically considering what additionality or different needs being a child looked after brings?

How well did practice across agencies align to recognising risk of self-harm and suicide? - thinking about both prevention and response to signs of self-harm. Are practitioners aware of and confident in considering Local Authority suicide prevention strategies and resources?

5. Family Involvement

5.1 The family asked for the review to refer to their daughter as Jamilia which is not her name but means ‘beautiful’ in Arabic.

5.2 Interviews have taken place with both parents separately and included Jamilia’s older siblings. Interpreters were available where required.

5.3 Jamilia’s father was married before he met Jamilia’s mother and had two children; one is reported to have been killed by militia. Jamilia’s parents married when her mother was 16. They had five children together, four daughters and one son who died in a road incident. Jamilia’s father is 16 years older than her mother. He has been a victim of torture and suffers from post-traumatic stress disorder (PTSD) and other health concerns. He has been in prison in his home country and in the United Kingdom (UK), and there is a history of crime that professionals in the UK were unaware of in detail. He described their home in the UK as ‘heaven’. He is unable to read or write in either Arabic or English.

5.4 Jamilia's mother is from a large family and left school at 13 years of age to help her mother, which was not uncommon for children in her home country. She reported that her husband raped her before their marriage. She said she was unable to disclose this due to the fear of bringing shame on her family and was obliged to marry because of the rape. She described coming to the UK and feeling happy to have a home and an education for her children. However, she and Jamilia’s older siblings described the risk from the father which remained. The mother found it difficult to integrate into the UK life and customs, even with support from charities and she explained how different life is in the UK to what she was used to.

6. Summary of circumstances leading to the review

6.1 Jamilia was a child looked after with a Full Care Order from September 2023. She was settling into a new home and there was just one other child who spoke the same language. The day of her death, she had spoken to an older male who is referred to as her ‘friend/boyfriend’, someone she had been in contact with for a while and had met on an app that connects people anonymously. She was upset at him delaying their meeting time and this appears to have been the trigger for her to take action that ended her life.

7. Findings in brief

- **Culture and Past Harm:** While there was some support for Jamilia's cultural needs, professionals failed to delve deeply enough to connect her family's

profound past trauma with what she was telling us through her actions and responses to events.

- **Impact of Language:** The language some professionals used to describe children negatively affects perceptions and actions, thus reducing the worries, which can mask the true nature of abuse or exploitation.
- **Commissioning Challenges:** There was a lack of clarity between Children's Social Care and providers as to what was expected. Clinical oversight will benefit Children's Social Care in quality assuring potential provisions. There are challenges in finding adequate provisions for high-need children that are more local.
- **Engagement and Relationship Building:** Jamilia struggled to trust anyone but was more comfortable speaking with professionals who did not hold perceived authority. Professionals frequently used dismissive phrases like "will not engage" rather than taking responsibility and persistence in building trust.
- **Information Sharing:** Clearer multi-agency communication and information sharing were identified as areas for improvement. Challenges working across boroughs remain when there are multiple police forces involved. Some professionals felt siloed in terms of communication.
- **Mental Health and Self-Harm Response:** Mental health support was hindered when professionals could not engage, or appointments not considered in the child's environment. Furthermore, Jamilia's escalating self-harm was not met with a vigorous response (such as a strategy meeting and child protection medical), and professionals failed to link her history of neglect and domestic abuse to her risk of self-harm.
- **Process Delays:** Although many processes met expected timescales, there were delays and areas for improvement.
- **Online vulnerability and harm:** Professionals could have been more curious about the use of phones and how this linked to increasing vulnerability, exploitation and impact on mental health.

8. Responding to the Key Lines of Enquiry

How do practitioners understand and address issues relating to safeguarding and need for a child/family, which is culturally competent and considers the impact of intersectionality, when working with children, supporting children and creating (but not limited to) care plans for children and young people? How does the status of being refugees inform and impact the responses from agencies?

8.1 Partners provided examples of practical support for Jamilia's culture and identity. Furthermore, most practitioners demonstrated an awareness of her past trauma. One

provider escalated a very thorough safeguarding review requesting a strategy meeting. Jamilia's voice was used to illustrate and define the risks, it identified places and spaces of concern, people who posed a risk and considered Jamilia's responses in a trauma informed way. It is a concern that this multi-agency strategy meeting did not lead to a Section 47 investigation Children Act 1989, Section 47. The outcome decision from the strategy meeting was 'no clear evidence of exploitation' with actions to gain more evidence.

8.2 While written documents refer to Jamilia's past trauma most tended to be superficial therefore could delve further to create a meaningful understanding that links past experiences and family culture to current safeguarding concerns. Jamilia and her family experienced profound trauma, not least from domestic abuse, therefore understanding the impact needs considerable thought and support through effective supervision, training, reflection, and research.

8.3 All practitioners understood the family were refugees with settled status. The evidence shows professionals working hard to ensure their needs were met against the challenges of trauma, difficulties in engagement and reluctance to take advice or engage with certain services.

8.4 Jamilia appeared to engage with education until secondary school where attendance dropped off. Placement moves and the need for an Education, Health and Care Plan (EHCP) also impacted education. The Virtual School put in place tuition and applied for the EHCP. The Virtual School were invited to all pertinent meetings including strategy meetings, although were not always in attendance. Education and school are known to be protective factors which tend to be compromised when there are placement moves.

8.5 Understanding intersectionality for refugee families with settled status involves recognising that, while legal insecurity is reduced, structural inequalities such as racism, class, language, religion and gendered expectation continue to intersect, creating unique barriers to integration and wellbeing. This can be observed for the family on arrival in the UK and for Jamilia in her first home where she described racism, feeling different and lonely.

8.6 Settled status does not erase the lasting effects of previous trauma or the ongoing impact of systemic inequalities. Although this review considered the time period of one year prior to death it has looked briefly at early records and it is here where intersectionality is seen as the most compromised. There was minimal understanding of what the family had lost by moving countries such as community support, and they

received little help in navigating the UK legal system. It is possible but not confirmed that agencies felt the family were now safe but did not fully comprehend the risk that remained given the significant domestic abuse.

8.7 There is evidence of interpreters being engaged and some legal documents being translated. Most documents were predominantly written in English for the family who had yet to learn English. Without documents being translated so the family can refer to them, it is questionable how they may have understood or remembered information for any agency involvement. The father's illiteracy adds another layer of complexity.

8.8 The thread of emotional health needs should weave through every interaction and although early involvement and plans identified some actions to address emotional health needs they did not continue and were not a feature in more recent care plans. It was positive to see early plans contain actions to work with the family on the role of women, gender roles, and considerable safety work which recognised cultural practices and exploitation as a potential risk.

8.9 Recent assessments acknowledge Jamilia's emotional health needs in terms of her experiences by referencing some of the findings from the earlier psychological assessment. However, the crucial link between the assessment and concrete multi-agency actions within the child's plan is absent. It is noted that Jamilia was at times offered support by a referral to specialist mental health services which she declined. This non-engagement was not recognised as a form of communication and highlights the challenges in the role of corporate parent and whether there is scope to draw on others in the network or even the birth parent to support engagement.

8.10 Not in the remit of this review, however pertinent, is the level of information gathered prior to a family being resettled over and above that of basic needs. It may be helpful for the partnership to consider if there was sufficient understanding of the family's needs as a whole when they were resettled in the UK. The primary issue of 'Rights' was not understood by the family and their lack of access to advice, guidance and support around this issue may have limited their choices. It is likely the level of domestic abuse was not fully understood through a cultural lens nor the lengthy history of abuse and criminal history relating to the father; although it is referenced through the mother informing police. Greater understanding might have led to a more robust assessment of needs on arrival in the UK and a clearer understanding that significant risk remained in the family from the father. There are some records which refer to needing to understand more, which is evidence professionals knew it was necessary.

8.11 While most professionals were aware that Jamilia originated from a war-torn country, there is little evidence that the implications of this were explored, particularly

given she had not lived there, which was not understood by all. There was a missed opportunity to address her specific needs through direct work and to incorporate the child's lived experience into the plan.

Language in respect of child exploitation - how it contributes to reducing/increasing worries

8.12 Language used to describe children has a profound effect, not just on the children, but also on the professionals who employ it. According to the NSPCC (2023) Why language matters: how the label 'older boyfriend' can mask child sexual exploitation | NSPCC Learning, the choice of words can shape how professionals perceive, think about, and act toward children, ultimately influencing their professional practice. The reference to 'boyfriend', 'male friend', and 'love bites' within documentation and interviews, leads one to have a more positive understanding about Jamilia's relationships than was reality, it implies a choice and consent. Police forces have taken steps to improve their training and use of language with one force confident in their audit programme evidencing improvement. However, recent Police documents continue to reflect child blaming phrases such as ''putting themselves in danger', 'overly sexualised', 'is continuing to put herself into ever increasing harm', and 'engages in sexual activities'.

8.13 There was significant evidence of child exploitation and yet much documentation refers to Jamilia as being 'at risk of exploitation' rather than 'is being exploited'. This indicates the lack of cumulative chronological understanding and a focus only on the immediate issue. One multi-agency strategy meeting considered the threshold as 'low' for exploitation, which prevented a referral to pre-Mace (multi-agency child exploitation panel): other strategy meetings did not evidence they considered pre-Mace and that significant harm outside the home was not met. However, good practice was identified where the pre-Mace chair reached out to request Jamilia be discussed at pre-Mace given their knowledge of the concerns.

Trauma informed practice

8.14 Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.
Working definition of trauma-informed practice - GOV.UK

8.15 Jamilia did not recognise why people were worried about her saying it was nothing

to what she had experienced before the UK. This provides an insight into the level of trauma she had experienced and an opening to be more curious.

8.16 While practitioners across the partnership acknowledged Jamilia's traumatic history, including her journey to the UK, the review identified a lack of in-depth analysis concerning the cumulative impact of these influences on both Jamilia and her family. Jamilia's behaviours and actions were often viewed in isolation, without sufficient consideration of their collective significance. Specifically, there was inadequate gravity given to how these actions might be the consequence of her experiences, such as witnessing domestic abuse and being a victim of physical and historic sexual abuse.

8.17 The multi-professional network would have benefited from being aware of the Court-ordered psychological assessment which contained considerable detail including the following observation "emerging borderline/emotionally unstable presentations with increasing self-harm, and emotional dysregulation". Most professionals who engaged in the review were not aware of the psychological report even though it was referenced in the social care assessment. This case therefore highlights the crucial need for relevant court documents or specific content to be shared, discussed and understood, subject to agreement with the Court, to inform and shape the child's plan.

8.18 It is positive to know that all police forces interviewed have a robust training programme for Trauma Informed Practice as do other professional organisations; a trauma informed approach is embedded in the local Children's Social Care practice model. It is not clear how confident those in frontline practice and their line managers are in implementing this approach and its impact.

Working with complex high-risk children and how practitioners can be supported to do this

8.19 There are several ways to enable and support social care staff and partner agencies in being able to slow down thinking and reflect on practice. Strategy meetings and professional meetings should be considered supervisory in nature and therefore also a platform for support, sharing information and decision making. Individual supervision took place regularly; however, this review evidenced that most professionals were unaware that they could consider multi-agency joint supervision.

8.20 Multi-agency joint supervision is an available activity in the local children's social care services to support professionals in working together, sharing chronologies, information, and developing shared plans. In addition, there is Think Space, Signs of Safety Appreciative Inquiry, and ad-hoc professional meetings. The network did not

consider any of these approaches in this case. This underscores the importance of experienced leaders being knowledgeable about internal protocols, and partners being confident in requesting and considering a variety of approaches outside of their single agency approaches.

8.21 There was evidence that Jamilia would engage with those who were seen to hold less authority and those who were persistent and showed they cared. This is evidenced when she disclosed historical harm to a youth worker but felt betrayed when this was shared with the police who she would not then engage with. The professionals who engaged better with Jamilia either waited patiently until she was ready to see them, one sat outside her door talking softly, or they asked her keyworker to support them and waited until she was ready to talk.

Working with children affected by self-harm and suicidal ideation How well did practice across agencies align to recognising risk of self-harm and suicide - thinking about both prevention and response to signs of self-harm. Are practitioners aware of and confident in considering Local Authority suicide prevention strategies and resources.

8.22 Self-harm was observed from 2023; however, there is reference to the police reporting Jamilia was self-harming in 2022. In one health assessment Jamilia responds saying she had not self-harmed for years, she was 13 years of age therefore offering evidence of a longer timeframe than was explored. A strategy meeting record in 2022 flags up worries about family abuse, difficult family relationships and drawings done by Jamilia that should have triggered professional curiosity in respect of sexual harm. It was also recorded that Jamilia ‘was upset and started screaming that she wanted to kill herself’. There were missed opportunities to investigate this further with no action to follow up these specific observations identified in the multi-agency strategy meeting outcome. A standalone section addressing self-harm within the child’s assessment may help to highlight and prioritise a child’s self-harm. Exploring this further might have led to Jamilia feeling 'heard' and the potential for the initial elements of trust to develop. Children’s Services have a protocol that requires a paediatrician to be invited and attend all strategy meetings where sexual harm or injuries are identified and is an area that needs strengthening.

8.23 Upon relocating nearer to her family, Jamilia's missing episodes and self-harm increased in frequency and severity, presenting with visible cutting, bruises and burns. The nature of these injuries suggests that some might have been non-consensual and inflicted by another person, necessitating a strategy meeting to consider this possibility and recommend a child protection medical examination. This course of action was not

considered. While the difficulty in encouraging Jamilia to attend medical appointments is acknowledged, greater effort could have been made with support from health colleagues. The review highlights a lack of persistent curiosity regarding the 'self' harm, with minimal attempts to understand its underlying triggers. A deeper appreciation of Jamilia's past trauma could have fostered greater understanding, informed direct therapeutic work, and guided exploratory questioning.

8.24 Although self-harm does not inevitably lead to suicide, evidence indicates that around half of suicide cases involve a known mental health concern. Crucially, the child's care plan fails to reflect actions addressing her self-harm and emotional wellbeing. Given the complexities and challenges in working not just with multiple trauma and emotional needs but further complicated by cross borough working it suggests the potential to strengthen mental health pathways to aid the different agencies to feel confident in addressing mental health needs for children.

8.25 The local area Suicide & Self Harm Prevention Strategy is due for review and updating. The phrase ‘Suicide is everyone’s business’ aims to ensure everyone should feel they have the confidence and skills to play their part in preventing suicides and not just those who work in mental health and/or suicide prevention directly. Not all practitioners are aware of local resources and thresholds for accessing support, therefore this approach could form the necessary steps the partnership may take to upskill front line professionals and first line management in responding to self-harm. In addition, the Councils might consider the need to raise the profile of their resources and ensure easy access particularly to those professionals working across more than one borough.

Responding to the impact of domestic abuse

8.26 When considering domestic abuse, it is crucial to examine the family's collective experience, the influence of cultural factors, and the individual impact on each member. The mother's history as a child and adult victim of domestic abuse is a significant factor. This highlights the importance of understanding the long-term effects on her development and how the normalisation of this experience culturally shapes her support needs as a parent, and of other family members. This also supports the question of how permanency teams are able to hold a position of working with the family while supporting the child.

8.27 Statutory services first became involved following a serious domestic abuse incident, and the response at that time was thorough. Support to parents tends to reduce when children become looked after when it is beneficial to continue and promote

engagement.

8.28 Intersectionality offers a valuable framework for professionals to examine cultural dimensions and could have helped anticipate the increased risk of domestic abuse the family faced upon moving to the UK. Several factors contribute to this risk: the loss of community support and traditional systems, which heightens dependency on the abusive partner; distrust of authorities, stemming from experiences in a war-torn country, leading to reduced disclosure; and the compounding impact of isolation and the main earner being unable to work. This underscores the necessity for a more thorough understanding of these dynamics before families arrive in the UK.

How to mitigate narrowing of focus to a specific concern (tunnel vision), at the exclusion of a holistic understanding of a range of complex concerns.

8.29 It is a frequent worry that safeguarding children may only focus on the presenting crisis. There is evidence of this in respect of Jamilia. One aspect to consider would be the pros and cons of having the same social worker for both Jamilia and her sister. There were some benefits to having oversight of both siblings; - however, it was felt by most professionals that her sister presented with higher risks and therefore Jamilia's needs were overshadowed and seen as less concerning. There is no doubt that moving Jamilia at her request to be nearer family increased the risks of exploitation due to accessibility and influences from previous contacts, her sister and her network. Effective multi-agency risk assessment at this time may have provided a lens into the wider risks and pull factors and developed a plan to mitigate the risks.

8.30 Jamilia's comment that her social worker only saw her when there was a crisis is a reminder of the need to work holistically to address the multi-layer of need and not just those that are visible during incidents. A further factor may be the inherent difficulties of engaging with children, given the time required, who reside outside of their home local authority area.

8.31 Adherence to strategy meeting procedures was inconsistent. Specifically, meetings were not always timely, did not include all relevant professionals, failed to consistently assess the need for a medical, did not review a full chronology to consider cumulative harm, and overlooked the child's needs for support. Furthermore, when some professionals disagreed with meeting outcomes, these concerns were not raised at the time. All professionals attending strategy meetings must be confident and empowered to challenge decisions if they disagree with the proposed outcomes.

8.32 Focusing on the strategy meeting following the disclosure of historical sexual abuse it is notable that the professional who Jamilia disclosed to was not present. The omission of any health professional and specifically a paediatrician given the local area protocol is a concern. The outcomes evidenced a narrow focus on the police role and did not consider an updating assessment or child focused actions. The response to Jamilia's disclosure may have lacked robustness due to several concurrent and subsequent safeguarding concerns. Specifically, the case file reveals:

- A delay in sharing information following the disclosure.
- No evidence that Jamilia was aware of what would happen following her disclosure.
- A delayed strategy meeting.
- Police actions being taken prior to the strategy meeting.
- No consideration of the support Jamilia would likely require.

These issues highlight the need for a review of the processes for responding to disclosures of child sexual abuse.

8.33 There are various actions and activities that would mitigate the narrow focus. These include developing a more trusting working relationship, maintaining and using multi-agency chronologies, thorough reading of records, joint supervision, multi-agency mapping meetings, using tools such as the Risk Minimisation plan, Risk management plan (grab pack) which is currently being rolled out in the Return Interview Service, Think Space, and ensuring the child's plan is responding to the child's needs as they change. Strategy meetings should be considered by all agencies as a platform to share their own chronologies and information in order to inform decisions and develop actions with a focus on the child's needs.

Placements: including commissioning, matching, management of moves (within that: information sharing, risk assessment and care planning), what therapeutic placements can offer and how this can be optimised, and quality assurance.

8.34 There is a national picture of placements not being able to meet increasingly complex needs and this results in children being placed away from their home areas. This issue has been recognised by the local children's services who are working towards increasing their capacity to have more children living in the local area.

8.35 Focusing on the final home for Jamilia which was chosen from a choice of four options, primarily due to the provider's capacity to comply with a Deprivation of Liberty Safeguards Order (DoLs) and the presence of another child with some cultural matching. Given this was an emergency request, it was good practice there were

several choices sought. However, the provider and Children's Social Care Commissioning Team may not have had the same understanding as to what was meant by certain terminology. A limitation of the review is not being able to gain the views from this provider; however, a contractual specification of expectations and definitions is recommended from a commissioning perspective.

8.36 Furthermore, children with highly complex needs often require therapeutic placements and/or access to therapy. Therefore, it would be beneficial to introduce clinical oversight, which is not in place currently, to advise on the suitability of any placement and to provide a more robust clinical view on what the provider should offer a specific child.

8.37 Finally, the use of multi-agency risk assessments was not evident and should be essential when considering a move for a child.

How well do we listen to, and act upon, the wishes and feelings of young people particularly considering disclosure of child sexual abuse and how agencies respond; specifically considering what additionality or different needs being a child looked after brings.

8.38 The need to understand what children are telling professionals through their actions is highlighted through learning from case reviews The voice of the child: learning from case reviews. A trusted relationship between a child and a professional is essential to hearing, listening, observing, understanding and acting upon what a child is communicating. It will also help children to feel confident and reassured that anything they say will be responded to thoughtfully and that the necessary action will be taken. The review has identified Jamilia drew pictures with sexual content in 2022 that should have led to more curiosity - her 'voice' was not understood. The Child Safeguarding Practice Review Panel - I wanted them all to notice provides evidence of some of the challenges for practitioners which are pertinent to this review.

8.39 Jamilia's voice and wishes more recently shaped decisions regarding her care, with her desire to live closer to her family being the primary driver for her move nearer to her home borough. Although worries were raised about her move, things were predominantly going well for Jamilia, and it was ultimately agreed upon as a positive step. A key omission was the absence of a multi-agency risk assessment or safety planning to inform the move and mitigate risk; there was a risk assessment which informed the final move however it would be improved by multi-agency input. This is particularly pertinent for children whose life experiences and emotional needs make them more vulnerable to child exploitation.

8.40 Jamilia disclosed historical sexual abuse to a male youth worker. It is speculated that her willingness to disclose at that moment may have been due to her not perceiving his role as one of 'authority,' and she was not made aware that the disclosure would lead to further actions and police involvement. Significantly, the police interviewed Jamilia about her disclosure *before* the strategy meeting took place. During this meeting, Jamilia declined to speak further, stating she would 'no longer share anything'. This highlights a potential procedural failure and a need to ensure all professionals are reminded of what to do when a child discloses to them. Had the strategy meeting occurred first, the investigation would have been planned, taking into account the challenges posed by Jamilia's past experiences and determining the best approach for Jamilia's current needs, which may have resulted in a different outcome.

Online Harm

8.41 All children and young people are at risk of experiencing the negative effects of screen time on their mental health, physical health and educational outcomes. However, it is apparent that certain factors can make a child or young person more at risk of harmful effects than others. Barnardo's cited in a government document Screen time: impacts on education and wellbeing - Education Committee states that children in care are among the more vulnerable groups. These groups were more susceptible either because of their increased use of screens in comparison to other children, or because of their decreased ability to approach and interact with social media in a self-protective manner. This review has not found direct evidence linking screen time to Jamilia's mental health concerns however she was observed to use her phone constantly, she had more than one phone, she became reluctant to share her online communications and she used a variety of apps of which some it can be ascertained led her to being exploited. Children will benefit from practitioners being more professionally curious about how a child's phone use and online presence may link to their increasing vulnerability and exploitation.

9. Summary & Recommendations

The review concludes with recommendations which build on the recommendations and actions already identified for learning from the rapid review: online risk, responses to child sexual abuse with a clear pathway to support, promoting training for trauma informed practice, cultural competency, self-harm and suicide, and legal responses. In a number of areas, actions have already been taken to improve arrangements/systems.

9.1 The following additional recommendations are provided to ensure children's social care and its partner agencies are confident that any other areas are addressed and the partnership is able to monitor progress.

Culture, identity, intersectionality and past harm

9.2 Most partners demonstrated awareness of Jamilia's past trauma and provided good examples of practical support for her culture and identity. The next steps will be for practitioners to consider how they can maintain a cultural lens which delves further linking past experiences to current worries. While a variety of training events are accessible to all agencies, including the importance of language and cultural competency, the focus now needs to be on the impact on practice. Specifically, children's plans must clearly evidence multi-agency actions that are derived from comprehensive, culturally aware assessments and follow up actions from specialist reports.

- The partnership to consider a learning event which will focus on improving the multi-agency responsibility to develop cohesive and SMART plans.
- There is a need for practitioners to delve deeper to create a meaningful understanding that links past experiences and family culture to current concerns; this may be achieved through auditing the impact of training across the multi-agency network.
- Establish mechanisms to oversee the elimination of 'child-blaming' terminology across the multi-agency network but more specifically the police should provide evidence through audit of the effectiveness of police training initiatives to the partnership.
- The partnership should consider engaging with the resettlement team to review practice and develop future responses to the resettlement of refugees.
- Individual agencies should review their resources for practitioners to support them in working with trauma and ensure mental health professionals are more accessible for advice and guidance where self-harm is a concern.

Commissioning

9.3 The primary difference between a therapeutic placement and providing therapy lies in the environment and intensity of care, and a child may require both. Commissioners and providers will benefit from more detailed contracts that ensure a shared expectation between those involved. The commissioning process is being reviewed across the local children's services, adult social care and SEND to ensure a more joined-up, robust approach.

- The commissioning process needs clinical oversight regarding what a placement is offering, how it meets a child's specific therapeutic needs and this should be monitored throughout the time the child is placed there.

Engagement & Relationship Building

9.4 'Will not engage', 'does not engage', 'did not opt in', 'does not consent', and 'declined the support' are some of the phrases noted. It is vital for all professionals to recognise that it is their responsibility to engage with a child and/or their family knowing it is not an easy task, but it is necessary to be persistent, consistent, trustworthy and to seek out support from others if required.

Multi-agency practitioners need to be equipped with skills to effectively engage with children and their families.

- Renew focus on the basics of practice on which to build greater confidence and competence. This will include ensuring risk assessments are completed to inform safety plans at times of change for a child.
- One professional used a communication profile to good effect; children who are looked after will benefit from this being readily available to all who work directly with them.

Information Sharing and Communication

9.5 Strong multi-agency working and clear information sharing are fundamental to achieving effective outcomes for children, and this remains an area for continued improvement. While communication between the police forces was effective, social care and providers experienced difficulties engaging with the appropriate police force and securing the attendance of the officer with relevant knowledge at meetings, a difficulty also observed during the review process itself.

9.6 Cross borough working adds additional challenges in both securing the right support, maintaining birth family inclusion as well as sharing information. For children who are looked after it may be an opportunity for agencies to trigger multi-agency supervision as the platform to enhance working together.

- Agencies to consider how to improve consistency and information sharing when children are placed out of borough and when moving to different placements. As part of this, the local police should investigate the feasibility of establishing a dedicated single point of contact within the child's home borough.

- Access to reflective, multi-agency spaces would significantly support professionals in their practice. In addition, it is recommended that a specific threshold of case complexity be established to automatically initiate multi-agency supervision.

Working with Mental Health, Self harm and Suicide

9.7 Mental health concerns were identified, and consultations with partners from the Emotional Health Service and Child and Adolescent Mental Health Services (CAMHS) single point of contact took place but were limited. Thresholds may have been slightly confusing, and challenges arose when the family or Jamilia did not opt in, or when Jamilia relocated to a different borough. Despite Jamilia's self-harm being observed and discussed, it was not considered that it might be non-consensual or the escalation in harm recognised. This omission meant a more vigorous response, such as a strategy meeting and child protection medical, was not pursued. Where there is known self-harm, children we care for should have a clearly articulated self-harm prevention plan which takes account of emotional, behavioural and situational risks. This relies upon practitioners being fully informed and aware of the differing thresholds for gaining support from mental health services and knowing the referral pathways.

- The partnership to ensure the multi-agency practitioners are equipped to recognise and respond to self-harm and suicide with clear mental health thresholds and pathways developed and understood by all agencies. Key documents such as assessments and plans may benefit from having a standalone section to respond to self-harm.

Delays

9.8 There were many responses and processes that met the expected timescales; however, a few areas of improvement were noted regarding:- review assessments, out-of-borough health assessments, and actions following legal planning meetings. There is a collective responsibility to ensure timeliness and adherence to procedures.

- Multi-agency managers need to evidence proactive oversight, e.g. audits, supervision, review actions, performance reviews, to support practitioners to meet expected timescales and adherence to statutory processes

Closing Statement

9.9 The review highlights the considerable difficulties in understanding the realities of young people's lives and delivering timely, effective support. Adolescence is inherently challenging, yet this is profoundly compounded for those whose childhoods have involved significant trauma, loss, bereavement, abuse and exploitation. These complexities are further intensified for children from diverse cultural backgrounds who must simultaneously navigate discrimination, racism, and language barriers, all while striving for a sense of belonging, friendships, and pursuing independence.

9.10 All professionals involved in Jamilia's care and support undoubtedly strove to enhance her life and improve her safety. Nevertheless, areas for collective learning have been identified that can contribute to future improvements in practice.

9.11 The circumstances in which Jamilia died came as a shock to all who knew and worked with her and could not have been predicted. The immediate catalyst appeared to be an impulsive, acute emotional reaction when an older male delayed their meeting time. However, while the actions that ended her life could not have been predicted, the review strongly emphasises that there were escalating warning signs of exploitation and risk factors that were inadequately addressed.

9.12 There are several crucial areas for professional consideration. These include the necessity of understanding cultural influences, intersectionality, the cumulative effect of various risk factors, and the impact of multiple traumatic events. Furthermore, professionals must recognise and address the compounding effect of 'living losses' (such as parental separation, loss of friendships, or disrupted routines and relationships due to moving). Ultimately, the importance of fostering a sense of belonging through promoting trusted relationships and providing stable care is underlined to enable effective engagement and support to take place.

9.13 Emotional health worries were a consistent, underlying theme relating to Jamilia and her family and although recognised and supported to a basic level, they were not adequately explored to ensure appropriate support was provided with a long-term focus. It has to be noted that working across different boroughs causes additional challenges to providing consistent and robust emotional health support. It is important to note that a history of non-recent abuse, including childhood neglect and domestic abuse, is recognised as a risk factor for self-harm and suicide in young people (NSPCC 2024) Suicide: learning from case reviews