KNOWSLEY SAFEGUARDING CHILDREN BOARD

CHILD Q & S SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

The Knowsley Safeguarding Children Board (KSCB) has published the independent serious case review concerning two looked after children who were victims of child sexual exploitation.

These cases are independent from each other; however the decision was made by the board to merge the cases into one serious case review in order to increase the learning opportunities in respect of child sexual exploitation (CSE).

AGENCY INVOLVEMENT

The review identified numerous contacts with agencies supporting both children, during the period under review. The primary agencies involved included Children's Social Care NHS Foundation Trust, independent residential children's homes, Education, Police

Child Q

Background

Child Q was the third child born into a large sibling group. Child Q and the sibling group were parented by their birth parents and had extended family networks, inclusive of grandparents.

Child Q experienced a neglectful home environment due to a parental inability to keep the children safe, a significant history of the older siblings going missing from home, the children being allowed to wander the streets, family violence within a context of parental mental ill health and parental substance misuse. It was highlighted that Child Q also assumed significant child care responsibilities for the younger children in the family.

In 2006, Child Q and the sibling group were made subject to child protection proceedings under the category of neglect. Care proceedings were instigated and the children became subject to full care orders.

Initial attempts to place the children together were unsuccessful resulting in Child Q being accommodated by the Local Authority separately. Permanency was not successful and Child Q was frequently moved between foster carers, eventually being placed in a specialist residential children's home.

Child Q could at times present with significant behavioural difficulties, which was considered to be an effect of living with long term abuse and neglect, insecure attachments, loss and bereavement and placement instability

In December 2014, Child Q was looked after in a cross boundary local authority area independent specialist multi occupancy residential children's home. Child Q was considered to be a child at risk of CSE, due to increasing missing from care episodes and inappropriate internet use. There was regular contact and close communication between the Police and the residential Care Workers to manage the risk.

Time period of review

The panel agreed that the period under review would be from January 2013 to February 2015 on the basis that this timeline encompassed significant events and themes.

Events giving rise to the serious case review.

In February 2015, Child Q had a first missing episode overnight. It was not known at that point the child had stayed at the home of a registered sex offender.

The following weekend, Child Q went missing from care again, staying at the home of the same offender. Child Q later disclosed a serious sexual assault had occurred during the second missing episode.

Child Q had been taken to a local roller skating rink by residential care staff and left to enjoy the activity. The care staff arranged to pick the child up at an agreed time. Child Q did not want to "*stand out"* as being different from the other children attending the activity. It was not unusual for children roller skating to be left and picked up later by their parents. The carers had to balance the child's wishes with the risk of another possible missing episode. The carers stayed in the vicinity of the roller skating rink, rather than inside the building. Child Q rang the carers, asking to be picked up earlier than the agreed time. The carers duly arrived and were informed the child had left ten minutes previously.

The Police's expectation was that Child Q would not be left unsupervised, as part of the risk management strategy.

Following an immediate local search by the carers, the Police were informed. They graded the missing child as 'high risk.' Immediate enquiries to trace Child Q ensued. These enquiries led to ultimately to the arrest of a known registered sex-offender. Further enquiries Child Q being traced to a friend's home, in a bordering local authority area.

Child Q had been missing from care for 42 hours 45 minutes, having spent the two nights at the home of a registered sex-offender. The offender had given Child Q alcohol and cocaine and "*had made threats to get and kill"* the child in the event of disclosure. The offender was convicted in respect of the assault.

On-going enquiries identified that Child Q had been communicating with other adults, on social media sites, across the United Kingdom and that this communication involved sexualised chat. Further convictions have been secured against other non-related adults in respect of these offences.

Child Q is now placed in a stable environment with two carers. The child is now reported to be gradually responding to the behaviour management strategies and care arrangements that have been developed to support the child.

Child Q has developed a positive relationship with the key, experienced Social Worker who has been consistently allocated to the case worker since December 2012.

Conclusion

The review considered whether the events leading to Child Q becoming a victim of CSE could have been predicted or prevented.

The key trigger event identified Child Q was left alone at an external activity, despite the high risk of CSE. At the time workers had to balance the child's wishes, the legislation regarding restricting a child's liberty with the risk of CSE. The workers knew the child was at high risk and had to make a difficult decision in light of the child's wishes not to be seen as different from the peer group.

The review considered whether the LSCB can be assured that we protect children at risk of CSE when placed outside the borough. The review found there were good multi-agency communications and partnership working across boundaries, information sharing was generally positive.

Both areas had established CSE teams to coordinate cases and support the management of risk. Support and learning opportunities were available for the workforce. In this case the cross boundary authority had established respected and nationally accredited systems for the management of CSE.

The review concluded that the possibility of Child Q becoming a victim of CSE was potentially predictable but at the time not preventable. There is not one identifiable factor/event that could have led to CSE from being prevented.

The outcome for Child Q was due to an accumulation of negative life experiences and long term abuse/neglect. This resulting in the child developing strategies and behaviours to cope with day to day life. Ultimately these behaviours placed the child at significant risk from sexual predators determined to abuse Child Q through CSE.

Child S

Background

Child S was an only child and lived with the child's mother. Child S's birth parents separated in the child's early years. Child S resided with the maternal grandma and mother until 6 years of age. The maternal grandma was a significant carer for Child S in the early years.

Child S was 6 years of age when the child and mother moved out of the family home. This coincided with a number of significant family events including; two significant family bereavements, the maternal grandma went missing for approximately one year and Child S's mother also spent some time away in prison.

Child S suffered enduring and long term neglect combined with inadequate care and poor parenting. The child regularly disclosed an insufficient food supply at home and a chaotic environment. There were significant challenges in securing Child S' attendance at school, despite intervention by professionals in Child S's Primary School.

Child S's attendance and presentation at Secondary School deteriorated. The school continued to provide additional support for Child S and regularly contacted multi-agency professionals and Children's Social Care expressing concerns for the welfare of the child.

Child S was regularly reported missing from care, school and home. This pattern of behaviour escalated when the child became accommodated as a looked after child, with increasing and longer missing episodes including overnight. Between 2013 and 2015, Child S was subject to monitoring and intervention by multi-agency services due to escalating child concerns.

Early in 2015, Child S became subject to child protection proceedings and a child protection plan was formulated under the category of neglect. In mid-2015, interim care proceedings were instigated resulting in Child S becoming subject to a full care order a few months later and accommodated in a series of foster care placements and residential children's homes locally and in cross boundary areas.

In November 2014, a referral was made to the local, newly established, specialist CSE team. However, the risk was assessed as low and the case closed following a referral to Barnardo for therapeutic work.

In May 2015 another referral was made to the specialist CSE team; however the risk of CSE was again assessed as low with a referral to Barnardo to be considered. In July 2015 a further referral was made to Barnardo for support.

Time period of review

The panel agreed that the period under review would be from November13 to January 2016 on the basis that this timeline encompassed significant events and themes.

Events giving rise to the serious case review.

In December 2015, Child S was placed in an out of area placement but went missing two days later. Child S was not found until 10 days later, however went missing again the same day. Child S was then not found for another 8 days, despite a national alert and media reporting.

A legal planning meeting was held which considered both residential and secure accommodation, it was agreed that residential care with appropriate safeguards was the preferred option. This incident was assessed as a CSE incident due to the previously known risk factors, previous intelligence about the parties involved and concerns that a male had seen Child S whilst knowing the child was missing from care.

Whilst there have been criminal investigations in respect of potential offenders, there have been no disclosures made by Child S and no convictions secured in respect of potential offences against the child. Child S does not perceive that they have been a victim of CSE, believing that all activities were consensual and within the range of activities for all young people.

Child S is now placed in a specialist residential children's Home with care and educational facilities. Child S has been assessed psychologically and is responding well to the behaviour management strategies, developed as a result of this assessment.

Child S is responding well to the care plan and there have been no recent concerning incidents or missing events. Placement stability has been achieved and Child S has been able to maintain some level of contact with family members as part of the care plan.

Child S has also been able to develop a positive relationship with the allocated LAC Social Worker who has been consistently allocated since Child S became looked after in May 2015.

Conclusion

The review considered whether the events leading to Child S becoming a victim of CSE could have been predicted or prevented.

The child was assessed to be a victim of CSE because of previously known risk factors, the degree of missing episodes, previous intelligence about the parties involved and concerns that a male had seen Child S whilst knowing the child was missing from care. It has been evidenced that during the review process all multi-agency professionals have had development opportunities, understand the changing landscape and the policy development in respect of local CSE arrangements.

A significant factor was that Child S had lived with escalating levels of neglect and this was known to services, for at least 6 years, before any effective intervention was undertaken. The child then became subject to statutory processes and proceedings.

The early intervention processes around the Common assessment framework (CAF) should have been more effective to avoid the child's experience of neglect becoming entrenched. There was a reliance at times on children's social care to lead the CAF process, when multi-agency partners should have been able to undertake the function.

Professionals remained child centred, irrespective of the child's behaviours. They communicated with and endeavoured to ascertain the child's views and wishes.

Multi-agency partnership work was good especially when child protection and care proceedings were instigated. Practice guidance was followed and there was positive evidence of effective communications between partners. The management of missing episodes was well coordinated despite the challenges in recovering the child in late 2015. The specialist team for CSE was evolving during this period and was effective in providing leadership in the management of the case

There is significant evidence that despite the challenges in communications across local authority areas, the multi-agency services were able to work together effectively. The Children Looked after Social Worker and the Police were particularly effective in the coordination of communication and information sharing across the areas which enhanced the quality of intervention for Child S.

The review concluded that the possibility of Child S becoming a victim of CSE was potentially predictable but at the time not preventable. It could not be certain that had early intervention been more effectively implemented CSE would have been prevented. However, if intervention had been implemented and the outcomes evaluated the impact of neglect may have been minimised thereby reducing the risk of CSE.

FINDINGS

The review identified number of findings, where lessons can be learned across agencies on how we safeguard and promote the welfare of children in Knowsley in respect of CSE.

They have been summarised under two headings 'learning' and good practice and are summarised as follows;

Child Q: Good Practice.

1. Child Q was allocated an experienced Social Worker who has remained the key worker during the time scale of the review and during the recovery period following the trigger event. This has been supportive to multi-agency arrangements and provided a consistent professional with corporate parenting responsibilities for Child Q. This has been commended by multi-agency professionals.

2. The Social Worker was commended by multi-agency colleagues in attempts to share and coordinate information sharing with multi-agency colleagues across Local Authority boundaries.
3. The Independent Reviewing Officer offered scrutiny, expertise, case knowledge, positive leadership and constructive challenge. This was commended by multi-agency partners.
4. Multi-agency strategic leadership oversight and scrutiny of the case which was commended by frontline practitioners and line mangers as extremely supportive. This process should be strengthened to become a feature in the multi-agency management of complex cases.
5. The residential care staff maintained a focus on the child despite the significant challenges presented, line management focussed on supporting and developing resilience in the staff group recognising the unique challenges this case presented in the delivery of care pathways. This led to improvements in the child's behaviour.
6. The key Social Worker was commended by multi-agency practitioners in the coordination of multi-agency cooperation across the boundaries.
7. The Residential Care Workers across the areas were focused on Child Q needs and continually aspired to provide a caring, nurturing home environment to meet the child's complex needs.
8. The impact of bereavement on Child Q was acknowledged by Residential Care Workers who anticipated the potential impact on Child Q's emotional presentation and planned special activities with the child to acknowledge the event.
9. The Primary School were able to provide an environment that enabled Child Q to form positive and constructive relationships with the adults providing the service.
10. The decision to commission an Independent Expert Psychologist and Systemic Psychotherapist was a positive new initiative and supported the workforce to develop new confidence and skills when managing children with challenging behaviours. This development should be enabled to evolve.
11. The organisational assurance system for the management of restrictive practices when working with children in Residential Children's Homes was well organised with clear organisational reporting systems and independent scrutiny.
12. The Police were able to provide significant assurance that the process for monitoring registered sex offenders has evolved over a period of 10 years and is in line with expected practice.
13. The Police were effective in offender disruption and secured a range of convictions in respect of offences related to CSE**.**
14. The Constabulary across all areas prioritised and were effective in recovering Child Q during reported missing from care episodes.
15. The Police demonstrated good insight by using professional judgement in tandem with a standardised tool used for the assessment of CSE. The tool's assessment outcome indicated the case could be de-escalated however the use of professional judgement enabled the case to remain open.
16. The transition to Secondary School was well managed and on a daily basis the Residential Care establishments and Education establishments would ensure that relevant information was shared to ensure coordination and consistency in care planning.

Child S: Good Practice

17. The LAC social worker enhanced multi-agency professional's management of the case, through effective family communications which enabled greater insight into the root causes of the neglect issues and enhanced information sharing and communications.
18. The Primary School were very child centred and provided a very nurturing environment for Child S and then supported the transition into Secondary School
19. In 2014/15 the local Secondary School was very proactive in securing an early positive relationship with Child S, providing for the child's basic needs and following child protection procedures within multi-agency communications.
20. Multi-agency practitioners highlighted the stability of the social work workforce during the preceding 6 months and that this had a positive impact on frontline multi-agency safeguarding practice.
21. The Child Protection pathway was robust and implemented according to the expected pathway when the decision to proceed to case conference was agreed. The risk of significant harm was recognised through effective assessment.
22. The Children's Social Worker and the Constabulary worked clearly, directly and constructively with family members who were thought at times to be harbouring Child S and used legal powers to enforce this as necessary. This was a new initiative which possibly encouraged the family to work to recover Child S on occasions.
23. Whilst living in one local authority area, Child S experienced a period of stability. Agencies worked together well across the boundaries. The experienced Foster Carers were successful in containing Child S, improving school attendance, encouraging friendship groups and activities. The school quickly developed a plan of support to improve the child's educational attainments and support integration into the school.
24. There was evidence of constructive challenge between key agencies when managing the placements for Child S, high level strategic support was evidenced and the Local Authority were clear in their position regarding the preferred placement for this age of child.
25. The missing from care/home/education processes were frequently effective in recovering the child, the Local Authority and the Constabulary followed expected practice and were creative in using every strategy possible within the confines of legislation to secure the child's recovery.

Child Q: Learning Points.

All agencies should consider the following learning points to strengthen multiagency safeguarding practice when working with CSE. Guidance is offered is respect of key agencies with responsibility for the learning point.

1. The LSCB should evaluate on an ongoing basis the learning needs of multi-agency practitioners in relation to the changing national definitions of what constitutes CSE and receive assurance that emerging national CSE guidance is reflected in updated strategy.

2. The LSCB should audit the effectiveness of learning summaries when collating evidence for serious case and other reviews to ensure multi-agency partners contribute effectively to the process.
3. The practitioner events/conversations would be enriched by the participation of Education Professionals and Foster Carers. Their attendance at future events should be encouraged to enrich the learning from such cases.
4. The LSCB should be assured that professionals with responsibility for the health of LAC are invited to participate multi-agency care planning meetings and that a summary of the child's history is provided when new professionals join either review process.
5. The LSCB should be assured that the NHS has effective arrangements for transferring the health of LAC information across NHS boundaries. This could be evidenced through audit processes.
6. The LSCB should be assured that the focus on the implementation of the neglect strategy is maintained in order to influence front line practice and improve the short and long-term outcomes for children living with the experience of neglect.
7. The LSCB should be assured that the safeguarding pathways are clarified and local CSE data is consistently collated and evaluated to inform the commissioning of multi-agency services for children at risk of or subject to CSE. Does the LSCB currently have an overview on the extent and scope of the issue locally and nationally through problem profiling?
8. The LCSB should be assured that Secondary School provision is sufficient for local children exhibiting extremely challenging behaviour, recognising that the behaviour may improve as the child's daily experience of life improves to reflect that of other children who experience positive parenting and stability.
9. The LSCB should be assured by the Local Authority that placement planning will continually assess the child's presentation and re-consider placement plans if during the planning phase improvements are recognised.
10. The LSCB should be assured by the Local Authority that the opportunity will be given to enable children, at high risk of CSE to be placed with specialist foster carers, who are adequately trained and are able to build a safe and trusting relationship with the child. Commissioning arrangements should be strengthened to secure the availability of such places.
11. The LSCB should be assured that the pathway into CAMHS services for children in specialist placements are clarified. This will ensure multiple interventions are not implemented causing confusion for the child and that the thresholds for accessing CAMHS are clear for independent specialist providers already providing commissioned psychological/mental health care.
12. Is the LSCB assured that the psychological/mental health services are sufficiently resourced to provide research based trauma interventions for victims of CSE and expert consultation opportunities for front line carers?
13. The LSCB should be assured that the organisational staff care systems are sufficiently robust to support practitioners who are traumatised/anxious whilst working with children exhibiting challenging behaviours.
14. The LSCB should be assured that all organisations have an assurance system in place to provide confidence that the use of restrictive practices/restraint techniques are monitored, appropriate, consistently applied and in line with national expectations

when managing challenging behaviours in the child population. The scrutiny of these arrangements should have clear organisational reporting pathways.

15. The LSCB should be assured that the Local Authority and its commissioned provider units seek legal advice, reviews policies, procedures and practice guidance in respect to restricting a child's liberty to prevent further harm in line with emerging case law.

16. The LSCB should be assured that the Police investigate the opportunities to track local children across areas to support the assessment of missing from care episodes and more effectively manage the risk of CSE in the local child population.

17. The management of risk in cases with features of CSE is led by the specialist CSE multiagency team. Multi-agency partners should reflect on and understand their responsibilities within the plan and constructively challenge should the expectations of their service be unrealistic.

18. The LSCB should be assured that the Local Authority is responding to case law and guidance in respect of children looked after being deprived of their liberty. Consent to the deprivation can only be secured via a High Court ruling for children under the age of 16 years. Staff caring for LAC should be aware of the ruling and be provided with development opportunities in relation to deprivations that reduce the liberty of children when looked after.

19. The search for hidden mobile devices could be improved with the use of up to date information technology software. All practitioners living with and caring for children at risk of CSE should have access to and be competent and updated in the use of such software.

20. The LSCB should be assured that the NHS monitors the use and impact of restrictive practices when children attend for treatment. The use of physical restraint should be subject to organisational and external scrutiny and reporting. A key question is; do NHS organisations have the required assurance systems in place to safely manage the physical restraint of children and is the data subject to organisational scrutiny and analysis?

21. The LSCB should be assured that the NHS provides adequate development opportunities for the professionals who undertake health assessments on children who are looked after and/or have complex needs. Professionals should be trained and competent to undertake this work

22. The LSCB should be assured that the NHS reviews the capacity of the relevant services to ensure the health contribution to multi-agency arrangements relating to children looked after.

23. The LSCB should be assured that the NHS clarifies the contribution by General Practice in safeguarding and child review processes (in relation to the disclosure of relevant personal and sensitive medical information). Whilst this is a local issue it is also reflective of national discussions. Clarification should be sought from NHS England and or the Royal College of General Practitioners.

CHILD S: Learning Points.

24. The LSCB should be assured that Children's Social Care information system is able to collate a chronology of historical significant events to support information gathering for ongoing risk management, assessments and interventions. This is an action in the improvement plan.

25. There is a range of multi-agency, independent, statutory, voluntary services and adult services involved in the provision of services to children and families with complex safeguarding issues. It is crucial that their views contribute to the statutory and early intervention care planning and delivery processes.

26. The LSCB should be assured that the thresholds between CAF and CIN are understood in respect to practice and pathways. A threshold document has recently been produced and a work plan established to manage this issue.

27. Children who are at risk of or have experienced CSE should have access to early trauma based interventions to improve psychological outcomes. Professionals engaging in 1:1 work with children at risk of CSE should have the capacity, training and supervision to undertake such specific and bespoke work.

28. The placement of a child with family members should be subject to accurate assessment of the capacity of the carers to provide a stable and nurturing environment for the child.

29. In 2014, there were missed opportunities to refer Child S for child protection concerns. Services in daily contact with a child living with neglect may be required to "*nurture"* the child however the assessment of risk needs to be ongoing with the assessment of the provision of support and care to the child. There is a risk that the child's experience of abuse and neglect may become hidden and the accurate assessment of the child's experience and presentation are not documented, analysed or shared.

30. The LSCB should be assured that all multi-agency partners meet their obligations to ensure their workforce has the development and capacity to provide early intervention through the CAF process.

31. The LSCB should be assured that all multiagency partners understand and can escalate their concerns through the local managing case disagreement guidance.

32. The LSCB should be assured that the multi-agency supervision systems are sufficiently robust to identify cases of neglect that are drifting in universal and early intervention levels of concern.

33. The LSCB should be assured that effective assessment of the parental capacity to change is undertaken and that the Adult Services (e.g. drug and alcohol, housing, probation) are participative in early intervention processes when both the children and adults have significant vulnerabilities, to ensure single assessment process and joint planning for intervention and services.

34. The LSCB should be assured that multi-agency safeguarding supervision systems considers the worker/client/parental relationship and uses analysis to identify family strengths and weaknesses in practice.

35. Currently local Police systems do not always receive missing intelligence from cross boundary Police Forces in relation to children who go missing when placed in other cross boundary areas. It would be beneficial if the local systems enabled this information to be shared.

36. The LSCB should be assured that the Local Authority considers the development of "trigger plans" when working with children at high risk of CSE to manage the missing episodes and potential placement breakdown.

37. The LSCB should be assured that post the de-commissioning of Barnardo within the specialist CSE service the alternative provision is quality assured and is able to offer the necessary expertise.

38. The threshold for case management by the specialist CSE team should consider those children whose risk taking behaviours, parenting and environmental factors place them at significant risk of CSE and support the development of targeted individualised early intervention plans.

Recommendations

The LSCB should be assured that:

1. Evaluate on an ongoing basis the learning needs of multi-agency practitioners in relation to the changing national definitions of what constitutes CSE and receive assurance that emerging national CSE guidance is reflected in updated strategy.
2. Audit the effectiveness of learning summaries when collating evidence for serious case and other reviews to ensure multi-agency partners contribute effectively to the process.
3. Develop the practitioner events/conversations to ensure the participation of Education Professionals and Foster Carers. Their attendance at future events should be encouraged to enrich the learning from such cases.
4. Encourage the full participation of all relevant multi-agency partners in safeguarding work. There is a range of multi-agency, independent, statutory, voluntary services and adult services involved in the provision of services to children and families with complex safeguarding issues. It is crucial that their views contribute to the statutory and early intervention care planning and delivery processes.
5. Be assured that partner agencies have considered the learning for their agency from the relevant identified good practice and developed improvement plans in response to the relevant learning points contained within this combined overview report.

The Board accepts the findings of the review and is committed to learn from the lessons, which are identified in the report