



## Child Safeguarding Practice Review (CSPR) Part Two

### Marie

Agreed by the Warwickshire Safeguarding Partnership on 22 April 2025

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### Introduction

1. In 2020 the Warwickshire Safeguarding Partnership undertook a Local Child Safeguarding Practice Review (CSPR) which considered two unrelated children who had been sexually abused by their unrelated carers while placed in Local Authority care. Learning was identified about the way that agencies work together to safeguard children who are living outside of their birth family. Due to a significant delay in the criminal proceedings in respect of one of the children, this review was not published. However, in 2025, after consultation with the National CSPR panel, a decision has been made to extract the learning in respect of Marie and her sibling and for this to be published alongside this review.
2. In 2023, a child who was considered in the 2020 review, then a young adult, died. An inquest found cause of death as drug related misadventure. It was known prior to her death that this child, to be referred to as Marie, had been misusing cocaine and alcohol, that she had been suffering from seizures, and that she had fluctuating mental health difficulties. When considering her life experience from 2020, the ongoing impact of the many years of sexual abuse she suffered from her previous foster carer is clear.
3. It was recognised that learning was likely to be identified about the support the young person received as a child in care, as a care leaver and as a victim of sexual abuse. Marie received a large compensation payment when she was aged 18, so there has also been a focus on how she was supported with managing this money. It is now known that she spent over £100,000 in the seven months before she died.

### Process

4. The independent lead reviewer<sup>1</sup> who completed the original CSPR was commissioned to work alongside a panel of local professionals to undertake this further review. The detailed information provided to a rapid review meeting<sup>2</sup> held following Marie's death was considered.
5. Meetings were held with the professionals who worked with Marie. Some in a face-to-face event, with others who could not make the event spoken to individually.
6. The lead reviewer and a representative of the Partnership Business Unit met with Marie's Mother, sister, and with her Staying Put carer. She will be referred to in this report as 'foster mum', as this is what

<sup>1</sup> Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the WSP

<sup>2</sup> The Rapid Review was held under safeguarding adult procedures. As Child 2 was recent care leaver, it was agreed that it was more appropriate to undertake a CSPR than a Safeguarding Adult Review under the Care Act 2014.

Marie called her. They had hoped to meet with Marie's sibling. This was not possible, but they will be informed about the learning from this review and the original CSPR.

7. The lead reviewer met with Marie in 2021 as part of the previous CSPR.

### **Marie**

8. Marie had been in the care of Warwickshire County Council from a young age, having experienced significant neglect. She had several different placements, including an adoption placement that broke down. In 2020 it emerged that one of the foster carers she was living with was sexually abusing her. He has since received a long custodial sentence, including for his abuse of other children who had been in his care.
9. Marie moved to live with a new foster carer, who then became her Staying Put carer when she reached 18 years old in 2023. Part 5 of the Children and Families Act 2014, states that local authorities are required to facilitate, monitor and support 'staying put' arrangements for fostered young people until they reach the age of 21, where this is what they and their foster carers want. Marie had largely done well in placement. Her foster mum was known to have a genuine affection for Marie and was committed to providing her with a home and supporting her in adulthood.
10. In the months prior to her death, there were concerns about Marie's mental and physical health, and her misuse of drugs and alcohol. The Staying Put arrangement was increasingly vulnerable to breakdown. There were also concerns that Marie was being exploited by some of those close to her due to the amount of money she had received as compensation.
11. Marie's mother and sister spoke to the review about Marie, describing her as beautiful and a 'real firecracker'. She was also a bubbly and clever girl who loved to help others, but they said she was really struggling during the last year of her life. While Marie masked it as best she could, they knew she was lost and unhappy, and that a lot more was going on for her than they knew about at the time.
12. The professionals who knew Marie described her as friendly, open, and with a good sense of humour. The lead reviewer met her in October 2021, while undertaking the initial CSPR, and found her articulate, engaged, thoughtful and passionate about improving professional practice and support to children in care.
13. On her 18<sup>th</sup> birthday, Marie was aware that she was now an adult and of the responsibilities of this. She was reportedly adamant that turning 18 would be liberating for her. Her foster mum said she called it her 'Freedom Day'. Marie had little faith in most of the professionals who had worked with her previously, which led to her increasing avoidance of them. She was desperate to have a home of her own and to have the unconditional love of her own baby. She had started a course to become a nursery worker but gave this up to work in the hospitality sector. However, as her substance misuse increased, she worked less and spent less time at home and with her foster mum. In the last months of her life she had increasing health issues, including weight loss, insomnia, hallucinations, and depression.

### **Learning and analysis**

14. The areas of learning are identified below, followed by analysis, with additional specific learning points highlighted in each section.

#### Learning area 1: The particular vulnerabilities of care leavers

15. Marie was vulnerable due to her life experiences, both prior to coming into care and when in care. For any child it is a significant change when they reach 18 years old and legally become an adult. For a child in care, it is exceptionally significant, as they are no longer officially looked after by the Local Authority with a corporate parent. This can lead to uncertainty about their future, a change of where they live, and a decline in the support they receive. Legislation, procedures and systems for care leavers recognise this. Allowing these young people to Stay Put is positive and was used with Marie. She was able to remain with her foster mum, which was her wish and was an appropriate for her needs. In many ways, despite her age, Marie remained a traumatised child who had been failed and had to battle to get her needs met. Living independently at age 18 would not have been appropriate.

16. In Warwickshire, like in most local authorities, there is a specialist team in children's social care (CSC) that works with care leavers<sup>3</sup>. Marie was transferred to that team around four months before her 18th birthday. Initially she had a social worker in the team, then at 18 she was allocated to a personal advisor (PA). This is standard practice in the team, and there was a good handover of information and informal meetings were held with Marie and her foster mum at the time. Having an allocated PA is a choice for young people, and Marie agreed to this. The adjustment from being a child in care to being a care leaver was a new concept and was an adjustment for both Marie and her foster mum, who told the review that there is currently no programme of ongoing training for Staying Put carers like that available to foster carers. Marie and her foster mum agreed that there were benefits to having a PA, and that there would be more autonomy and less rigidity in a Staying Put placement than there had been in foster care.
17. Marie reportedly liked her allocated PA, which helped. Marie had not always liked her social workers and struggled with the number of times she had been transferred between workers, not feeling that she was able to build a meaningful relationship with any of them. She also felt let down by some poor practice and lack of communication. When Marie met the lead reviewer as part of the original CSPR, she said "how can I express myself when I don't know the social worker and there's no trust built up. I have had so many different social workers and they didn't have a clue what was happening". As a child who felt, rightly, that she had been let down by the local authority, she was upset, as was her foster mum, that stability of worker does not appear to have been prioritised for Marie following the sexual abuse, and that there was often little response to communication and requests for advice or support. Marie's foster mum told this review that she had to complain on occasion about practice with Marie prior to the transfer to the leaving care team. While Marie received financial compensation, she did not receive a service which made her feel compensated in any way.
18. Later, the leaving care team recognised the need for trauma informed practice with Marie. There was also an awareness of this from the child in care nursing team and from the medical staff who responded to Marie's seizures, realising they could be due to stress and trauma. While some children have good experiences in care and positive outcomes, for many their previous experiences and the challenge of being in care can lead to poor outcomes and increased vulnerabilities. Care experienced young people are more likely to be not in education, employment or training, to be homeless, to be known to the criminal justice system, to be a young parent, to have mental health issues, and to take their own life, for example.<sup>4</sup> The impact can be short, medium or long-term. Recognition of the impact of the trauma she experienced generally and then the serious abuse from a foster carer on her physical and mental health, was important for Marie.
19. The misuse of cocaine can trigger seizures, at the time of use or up to hours after it is taken. The Epilepsy Foundation UK states<sup>5</sup> that 'seizures caused by cocaine are uniquely dangerous and may be associated with heart attacks, disrupting the heart's normal rhythm (cardiac arrhythmia) and death.' Marie's Mother contacted the leaving care team following her first seizure in September 2023 and shared her concern about her daughter's drug use. She said that Marie had told a family member that she was spending £500 a time on cocaine, and that she had used cocaine again immediately following her discharge from hospital. Marie was spoken to but refused a referral to drug services and downplayed the issues.
20. Seizures that are not due to epilepsy may also have a psychological cause. They are called 'functional seizures' and are a severe stress response. Awareness of Marie's history recognised that this was a real possibility in her case. Marie was seen at the First Fit Clinic in November 2023, following a referral following an A&E attendance. They recorded their impression that the fits were non-epileptic and may be related to post traumatic stress. She was told to avoid the use of 'recreational drugs' and they planned to follow up in three to four months. It does not appear that they were made aware of the information shared by Marie's mother in the September about her significant cocaine misuse. Ensuring that young people are aware of the health dangers of any substances is crucial, along with encouragement to accept support and access to a timely and appropriate service.

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<sup>3</sup> <https://www.warwickshire.gov.uk/leavingcare>

<sup>4</sup> <https://www.nuffieldfoundation.org/wp-content/uploads/2021/10/The-lifelong-health-and-well-being-of-care-leavers.-Nuffield-Foundation-and-UCL-policy-briefing.-Oct-2021.pdf>

<sup>5</sup> <https://www.epilepsy.com/what-is-epilepsy/seizure-triggers/drug-abuse>

21. There is a need for good quality and timely planning for a child's 18<sup>th</sup> birthday and them leaving care. At the time of this change, Marie was relatively stable. She had a job, a boyfriend of a similar age who had a supportive family, and the plan for her to Stay Put and be supported by her foster mum was a good one. There were some gaps in the planning for 18+ however. Marie's last child in care medical with the nurse who she knew well did not happen. The CSPR was told that Marie's child in care team social worker had spoken to her about the need for a medical, but she said she did not want one. This was accepted, after reminding Marie that she would be eligible for the £10 incentive offered to children in care. The review believes that even if a child does not wish to have a medical, the request should still be made to the child in care nurses, who will then contact the child to speak to them about their concerns and try to encourage them to go ahead. The last child in care medical is an important time to discuss transition into adult health services with a child in care, as there is no statutory health service for care leavers. The review was told that it is hoped that leaving care nurses can be appointed to ensure better support to care leavers, and a recommendation has been made to support this.
22. Marie was thought to use drugs and alcohol to self-medicate, as the trauma she had experienced was significant. It is now known that her drug and alcohol use spiralled in her last months, and she was using a significant amount of cocaine and spending large amounts of money to purchase this before her death.
23. Marie also very clearly voiced her desire to become pregnant. It is thought that her mental health was impacted by her previous miscarriages. The fostering social worker who knew Marie well stated at the time that consideration needed to be given to referring her to a gynaecologist, as a reassurance about her reproductive health. Because of Marie's experience of sexual abuse, those with responsibility felt this would be too difficult for her. Her foster mum believes that seeing a gynaecologist would have been reassuring, as Marie was worried about the sexual abuse harming her physically.
24. There were also concerns about Marie's intimate relationships. One of her later partners was known to MARAC and was not allowed contact with his own child. This concerned those involved with Marie, and learning has been identified about the need to empower vulnerable young people about their right to request the disclosure of domestic abuse information about a partner. There is no evidence that helping Marie to access Clare's Law<sup>6</sup> was considered or happened. It later emerged that this partner had been physically violent on at least one occasion, but that Marie had not disclosed this to her foster mum or professionals at the time. The impact of a domestically abusive relationship would have added to Marie's trauma and exacerbated her mental health issues. A recommendation has been made.

Learning area 2: The benefits of multiagency information sharing and meetings when there are concerns about a care leaver.

25. When a child is in care, regular meetings are held that include the agencies involved. Such as those that consider the child's care plan, those that respond to any concerns, such as when there is a risk of placement or education breakdown, those held when a child is reported missing, or when there is a child protection concern. Post-18, these multi-agency meetings do not tend to happen. Those involved with Marie can see that a multi-agency meeting to discuss her mental health and the increase in concerns about her seizures would have been a good way to share information and make a plan to assess and support Marie, including with her substance misuse.
26. There are clear benefits of a multi-agency response to concerns about a care leaver. It is difficult for those working in social care to understand and recognise the significance of a health or mental health concern without advice and support from health professionals. Many CSPRs have identified the need for health professionals to provide clarifying information to non-health staff. About both physical and mental health matters. Holding a multi-agency meeting to share information, expertise and to reflect together on a child's situation is extremely helpful and can lead to more impactful and focused support. This review has found this would have been beneficial in the last months of Marie's life. It is acknowledged that consent from the young person would have been required, and it cannot be said whether this would have been given. If a worker she trusted, such as her PA, had pointed out the benefits to Marie, it is possible she would have agreed.

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<sup>6</sup> <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet>

27. Children approaching their 18<sup>th</sup> birthday will almost always have a last All About Me meeting (Child in Care Review) chaired by their independent reviewing officer (IRO) where their Pathway Plan is reviewed. This happened for Marie. The IRO allocated to Marie's prior to her 18<sup>th</sup> birthday knew her well. This CSRP has seen documents recorded by the IRO at the time, where concerns about children's services support of Marie in her last year as a child in care were noted. The IROs work to a system where they rate the care / pathways plans for a child using a traffic light RAG system. The review held around five months before her 18<sup>th</sup> birthday was rated as 'amber', due to concerns including statutory visits not being undertaken in time, reports for the reviews not being completed, and other outstanding social work tasks. When an 'amber' rating is made, this is copied to the operational manager for children in care. In Marie's case, the operational manager replied to the IRO recognising that there had been poor practice and outlining the plan to address the issues. It is not known if Marie (or her foster mum) was informed of the response and plan to address the issues that they had raised in her Child in Care review. IROs should always update older children on any actions they have taken about concerns shared during a review.
28. Rather than a review of their care plan, older children in care have a Pathway Plan that is drawn up with the young person's social worker and/or personal advisor from the age of 16 years. In Warwickshire there is a commitment to assigning a PA from just before the child's 17<sup>th</sup> birthday, to support with the pathway planning and to provide some consistency for the young person when they reach age 18. Pathway Plans set goals and make a plan for how they will be achieved. There are sections in the plan to cover accommodation, health<sup>7</sup>, education/training/employment, contact with family, and financial management. The plan is reviewed every six months. In some local authorities these reviews are chaired by IROs, who provide expertise, independence and quality assure care plans. In Warwickshire the review is undertaken by a senior social worker in the LCT but who is independent from the social worker, the PA, and their line manager. This model is in place until the care leaver is aged 25 years and can be RAG rated as with care plans for children in care. The review was told that this has been considered by Ofsted as good practice.
29. The social worker from the fostering team who supported Marie's carer (to be referred to as the fostering social worker) when Marie was in foster care, had less of a role when the placement changed to a Staying Put arrangement. The fostering social worker told the review that there is a clear drop in information sharing, invitations to meetings, and general involvement of the fostering social worker when a foster carer becomes a Staying Put carer. The fostering social worker had known Marie for over three years. She told the review that over the same timeframe Marie herself had around five different allocated social workers. This consistency enabled Marie to build a strong relationship with the Fostering social worker. This was largely unavailable to her from her 18<sup>th</sup> birthday. The fostering social worker stated that she had been able to advocate for Marie as well as for the carer during and between the All About Me reviews (child in care statutory reviews.) However, fostering social workers for Staying Put carers are not invited to Pathway Plan reviews following the 18<sup>th</sup> birthday.
30. The benefits of the involvement of the fostering social worker are not always acknowledged, but there is some evidence that they tend to know the children well, that they tend to stay in role longer than social workers for children do, and that children can see them as less formal than their own social workers. If a care leaver is staying with a foster carer into adulthood, their fostering social worker needs to be a key part of the plan for the care leaver and good information sharing is essential.
31. However, it is acknowledged that while fostering social workers are a key support to carers, the fostering social work service is part of the local authority. The fostering social worker helpfully reflected that when a child discloses serious abuse in the care system, and their new foster carer is their main and immediate support. This understandably can have an impact on the relationship between the carer and any representatives of the local authority. It is good practice to consider the therapeutic needs of the carers who are having to care for children who are severely traumatised, which should be provided independently of the Local Authority. While there is a need to consider how foster carers are better supported when they become Staying Put carers, there is also a need for the system around these young people to acknowledge their status and particular needs.

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<sup>7</sup> Including emotional, mental and physical health and their more general well-being. Statutory guidance 2018

32. It is also important that other agencies outside of the Local Authority to recognise and support care leavers, as they do for children in care. Professionals in CSC need to seek and receive support from health colleagues when there are concerns about a care leaver's mental or physical health. There is also a need for health colleagues and other professionals to recognise that when a young person is a care leaver, they are likely to have an allocated worker in CSC and to be more vulnerable than their typical peers. In February 2018 the Department for Education (DfE) published statutory guidance titled Applying Corporate Parenting Principles to looked-after children and care leavers<sup>8</sup>. The guidance is predominantly for local authorities<sup>9</sup> but recognises that 'relevant partners'<sup>10</sup> also have responsibilities to contribute to services provided to looked-after children and care leavers.<sup>10</sup>
33. The Corporate Parenting guidance is significant as it clarifies that the responsibility for children in care extends beyond their 18<sup>th</sup> birthday. All professionals across agencies need to be aware of this. Other agencies play an important role in supporting the Local Authority in carrying out their responsibilities to be a good corporate parent, including to care leavers, and there is a clear expectation that a joined-up approach is promoted and occurs. The DfE has introduced a care leaver covenant to ensure that all partners 'make commitments to care leavers within the spirit of the corporate parenting principles in a way that is most appropriate to them.' This covenant is established and signed up to in Warwickshire, but the review questioned how widely known this is to front line workers and care leavers themselves, and whether there is a need to ensure that it is shared and that it makes a pragmatic difference to young people.

### Learning area 3: The need for timely and responsive mental health assessment and support to care leavers in crisis

34. When considering Marie's lived experience from her 18<sup>th</sup> birthday until her death shortly after her 19<sup>th</sup> birthday, her vulnerability and the impact of the trauma she suffered is starkly apparent, as was her need for ongoing and timely support. In April 2023, Marie told her foster mum, her PA from the LCT and her GP (an appointment was made by the PA, and she accompanied Marie) that she was feeling suicidal. She was prescribed medication and was referred to a community mental health service for an assessment and support. The GP surgery and the LCT were regularly in touch with Marie to support her and they, along with her foster mum, encouraged her to cooperate with appointments. Marie shared that she was drinking and using cannabis at the time but refused a referral to drug and alcohol services and was reluctant to engage with a therapeutic service that required her to consider her past trauma. This is not unusual for traumatised young people as they reach adulthood.
35. In the months that followed, there were concerns that Marie was 'increasingly erratic' and she had her first known seizure in September 2023. Her PA was proactive in trying to get her appropriate mental health support. Marie had been discharged recently from community mental health services, as she had reportedly been feeling better. However, the foster mum told the review that she had been discharged for missing appointments and was not actually feeling better. This escalation of concern required a speedy reassessment and plan for support. The PA shared that Marie had a diagnosis of anxiety and complex PTSD, but that she was now having hallucinations, seizures and was again expressing suicidal ideation. There were further concerns about her losing weight, a potential eating disorder, and her increasing substance misuse. The PA requested support from adult services and an appointment with a mental health worker was offered. The PA tried to ensure Marie's attendance, but this was difficult due to her regularly not being available.
36. Two weeks before she died, Marie took an intentional overdose of paracetamol, ibuprofen and cocaine. She was seen and assessed by the acute mental health team. She admitted to alcohol and using 'weed' but did not disclose her use of cocaine or her recent seizures. It was recorded that she presented as insightful, and no evidence of acute mental illness was identified. Marie told the team that she did not

<sup>8</sup>[https://assets.publishing.service.gov.uk/media/5a93eb3ae5274a5b87c2fde4/Applying\\_corporate\\_parenting\\_principles\\_to\\_looked-after\\_children\\_and\\_care\\_leavers.pdf](https://assets.publishing.service.gov.uk/media/5a93eb3ae5274a5b87c2fde4/Applying_corporate_parenting_principles_to_looked-after_children_and_care_leavers.pdf)

<sup>9</sup> Not just those working in social care – all parts of a Local Authority have a responsibility.

<sup>10</sup> 'Relevant partners' include local policing bodies and Chief Officers of Police, local probation boards and probation services, youth offending teams, clinical commissioning groups, NHS England, schools and educational institutions. County councils should also work with their district councils, who need to act in accordance with the corporate parenting principles.

require any professional intervention, and this was accepted. There was no role identified at the assessment for any referral on for mental health support, and no follow-up appointment was offered. It does not appear that the assessment took into consideration her vulnerability as a care leaver, the wider mental health concerns, including those shared by her PA from September, her physical health presentations (including seizures) or her increasing use of cocaine. This assessment was undertaken in isolation. If there had been a follow up appointment a week later, it would have enabled Marie to reflect on her needs and have given the mental health service the opportunity to seek more information about her. This could also have led to a multiagency response to her wider needs.

37. A 2021 policy briefing on 'the lifelong health and well-being of care leavers'<sup>11</sup> proposes regular 'mental health MOTs' for care leavers throughout their adult lives. They envisage that this would be similar to the NHS Health Check scheme and could help ensure care leavers' mental health needs are recognised and that they are then fast-tracked to receive appropriate support. While Marie's needs required more than this, but the need to fast track her for assessments and support is relevant. **All care leavers need support and understanding across agencies and for their status to be seen as an additional vulnerability.**

#### Learning area 4: Using processes for considering frequent users of health services

38. Marie was a frequent user of GP services. Between her 18<sup>th</sup> birthday and her death just after her 19<sup>th</sup> birthday, she had contact with her GP surgery at least 30 times. She was also seen in hospital on ten occasions in the year between her 18<sup>th</sup> birthday and her death. Eight of the attendances were at one hospital, two at another. The attendances were for various issues but included four attendances for seizures and one for an intentional overdose. The review has noted that **while professionals working in A&E would have a good awareness of the additional vulnerabilities of a care experienced young person, they would largely be relying on the young person self-reporting as they do not have any 'flags' to identify anyone 18+ as a care leaver.** It is recognised that this is sensitive issue for care leavers, and a recommendation has been made.
39. The GP surgery knew Marie well and there is evidence of conversations with the PA regarding concerns and to share information. However, with the number of health providers being accessed by Marie, there was **a need for coordination of health tests and medication.** It is noted that Marie was on a large amount of prescribed medication for a young person of her age. There is a process for High Frequency Users (HFU) to hospitals, including A&E departments, that may have been of benefit to Marie. As it could be to other care leavers. In 2022 NHS England published a guidance note for supporting High Frequency Users (HFU) which set out 'the principles and recommended approach for offering proactive, personalised care for those at higher risk of hospital admissions due to psychosocial needs, as part of a broader strategy to tackle winter pressures and reduce unplanned admissions. These are patients who use services more frequently than usual, including A&E attendances or unplanned hospital admissions and may be identified as being vulnerable, where lifestyle, behavioural or social risk factors are impacting on primary and secondary care service usage.' There is a need for care leavers to be recognised as particularly vulnerable within this approach. **When the patient is a care leaver, there is a need to consider information sharing and a multi-agency response.**
40. Marie was regularly in touch with the leaving care team. She knew how to contact them and did so when she felt she needed a response. The team felt that her engagement was good, both face to face and on the telephone. She was nearly always friendly and polite. It was recognised that the part-time PA required support in providing a responsive service to Marie, so a decision was made to co-work the case between two PAs. Marie's foster mum told the review that this plan had not been popular with Marie, and that she required reassurance that the new worker would only become involved if the original PA was not available.

#### Learning area 5: Supporting a care leaver with managing large sums of money.

41. Following her prolonged sexual abuse from her then foster carer, Marie made an application for compensation from the Local Authority and received a significant amount of money following her 18<sup>th</sup> birthday. Concerns later began to emerge, around 6 months after she received the payment, about how

<sup>11</sup> <https://www.nuffieldfoundation.org/wp-content/uploads/2021/10/The-lifelong-health-and-well-being-of-care-leavers.-Nuffield-Foundation-and-UCL-policy-briefing.-Oct-2021.pdf>

much money she was spending, including fears about substance misuse. After her death, her foster mum told the police that the money had been 'a curse', with Marie spending frivolously on taxis, nights out, takeaways, alcohol and an increasingly uncontrollable cocaine habit. A victim of a sexual offense can feel that any money provided as compensation can feel tainted and 'dirty' bringing additional stress and mixed feelings<sup>12</sup>. This appears to have been the case for Marie. Her mother told the review that the money was not positive for Marie. **When a child or care leaver receives compensation following sexual abuse or exploitation, there is a need to consider if a therapeutic intervention is required in respect of the psychological impact of this.**

42. Prior to the claim being settled and paid, both Marie and the Local Authority had separate independent legal advice. Marie had a psychological assessment that established she had capacity. As an adult, with capacity, the court (and/or the local authority) had no powers to state how the money should be invested or spent. The review reflected that while Marie had capacity at the time of the payment, the significant abuse which led to the compensation impacted on her emotional vulnerability and is very likely to have led to her making unwise and sometimes unsafe decisions. It has been very hard for those involved at the time and during this CSPR to accept that consideration of a young person's capacity is not issue specific.
43. There was evidence that Marie was advised both legally and financially in respect of the payment at the time it was made. It cannot be said what the legal advice was from her own solicitors, as this is legally privileged and confidential. The advice given was that it should be held in a trust. It is known that her foster mum, and those working with her from the LCT, were persistently trying to engage with Marie about this, and about better managing her money and planning for her future. Much of the advice and support offered was declined. As she was an 18-year deemed as having capacity, those working with Marie reported that they felt there was little they could do, other than to offer advice.
44. Her family told the review that it was their belief that her capacity fluctuated and that she was largely unable to manage the money. This was based on common sense rather than a legal understanding of what capacity means. Professionals involved at the time did not think that it warranted a further capacity assessment or the involvement of the court of protection. It was acknowledged that Marie needed to invest her money in a way that would ensure she was able to claim support such as housing benefit, if required. While she was settled with her foster mum at the time of the pay out, contingency planning was necessary in respect of future accommodation needs. **Consideration should always be given to money being held in a Compensation Protection Trust, so it does not impact on eligibility for benefits.**
45. Marie had no will when she died. The review has found that **any young person in the care of the Local Authority or receiving support as a care leaver, and who has received any significant financial gain, should receive support to make a will**, so that they can think about who should benefit if anything happens to them, what their wishes are, and who should be executor of their affairs.
46. In September 2023, adult social care contacted the LCT about an anonymous<sup>13</sup> referral received, sharing concerns about Marie's wellbeing. There was a systems issue as the IT system record for Marie was restricted (probably due to the on-going CSPR) and the WCC Customer Service Centre could not see that Marie was allocated to the LCT. This information was available to adult safeguarding however, and they quickly forwarded the information to the allocated PA. The concerns shared included Marie not eating or sleeping, using cocaine, not often staying with her Staying Put carer, and being financially exploited. There was no consideration at the time of whether this later concern was an adult safeguarding issue, and the matter was dealt with by the LCT.
47. Financial abuse<sup>14</sup> is a safeguarding issue. It can have a serious impact on a person's overall wellbeing, physical and mental health, as well as on their financial security. It can span all age groups and circumstances. Like with all adult safeguarding issues, taking action largely applies to those with recognised care and support needs. While it is not clear that the concerns about Marie would have met

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<sup>12</sup> The Independent Inquiry into Child Sexual Abuse published October 2022.

<sup>13</sup> The referrer was a friend who wanted to remain anonymous but gave her name and contact details when speaking to the WCC customer service centre.

<sup>14</sup> Financial abuse is detailed within Section 42 (3) of the Care Act 2014 and the Care and Support Statutory Guidance.

the criteria for an adult safeguarding response, it would have been helpful for there to be a discussion between the LCT and the adult safeguarding service about this. Professionals working with care leavers need to work across both children and adult services. They must take advice and seek support from the Local Authority adult safeguarding team when there may be a safeguarding risk to a young person over 18 years of age.

Learning area 6: The importance of saying 'sorry' and showing, through actions, that amends are being made

48. For young people who have been let down within the care system, and who have been abused when they should have been protected and cared for, there is a need for a sincere and meaningful apology. The victims and survivors interviewed in the Independent Inquiry into Child Sexual Abuse, published in 2022, were quoted in the Accountability and Reparations Investigation Report<sup>15</sup>. They repeatedly emphasised the importance of receiving genuine and meaningful apologies from the institutions they saw as responsible for their abuse.
49. Also required is a determination from partner agencies that for the remainder of that child's time in care there will be consistent and good quality support from the agencies involved. When that child is the subject of a CSPR, there is a need for managers to have a role in overseeing their care, to ensure that it is effective and that any issues are dealt with quickly and sensitively to minimise ongoing trauma. When the lead reviewer met with Marie in 2021 it was clear that she felt ongoing disappointment about the response to her from the services involved. Both Marie and her foster mum had made several complaints but did not feel that they were being addressed adequately. What they shared led the representative of the safeguarding partnership in attendance raising concerns with children's services. Her foster mum told this review that Marie was sad because she felt that she never received an apology. Her consistent feeling, according to her foster mum, was that no one who worked with her or who was responsible for her, cared about her. It does not appear, to this review, that there was a real acknowledgement (other than financial compensation) that Marie had been failed by the system. Marie's foster mum provided a statement to this review. Her powerful words have been considered throughout the review and have been shared with the senior partners, as have Marie's words that shared with the review.
50. The lead reviewer and the partnership have acknowledged learning about the way that the first part of the CSPR was managed. Publication has been significantly delayed as there was a wish for the CSPR to remain as a thematic review when published. Although the CSPR in relation to Marie was completed and signed off in 2021, the action plan was completed, and the learning widely disseminated, significant (and ongoing) delays in the criminal processes for the abuse suffered by the other child considered means that it was not published. To Marie this was a further frustration and understandably led to more feelings of being let down. Consideration should have been given to splitting the report and publishing the extensive learning identified about services received by Marie and her sibling, which would have included her being seen and the findings of the review being explained. It is a significant and heartfelt regret of the Partnership Business Unit and the lead reviewer that this did not happen before her death. The Partnership Business Unit acknowledges the need to review their plans for publishing CSPRs and for informing children and/or families of the learning identified when any delay is expected. A recommendation has been made.

## **Conclusion and recommendations**

51. From the age of nine to fifteen years, Marie was groomed and sexually abused by one of her foster carers. The original CSPR found significant learning for the system about how perpetrators groom and manipulate children and professionals. Marie was abused by someone who should have cared for and nurtured her, and this further CSPR has identified additional learning about the care and support provided to Marie after her abuse was identified. Marie's need for exceptional compensatory care and support with her many needs was only partially met in the years since 2020. Due to resource issues, including recruitment and retention difficulties in children's services, Marie did not always receive the quality of care that she required. She was in a placement with a supportive carer, but she required more. There is a

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<sup>15</sup> <https://www.iicsa.org.uk/reports-recommendations/publications/investigation/accountability-reparations/part-c-civil-justice-system/c11-apologies-explanations-and-assurances.html>

wider issue for society about children who reach adulthood without the care and support of a stable family to allow them to move into independence gradually with the safety net of unconditional family support should they require it. Without a shift in culture and a significant amount of joined up and committed resources, care leavers will often struggle to thrive as adults.

52. The death of Marie has been devastating to all who knew and loved her. Her mother and sister shared their memories and photographs of Marie with the review and stated their wish that lessons will be learned so that other children do not have to face what happened to Marie. There was a significant commitment to Marie from her foster mum, despite the difficulties and problems in their relationship in the last months. Her input to this review has been appreciated. Along with Marie's PA, the family and the foster mum have provided Marie's views and voice to the review. Her views were also shared with the lead reviewer as part of the original CSPR.
53. Single agency learning has been identified about the need to seek, consider and record the young person's voice, the need for holistic consideration about a child with physical health issues, the need to ensure a timely mental health response at a reachable moment (in other words as soon as possible when the young person agrees), and the long-term impact of child sexual abuse. Learning has also been identified about the CSPR process when there is a need to delay publication and how this is managed with children and their families and carers.
54. In addition to the completed recommendations made in the original CSPR, the following recommendations are made here:

#### **Recommendation 1**

On behalf of the partner agencies, the lead reviewer and the CSPR panel, WSCP are to publish a posthumous apology to Marie alongside publication of this report.

#### **Recommendation 2**

WSCP recommends all partners to implement a policy in cases where a person in a position of trust is convicted of abusing a child in care. The relevant policy should consider the following:

- Apologising directly to the child both in writing and in person to acknowledge the harm caused.
- Providing a compensatory service to the child, overseen by a senior manager to ensure the service is of quality and accountability

#### **Recommendation 3**

That the relevant government departments are contacted about the need for a review of the legislation in respect of vulnerable young people, including care leavers, when they require support in managing a significant financial gain (for example compensation, lottery wins and inheritance gain) to reduce the risk of financial exploitation. The legislation review is requested to consider both the resources to support young people to manage their significant financial gain and the age at which young people with capacity can receive and manage a substantial financial gain.

#### **Recommendation 4**

The Partnership to seek assurance that Children's Services staff with responsibility for care leavers are equipped with the following:

**Training & Development:**

- To enable staff to have the knowledge, skills and confidence to identify when a discussion with or referral to adult safeguarding is required to make a timely and appropriate referral.
- Ensure staff are confident in providing support to those care leavers who have received a financial gain, to make a will, get ongoing independent financial advice, and consider using an advocacy service to enable care leavers to manage their finances responsibly and have access to necessary legal and financial support.

**Awareness Raising of Clare's Law:**

- Ensure staff are briefed about advising the use of Clare's Law when young people enter a new relationship and there are any concerns about the potential for domestic abuse. This is to enable young people to make safer choices in relationships.

**Children in Care Medicals**

- Ensure staff consistently refer to the child in care nurses if a child under 18 refuses a medical, to enable the nurse to speak directly with them.

### **Recommendation 5**

The Partnership to seek assurance in writing from Children's Services to confirm that staff with responsibility for foster carers/Staying Put carers:

- Provide comprehensive training and support for Staying Put carers so they are well prepared and supported in their role in providing quality care for children and young people who have experienced trauma.
- Actively promoting the availability of independent therapeutic support for foster carers/Staying Put carers who are caring for children who have experienced significant trauma to improve the wellbeing of carers and children.

### **Recommendation 6**

To ensure ongoing support for care leavers beyond their 18th birthday, both the WSCP and WSAB to:

- Publish a joint statement affirming the commitment of all partner agencies to continue prioritising and supporting children in care into adulthood, reinforcing the role as corporate parent after the age of 18.
- Organise a multi-agency event within 12 months of publication that focuses on the vulnerabilities of care leavers, involving participation of care leavers to increase awareness and collaboration amongst partner agencies leading to better support for young people leaving care.

### **Recommendation 7**

The Integrated Care Board to confirm in writing to the WSCP, an update confirming the plans of implementation for the leaving care nurses. The aim of this is to ensure parity in service offered to children who are currently in care.

### **Recommendation 8**

Coventry & Warwickshire Partnership NHS Trust to write to the WSCP confirming the offer of a targeted and fast track service for care leavers aged 18-25 who require a mental health service.

### **Recommendation 9**

The WSCP Business Unit to review their CSPR processes to ensure that publication is undertaken promptly following the completion of a review. If this is not possible, the children and families/carers must be informed of the learning and actions being taken prior to publication and kept regularly updated on the progress of the review.

## **Recommendation 10**

To ensure timely and enhanced service for care leavers up to the age of 25:

- The WSCP to request that Children's Services, Adult Social Care & Support, Coventry & Warwickshire Partnership NHS Trust, South Warwickshire NHS Foundation Trust, alongside the Children in Care Council, collaborate to develop and implement practical strategies that will help to identify care leavers up to the age of 25 with the aim to receive a timely service that will help to support their needs.
- Prior to publication, the WSCP will write to the national CSPR panel to raise this issue to encourage broader consideration and action on this matter. This is with the aim to raise national awareness and potential policy changes to better support care leavers.