

Child B Serious Case Review

Findings and recommendations

Introduction

There is a requirement to publish serious case reviews in full. However, in this case the City of York Safeguarding Board (CYSCB) has decided against publication in order to protect Child B's welfare. Despite this, the CYSCB is committed to ensuring the lessons are disseminated and learned.

The case centres on a young person whose behaviour placed them at significant risk of harm of being sexually exploited. The young person was known to a range of agencies although despite evidence of significant harm the case was managed as a child in need of support rather than a child in need of protection. As such, the response failed to prevent ongoing harm to the young person.

Whilst all attempts have been made to anonymise the young person's identity, the CYSCB requires that the information is treated as sensitive and must only be used for the purpose of learning and improving practice.

Summary of conclusions and recommendations

"It could not have been predicted by any agency or individual who knew Child B that she would be the victim of sexual exploitation. However, given her background and the presenting issues which became evident during her adolescence it was predictable that she was vulnerable and at greater risk of abuse."

Key findings

Voice of Child B

Given Child B's age and level of understanding at the time, it is surprising that her expressed fears [redacted] were not explored more fully. Whilst these comments were recorded they were not shared across agencies and opportunities for assessment were missed.

Good Practice

It is important with any review that we learn from good practice as just much as from shortcomings. The following areas of good practice are identified:

- The school showed an awareness of Child B's needs and quickly acted upon concerns about her welfare throughout her time at the school.
- Health practitioners at a service attended by Child B identified concerns and referred these appropriately, supporting Child B in this process and following up contacts.
- School health practitioners responded appropriately in passing on information to a colleague who, in turn, demonstrated good practice by gathering relevant information from multi-disciplinary colleagues before meeting with Child B and, upon meeting with her, identified needs and followed these up with support.

Involvement of Relevant Agencies

- Practitioners did not have the specialist knowledge needed to progress the case effectively. As a result, information was not always being passed to Children's Social Care and also led to delay in the police taking action.
- There was evidence of failures to pass on information, or that the information was not passed on in a timely manner. As a result, key agencies were not kept informed or involved.
- There was a failure to 'step the case up' to a child protection level when the opportunity arose despite a number of referrals from different sources. As a result key relevant opportunities for assessment and decision making were missed.

Policy Framework

Whilst the concern related to concerns of child sexual exploitation, had the child protection procedures been invoked at an earlier stage they would have created an appropriate framework for practice in this case.

The Child Sexual Exploitation Procedures, which were close to implementation at the time, were sufficiently robust to have rectified the problems with the approach taken. However, these were not followed as they had not been publicised and there was insufficient knowledge about them within relevant organisations at the time. Arguably, the draft procedures alongside statutory guidance and other publications and research should have informed the approach of agencies if staff were aware of them.

Assessments and decision making

There were times when decisions were not reached in an informed way. At times the threshold for a social work assessment was met with evidence that Child B was suffering or at risk of significant harm. As a result the core assessment and subsequent work under child protection or child sexual exploitation procedures did not follow. Consequently, agencies dealing with Child B failed to obtain an in depth picture of Child B and her family and how they functioned.

Services Offered

Appropriate services were not always offered and relevant enquiries were not always made. Although the level of risk to Child B was partially understood in the initial assessment the weighting attached to the risk was insufficient, and consequently the response was inadequate.

Additionally, professionals were not sufficiently responsive to issues arising from high risk sexual behaviours and child sexual exploitation.

Interface with Children's Social Care

When agencies communicated with Children's Social Care, they were not always sure how their information was being dealt with.

The team who received the calls were sometimes giving advice and not keeping a running record of events as the procedures require.

There was also insufficient clarity for some referrers who wanted to know their calls were being treated as a child protection referral.

Strategy meetings

Three strategy meetings were held under the CYSCB's draft child sexual exploitation procedure in relation to Child B which did not always involve all relevant agencies. Most of the meetings did not include the views of Child B or her parents and some meetings did not identify specific actions or timescales. These issues combined greatly affected the strategy meeting's ability to have a positive impact.

The minutes of meetings were not recorded on the children's social care electronic recording system, nor were they added to the children and young person's record. This meant that when there was a change of social worker it was not easy for them to understand the plan and decisions that had been made.

Procedures

One health provider did not record the cumulative total of Child B's attendances at that department. Instead, only the annual total was recorded. If this information had been completed it would have revealed an unusually high pattern of attendance. This would have potentially been an issue to be referred to Children's Social Care and to Child B's GP. Significantly, this GP never knew of Child B's sexual exploitation due to lack of information sharing from other parts of the sector or other agencies.

Challenge

There were occasions when health professionals questioned the adequacy of the approach taken by Children's Social Care and the police, but did not challenge this on the assumption that these agencies knew best. It is accepted that challenge across disciplines and across levels of seniority is difficult and it is important to be realistic about what is to be expected of staff in this regard. However, there were formal routes to affect this challenge via safeguarding leads and managers which were not used.

Communication

There were elements of effective inter and intra-agency work and these provide valuable learning for agencies. For example:

- evidence of a high standard of communication within one of the health providers used by Child B;
- good communication between some services and Children's Social Care; and,
- appropriate referrals from practitioners to other support and specialist services.

However, information was not always shared both within and across agencies and there are lessons to be learned including:

- Agencies working with Child B were not always invited to, or were not represented at, multi-agency meetings;
- Referrals to services did not always include the fullest information to enable the service to understand their role;
- Services did not always follow up referrals appropriately, e.g. when a service found it difficult to engage with child B, they did not liaise with colleagues elsewhere;
- Key pieces of information, or details of reported incidents, were not passed on to colleagues or services, or did not lead to the appropriate checks being carried out, e.g. with police and/or Children's Social Care; *and*
- Relevant information from the family history which would have informed multi agency decision making was not shared. This, alongside Child B's own disclosures, may have prompted early intervention in her case.

Taking Advice

Some professionals had safeguarding leads available to them for advice and support and these were not always utilised or were utilised too late. In other cases safeguarding teams did not offer reflective supervision at appropriate points. In view of some unique features with the case such oversight would have been beneficial.

Implementation of learning

It is pleasing to note that learning has already been implemented across agencies in relation to some of the issues raised by Child B's case:

The CYSCB Child Sexual Exploitation Procedures have recently been amended and now appear on the City of York Safeguarding Children Board website.

City of York Council Children's Services have:

- Taken steps to ensure that all open cases have an up to date child plan in place;
- Implemented new processes for managing child in need cases;
- Reviewed and restructured the children's advice service and the daily meeting system and implemented formal reflective supervision processes for children's advice workers; and,
- Increased the level of awareness of child sexual exploitation cases since child B's case, and the teams understand they are to be dealt with under child protection procedures.

North Yorkshire Police have:

- Appointed an ACPO Lead (Association of Chief Police Officers) for child sexual exploitation and delivery of the recently published ACPO national plan to tackle child sexual exploitation;
- Adopted child sexual exploitation as a strategic priority in their force operational plans.
- Launched Operation Conceal, to promote early identification and intervention to child sexual exploitation;

- Introduced a Victim Location Offender Triangle, which is reported to have resulted in faster progression of cases and earlier escalation;
- Established, lead and chair multi-agency meetings every 2 months to identify children for whom a multi-agency response is needed, share intelligence and prioritise those cases in greatest need;
- Purchased a training package to be run in schools to highlight the keeping safe message;
- Developed a Missing From Home leaflet for use by officers who attend such incidents including a tear off slip for parents with advice on what to look for to identify a child at risk; and,
- Equipped all officers with an aide memoir with signs to identify a child at risk.

The Multi-Agency Safeguarding Hub (MASH)

The MASH initiative is of particular note. Plans are at an advanced stage to co-locate police and Children's Social Care within the same premises in York city centre. This approach will allow for joint daily management and information sharing where all agencies are present to consider cases, assess risk and provide a safeguarding response. In addition, live time information sharing and joint tasking of resources will be more streamlined and specialist knowledge of the co-located service will be improved for the staff involved.

Recommendations

Recommendations for LSCB

Recommendation 1

The City of York Safeguarding Children Board should establish a vulnerable adolescent's sub-group to develop and ensure implementation of the child sexual exploitation procedures.

This action should be backed by the Board ensuring there is a dedicated lead in each agency responsible for implementation of the procedures by 1st July 2013.

Recommendation 2

The City of York Safeguarding Children Board Child Sexual Exploitation Stakeholder Group should monitor compliance with the Child Sexual Exploitation Procedures for identification and intervention.

Recommendation 3

The LSCB Independent Chair should write to the Chief Constable of North Yorkshire Police by 1st April 2013 requesting that all cases involving a child or young person be dealt with by a specialist team of officers with appropriate safeguarding knowledge.

Recommendation 4

The LSCB Independent Chair should write to the Chief Executive of York Hospital Foundation Trust requesting assurance that the proposed escalation policy and flow chart will be completed within 3 months of the submission of the overview report.

Recommendation 5

The City of York Safeguarding Children Board should monitor the outcome of the review of the 'front door' of children's social care, notably the report on the Children's Advice Team being produced in February 2013. Monitoring should focus on whether proposals serve to improve the understanding and confidence of partners in the 'front door' of children's social care by providing clarity.

Recommendation 6

The City of York Safeguarding Children Board should monitor the plans to form a Multi-Agency Safeguarding Hub (MASH) with a view to ensuring its approach to daily meetings is maintained in addition to meetings undertaken by the Children's Advice Team.

Recommendation 7

The City of York Safeguarding Children Board should review its process for resolving disputes and professional disagreement in the light of the issues that have arisen in this review by 1st October 2013. The Board should consider what changes if any should be recommended to policy and how the policy should be disseminated to relevant practitioners.

Recommendation 8

The City of York Safeguarding Children Board should take account of the learning points within this Serious Case Review and ensure that they are incorporated into multi-agency training or dissemination events to engage as wide a range as possible of appropriate professionals across agencies. The training should incorporate:

- Use of in depth assessment to assess at an early stage vulnerability and risk in cases like that of Child B
- Issues of identity should inform assessments of children's needs and how services will meet these needs
- Remind all agencies of local and national guidance on information sharing and safeguarding children
- Clarity regarding the status of and framework for multi agency meetings
- How to resolve professional differences of opinion that impede safeguarding arrangements
- Ensuring that where a child is advised to attend emergency departments they have the means to do so

- Reminder of the importance of referral to children’s social care and clarity regarding how those referrals will be dealt with

Recommendations for Individual Agencies

These recommendations are the responsibility of the IMR report authors and are reproduced here for convenience. The following recommendations have been accepted as SMART by the senior officer signing off the IMR report on behalf of each agency.

Children’s Social Care

- Ensure the thresholds for the escalation of cases from advice team to the assessment team are appropriate and are consistently adhered to.
- Ensure the existing performance framework is fit for purpose and is being adhered to by managers and staff.
- Strengthen the current arrangements for communicating new policies and procedures in Children’s Social Care.
- Ensure staff and managers working in Children’s Social Care have the necessary level of knowledge and understanding of safeguarding issues to equip them to carry out their professional roles.
- Ensure a system is in place to record and identify all cases of CSE and carry out an audit of practice in 2013.
- That single agency training in respect of CSE is commissioned and priority is given to advice workers, front line assessment workers and managers.

York LSCB (arising from the IMR)

- Conducting strategy discussions or chairing of strategy meetings should be undertaken by a professional from Children’s Social Care.
- Strategy meetings under Child Sexual Exploitation procedures should always ensure that there is attendance (or information available) from other key

agencies, in particular health services and education providers (schools/ colleges). All agencies should be reminded of their duty to participate in Strategy Meetings where required.

- The CYSCB Child Sexual Exploitation Procedure should be amended in reference to the Strategic Management Group to state 'the group should also include the following members as necessary; LSCB legal adviser, senior health representative, press officer, other individuals as appropriate, specialist voluntary agency.
- Strategy meetings should record the chair of the meeting; those invited but did not attend, and contain all agreed actions with specific allocated responsibility and timescales. A clear differentiation should be made between an agreed action and an agreed recommendation.

Police

- All officers who have not worked in a protecting vulnerable person's environment to be trained in relation to safeguarding children with a particular focus on the need to make referrals to the Protecting Vulnerable Persons Unit and to Children's Social Care. Such training will be repeated over a 12-18 month period to take account of staff turnover and recruitment.
- All staff attending strategy meetings will be aware of the need to set accurate and realistic timescales for partner agencies and police alike, during strategy meetings. This will avoid confusion and ensure timely actions are agreed between agencies.
- Ensure accurate recording of risk assessments in relation to children reported as missing from home together with rationale and details of those consulted.

Education

- All schools should instigate an immediate review of the quality of its record keeping ensuring that the written records clearly and precisely record the actions taken by the school.
- All schools should arrange further staff training on spotting the indications of sexual exploitation and abuse.
- All schools should review their SRE programme to ensure that it develops young peoples understanding of appropriate relationships to prevent sexual exploitation.
- All schools should review their systems for calling for and passing information to other schools and agencies to ensure that information is shared appropriately between agencies.

Child and Adolescent Mental Health Service (CAMHS)

- All CAMHS clinical staff to be familiar with the Child Sexual Exploitation guidance to the LSCB to which they are affiliated.
- All information relating to the service users care must be held within one electronic or paper record. The record must contain details of action plans after all contacts, meetings and supervision relating to that service user.
- The identified area in the records in which to record racial, cultural, linguistic and religious identity and any issues of disability must be appropriately utilised by all staff, and these questions asked of every service user.
- CAMHS to review ways in which a child can be engaged or kept informed of any visits with other family members that take place in their absence.

Commissioners of GP Services

- The GP medical should always evidence that the GP has ascertained whether a child caller has the ability to travel to the accident and emergency department, if this is the recommended course of action.
- All GP out of hours consultations involving deliberate self-harm by children must record whether an adult, parent or carer is with the child and has also discussed concerns with the GP.

Hospital

- York Hospital Foundation Trust (YHFT) will ensure that level 3 training includes further information and guidance on when to and when not to inform young persons or their families that a referral to CSC is being made. This training should be consistent with the procedure on Referrals to Social Care Appendix 5.
- YHFT will take all necessary action to ensure that; when advice and/or supervision is given to less experienced staff by Team leaders (and equivalent) or the Safeguarding Team on the management of an active child protection case that (1) a written record is made (2) all necessary actions and timescales are agreed and recorded and (3) a suitable review date is agreed.
- That YHFT will take all necessary action to ensure that (i) health staff are trained to recognise when a child remains at risk of abuse or neglect despite multi agency involvement (ii) recognise when it is necessary to 'challenge' other agencies, and develop policy, procedures and training that ensures that when the need for challenge is recognised the Named Nurse or Named Doctor is informed.
- That YHFT will take all necessary action to ensure that following a telephone referral to Children's Social Care, timely written referrals are made and ensure that staff understand why this is important.

Health Overview Report

- YTHFT and the Leeds Partnership Foundation Trust (LPFT) will (a) ensure that all staff working with children, young people and their parents and carers are made aware of the CYSCB Resolution of Professional Disputes Procedure, and (b) amend their level 3 Safeguarding Children Training to ensure that the importance of and support for professional challenge is included in that training.
- Commissioners of GP out of hours services to review their service specification to ensure where a child or young person is advised by that service to attend the local hospital emergency department, the out of hours service ensures that an adult is present and agrees to take that child or young person to the emergency department, and also alerts the emergency department to expect the child within a specific timeframe.
- YTHFT review their Safeguarding Children procedures to ascertain whether they are clear enough regarding action to be taken on disclosure of potential or actual risk of significant harm made by one child regarding another child.
- Designated Nurse for Safeguarding Children to write formally to the CYC Interim Operations Manager to highlight the infrequency with which appropriate health professionals are invited to Strategy Meetings and Child in Need Planning Meetings and ask for this to be addressed within the Children's Advice and Assessment Team processes.
- All health service providers who have contributed to this SCR to remind all relevant professionals of the importance of recording that consideration of a patient's racial, cultural, religious, linguistic and disability needs have been considered by the professional working with the patient.
- Work to be initiated by YTHFT to engage CYC Children's Social Care senior managers, aimed at improving the culture of professional respect and balance of authority between community nursing staff and CYC Children's Social Care professionals.

- Designated Nurse for Safeguarding Children to request the CYC Children's Social Care interim manager for operations that health professionals can make child protection referrals to Children's Social Care, rather than such referrals being classed as contacts by CSC.
- Designated Nurse for Safeguarding Children to write to the YPSHOT Nurse, school nurse for Child B and GP to highlight their good practice identified in this case, ensuring that their Director also receives a copy of the letter.